Robert A. Barton
Inspector General

Office of the Inspector General

California Health Care Facility
Medical Inspection Results
Cycle 4

April 2017

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

Office of the Inspector General
CALIFORNIA HEALTH CARE FACILITY
Medical Inspection Results
Cycle 4

Robert A. Barton
Inspector General

Roy W. Wesley
Chief Deputy Inspector General

Shaun R. Spillane
Public Information Officer

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TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

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 California Health Care Facility (CHCF).

The OIG performed its Cycle 4 medical inspection at CHCF from July to October 2016. The inspection included in-depth reviews of 76 patient files conducted by case review clinicians, as well as reviews of documents from 426 patient files, covering 92 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 CHCF using 14 health care quality indicators applicable to the institution, made up of 12 primary clinical indicators and two secondary administrative indicators. To conduct clinical case reviews, the OIG employs a clinician team consisting of a physician and a registered nurse consultant, while a team of deputy inspectors general and registered nurses trained in monitoring medical compliance does compliance testing. Of the 12 primary indicators, 7 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. 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 CHCF was ***adequate***.

Health Care Quality Indicators

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

Overall Assessment Rating:

Adequate

Based on the clinical case reviews and compliance testing, the OIG's overall assessment rating for CHCF was *adequate*, barely. Of the 12 primary (clinical) quality indicators applicable to CHCF, the OIG found one *proficient*, seven *adequate* and four *inadequate*. Of the two secondary (administrative) quality indicators, the OIG found both *inadequate*. To determine the overall assessment for CHCF, 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 CHCF.

Clinical Case Review and OIG Clinician Inspection Results

The clinicians' case reviews sampled patients with high medical needs and included a review of 3,747 patient care events.[1] This number of events exceeded all other institutions reviewed in Cycle 4, with a range of 853 to 2,117 events among the other prisons. Because most CHCF patients were at high medical risk and lived in specialized medical housing units, patients had a higher occurrence of serious health care events than would typically have occurred for patients at other CDCR institutions. The complexity and medical risk were also increased for this institution.

Of the 12 primary indicators applicable to CHCF, 10 were evaluated by clinician case review; 7 were *adequate*, and 3 were *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.

Several pervasive factors contributed to CHCF's overall rating. This report's findings should be considered against the backdrop of the following conditions: CHCF is a unique institution as revealed by the medical complexity of the patient population. Other institutions throughout the state commonly transfer patients to CHCF because of the well-trained providers and ancillary staff, and the facility infrastructure that was specially designed to handle a large volume of high-risk patients. This recently built facility manages and provides the resources necessary to support medically complex patients. The staff's management of medically complex patients was generally adequate. The providers appropriately evaluated these patients and provided necessary treatments.

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

The CHCF patient population presented unique challenges to the delivery of medical care. A large proportion of the population resides in specialized medical housing. There were 12 correctional treatment centers (CTCs) and 14 outpatient housing units (OHUs). The patients in these areas were often long-term residents of the medical care facility; therefore, a modality of management was applied to patient care that contrasted with that of other institutions. This care model, while in its infancy, will need to be continually modified until an adequate workflow becomes a realization for all health care staff involved. As a patient is either admitted or transferred into a higher level of care (OHU or CTC), in addition to a comprehensive medical exam, a comprehensive rehabilitative plan needs to be formulated with the goal of returning these long-term patients to an outpatient setting, if possible. This goal should be monitored and if not met, new treatment modalities initiated. Monitoring of daily living activities should coincide with management of medical care with the goal of medical disease stabilization and the possibility of needs reduction, so patients can develop independent lifestyles within the confines of the institution.

While the overall rating for this institution was *adequate*, it was just barely passing. The high quality of medical staff employed at CHCF managed to compensate for the staffing vacancies. They directed resources and often focused care to those patients needing the more urgent care. However, the OIG identified many deficiencies during the inspection, which highlighted the strain on several systems. One example was the providers' incomplete medical record reviews due to their highly demanding workload. In addition, there was no system in place to identify and avoid recurrent medical problems. This was apparent in nursing for a patient with uncontrolled seizures and repeated falls.

The OIG's main concern was the critical shortage of providers. Medical leadership at CHCF described an inability to recruit and retain medical providers since the institution's inception. CHCF providers had difficulty providing continuity of care, resulting in failures to appropriately review medical records and delays of treatment. CHCF providers expressed concerns about provider fatigue and unsustainable work conditions resulting in several providers actively looking for employment elsewhere. CHCF's provider shortage is further discussed in the *Quality of Provider Performance* indicator.

These staffing concerns, and the other system deficiencies described in this report, raise the real possibility that this institution will not be able to sustain an adequate level of care in the future.

Program Strengths — Clinical

- Providers at CHCF gave adequate care and made sound medical decisions regarding the most complex medical patients housed in the institution.

- Most patients at CHCF required specialized housing in either a CTC or OHU. Both providers and nursing staff were able to perform adequately in these settings and provide necessary care for patients.

- Motivated administration and ancillary staff provided care in this new institution.

- The medically complex patient population received timely access to care.
- The institution's infrastructure was well built and able to sustain the medical needs of the patients.

Program Weaknesses — Clinical

- The provider staffing level was insufficient for the high complexity of patient care, and the documentation requirements of many state-mandated forms posed an unrealistic burden.
- The institution planned to activate a 60-bed palliative care unit, but did not include the assignment of a specially trained palliative care provider to work in the unit.
- Nurses performed sub-optimally with wound care.
- The institution had insufficient physical therapy staffing levels, so patients did not always receive adequate or timely rehabilitative care.
- The pharmacy at CHCF failed to account for distributed and returned medications appropriately.
- Radiology results were not tracked properly.

Compliance Testing Results

Of the 14 health care indicators applicable to CHCF, compliance inspectors evaluated 11.[2] There were 92 individual compliance questions within those 11 indicators. This generated 1,716 data points that tested CHCF's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[3] Those 92 questions are detailed in *Appendix A — Compliance Test Results*. The institution's inspection scores in the 11 applicable indicators ranged from 52.5 percent to 89.0 percent, with the secondary (administrative) indicator *Job Performance, Training, Licensing and Certifications* receiving the lowest score, and the primary indicator *Access to Care* receiving the highest. Of the nine primary indicators applicable to compliance testing, the OIG rated one *proficient,* three *adequate,* and five *inadequate.* Two secondary indicators relating to administrative health care functions were rated *inadequate*.

[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.

Program Strengths — Compliance

As the *CHCF Executive Summary Table* on page *ix* indicates, the institution's compliance rating was *proficient,* scoring above 85 percent, in the primary indicator *Access to Care.* The following are some of CHCF'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 forms for health care services, and nursing staff timely reviewed those requests and completed face-to-face visits with patients.
- After discharge from community hospitals, patients received timely follow-up appointments with a provider.
- CHCF scanned dictated and non-dictated progress notes, initial health screening forms, health care service requests, specialty service documents, hospital discharge documents, and medication administration records into patients' medical record within appropriate time frames.
- The institution properly sterilized or disinfected its invasive and noninvasive medical equipment.
- Clinic common areas had an adequate environment conducive to providing medical care.
- Nursing staff completed the assessment and disposition section of the health screening forms for patients received from other CDCR institutions.
- Nursing staff followed appropriate administrative controls and protocols during medication preparation.
- In its main and satellite pharmacies, CHCF followed general security, organization, and cleanliness management protocols; properly stored and monitored refrigerated and non-refrigerated medications; and properly accounted for narcotic medications.
- CHCF offered influenza vaccinations to all sampled patients during the most recent influenza season.
- The institution ensured that patients were offered colorectal cancer screenings, when required.
- The institution offered required immunizations to its chronic care patients.
- Nursing staff timely completed initial assessments on patients admitted to specialty housing.
- Patients received routine specialty service appointments within required time frames.

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

- CHCF promptly processed patients' initial medical appeals and addressed all issues of patients' secondary medical appeals.
- CHCF's Quality Management Committee took adequate steps to ensure the accuracy of its Dashboard data reporting.
- The institution's local governing body committee met at least quarterly and exercised responsibility for the quality management of patient health care.
- All applicable providers, nursing staff, and the pharmacist in charge were current with their professional licenses and certifications.
- All nurses were current on their clinical competency validations.

Program Weaknesses — Compliance

The institution received ratings of *inadequate*, scoring below 75 percent, in the following five primary indicators: *Diagnostic Services*, *Health Care Environment*, *Pharmacy and Medication Management, Specialized Medical Housing,* and *Specialty Services*. The institution also received an *inadequate* score in the 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 CHCF's compliance scores on individual questions in all the primary health care indicators:

- Patients did not always receive timely follow-up appointments with a provider after specialty service visits.
- The institution's providers did not timely review radiology and pathology reports or timely communicate the results of those reports to patients.
- CHCF did not properly label and file scanned documents into patients' medical records.
- Clinical health care areas were not always appropriately disinfected, cleaned, or sanitized; and health care staff did not always routinely sanitize their hands before or after patient contact, before donning gloves, and after drawing blood.
- Clinical common areas and exam rooms were often missing core medical equipment and supplies; most clinics inspected had exam rooms that did not have an environment conducive to providing medical services; many emergency response bags were missing essential items.

- When patients transferred out of the institution, nurses did not routinely identify pending or approved specialty services on the health care information transfer form.

- Chronic care patients did not receive all medications within required time frames; staff at the institution's clinic and medication line locations did not always employ strong security controls over narcotic medications; refrigerated and non-refrigerated non-narcotic medications were not always properly stored.

- Primary care providers did not complete their subjective, objective, assessment, plan, and education (SOAPE) notes at the minimum required intervals for specialized medical housing unit patients.

- Primary care providers did not review specialty service consultant reports within required time frames; patients received from other CDCR institutions did not receive their approved specialty service appointments within required time frames.

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

- The institution's Emergency Medical Response Review Committee's incident package reviews did not include the required review documents; CHCF did not complete the required documentation to support their medical emergency response drills.

- CHCF nursing supervisors did not always complete required clinical performance evaluations for their subordinates and did not provide timely new employee orientation for nurses hired in the most recent 12 months; structured clinical performance appraisals of provider staff were not completed with required time limits.

- The pharmacist in charge did not have a system in place to monitor Drug Enforcement Administration registrations for providers who prescribed controlled substances.

The *CHCF Executive Summary Table* on the following page lists the quality indicators the OIG inspected and assessed during the clinical case reviews and objective compliance testing. The table also provides the overall indicator rating of the institution in each area. The OIG's clinicians and non-clinical inspectors determined the overall indicator ratings by consensus decision.

CHCF Executive Summary Table

Primary Indicators (Clinical)	Case Review Rating	Compliance Rating	Overall Indicator Rating
Access to Care	*Adequate*	*Proficient*	*Proficient*
Diagnostic Services	*Inadequate*	*Inadequate*	*Inadequate*
Emergency Services	*Adequate*	Not Applicable	*Adequate*
Health Information Management (Medical Records)	*Adequate*	*Adequate*	*Adequate*
Health Care Environment	Not Applicable	*Inadequate*	*Inadequate*
Inter- and Intra-System Transfers	*Adequate*	*Adequate*	*Adequate*
Pharmacy and Medication Management	*Inadequate*	*Inadequate*	*Inadequate*
Preventive Services	Not Applicable	*Adequate*	*Adequate*
Quality of Nursing Performance	*Adequate*	Not Applicable	*Adequate*
Quality of Provider Performance	*Adequate*	Not Applicable	*Adequate*
Specialized Medical Housing (OHU, CTC, SNF, Hospice)	*Adequate*	*Inadequate*	*Adequate*
Specialty Services	*Inadequate*	*Inadequate*	*Inadequate*

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

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

CHCF performed adequately in most of the population-based metric areas, which were selected in the areas of comprehensive diabetes care, immunizations, and colorectal cancer screening.

For comprehensive diabetes management, the OIG chose five measures by which to compare its performance with other entities': diabetes monitoring, patients under good HbA1c diabetic control, patients under poor HbA1c diabetic control, diabetic blood pressure monitoring, and diabetic dilated eye exams. On a state level, CHCF outperformed Medi-Cal in all five diabetic measures selected, and outperformed Kaiser Permanente in three of the five measures, but not in blood pressure control and eye exams. Nationally, CHCF significantly outperformed Medicare, Medicaid, and commercial health plans in all five diabetic measures selected, but outperformed the United States Department of Veteran's Affairs (VA) in only two of the four measures applicable (diabetes monitoring and management of poorly controlled diabetes). CHCF matched the VA in a third measure (blood pressure control), but CHCF's score was significantly lower than the VA's for a fourth measure (eye exams).

With regard to influenza and pneumococcal immunization measures, CHCF significantly outperformed all state and national health care plans; however, the institution's performance was less than optimal due to patient refusals, which adversely affected the institution's comparable score.

For colorectal screening, CHCF performed at only a moderate level. More specifically, CHCF scored better than Medicare and commercial health plans, but not as well as Kaiser or the VA. However, if not for the 24 percent patient refusal rate among sampled patients, CHCF would have outperformed all statewide and national plans for colorectal cancer screenings.

Overall, CHCF's performance as calculated by population-based metrics demonstrated an adequate chronic care and preventive services program. However, the institution could further improve its performance by implementing patient education measures designed to reduce the rate of refusals for colorectal cancer screenings and by ensuring that more diabetic patients receive their required eye exams.

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.

The California Health Care Facility (CHCF) was the 35th and final medical inspection of Cycle 4. During the inspection process, the OIG assessed the delivery of medical care to patients using 12 primary clinical health care indicators and 2 secondary administrative indicators applicable to the institution. It is important to note that while the primary quality indicators represent the clinical care provided by the institution at the time of the inspection, the secondary quality indicators are purely administrative and are not reflective of 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 California Health Care Facility is a 1.4 million square foot facility that opened in July 2013. The 54-building complex is located in Stockton and houses a population of over 2,250 patients, mostly classified as medium or high medical risk. Medical and psychiatric treatment is delivered by professional health care staff from CDCR, the Department of State Hospitals, and California Correctional Health Care Services. CHCF is designated as an "intermediate care prison"; these institutions are located in predominantly urban areas close to tertiary care centers and specialty care providers for the most cost-effective care and to complement less acute treatment provided in other CDCR institutions.

At the time of the OIG's inspection, the institution had 12 licensed correctional treatment centers (CTCs), which provided inpatient medical care, diagnostic evaluation, and treatment. There were also 14 outpatient housing units (OHUs) for patients requiring assistance with daily living activities, as well as inpatient and outpatient psychiatric treatment units. Mental health crisis bed (MHCB) housing was also available. CHCF had multiple outpatient clinics to handle daily, non-urgent requests for medical services, as well as a licensed standby emergency medical services (SEMS) unit to deal with urgent/emergent care issues. This unit is typically referred to as a triage and treatment area (TTA) at other CDCR institutions.

CHCF provided multiple medical services onsite, including the following: audiology, cardiology, gastroenterology, infectious disease, nephrology, oncology, orthopedics, ophthalmology, orthotics, ocular prosthesis, physical therapy, podiatry, radiology, and urology. The institution had licensure for 29 dialysis stations at the time of the OIG's inspection. CHCF also used telemedicine for treatment of human immunodeficiency virus (HIV) patients and specialty services in its "E" facility and Facility Shared Services (FSS) buildings.

At the time of the OIG's inspection, CHCF had not yet received a review 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 (ACA). CHCF is in the process of seeking this accreditation, and ACA's review of the institution is scheduled for April 2017.

According to July 2016 staffing information provided by the institution, CHCF's vacancy rate among medical managers, primary care providers, nursing supervisors, and regular nursing staff was 18 percent. The highest vacancy percentage was among primary care providers with a 29 percent vacancy rate, which equated to 12 vacant provider positions out of 41 authorized positions. However, CHCF also reported that nursing staff had a 17 percent vacancy rate, which equated to 160 vacant positions. Another 19 nursing staff members (3 percent) were on long-term medical leave and thus not participating in the delivery of health care. In addition, the institution's chief executive officer reported that as of July 2016, there were 29 different medical staff members who were (or recently had been) under disciplinary review at CHCF. Two of the 29 staff members were nurses who were reassigned to non-clinical duties. To offset some of the nursing shortfall, CHCF utilized nine contracted registry nurses. CHCF's staffing resources are summarized on the following page.

CHCF Health Care Staffing Resources as of July 2016

	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff		Totals	
Description	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Authorized Positions	6	1%	41	4%	60.4	6%	915.8	89%	1,023.2	100%
Filled Positions	5	83%	29	71%	46	76%	756	83%	836	82%
Vacancies	1	17%	12	29%	14.4	24%	159.8	17%	187.2	18%
Recent Hires (within 12 months)	2	40%	18	62%	21	46%	313	41%	354	42%
Staff Utilized from Registry	0	0%	2	7%	0	0%	9	1%	11	1%
Redirected Staff (to Non-Patient Care Areas)	0	0%	0	0%	1	2%	2	0%	3	0%
Staff on Long-term Medical Leave	0	0%	0	0%	0	0%	19	3%	19	2%

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

As of July 11, 2016, the Master Registry for CHCF showed that the institution had a total population of 2,262. Within that total population, 43.9 percent were designated as high medical risk, Priority 1 (High 1), and 17.8 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 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.

CHCF Master Registry Data as of July 11, 2016

Medical Risk Level	# of Patients	Percentage
High 1	994	43.94%
High 2	403	17.82%
Medium	601	26.57%
Low	264	11.67%
Total	**2,262**	**100.00%**

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	**POC**	Point of Contact
CT	Computerized Tomography	**PPD**	Purified Protein Derivative
CTC	Correctional Treatment Center	**PRN**	As Needed (in taking medications)
DM	Diabetes Mellitus	**RN**	Registered Nurse
DOT	Directly Observed Therapy (in taking medications)	**Rx**	Prescription
Dx	Diagnosis	**SNF**	Skilled Nursing Facility
EKG	Electrocardiogram	**SOAPE**	Subjective, Objective, Assessment, Plan, Education
ENT	Ear, Nose and Throat	**SOMS**	Strategic Offender Management System
ER	Emergency Room	**S/P**	Status Post
eUHR	electronic Unit Health Record	**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 derive 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* derive entirely from the case review results, while the ratings for the primary quality indicators *Health Care Environment* and *Preventive Services* derive 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 CHCF, 14 of the quality indicators were applicable, consisting of 12 primary clinical indicators and 2 secondary administrative indicators. Of the 12 primary indicators, seven 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.

Consistent with the OIG's agreement with the Receiver, this report addresses only 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 patients. The OIG 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 are considered high-risk and account for more than half of the institution's pharmaceutical, specialty, community hospital, and emergency costs.

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

Underlying the choice of high-risk patients for detailed case review, 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 entire 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 receiving 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: CHCF Sample Sets*, the OIG clinicians evaluated medical charts for 76 unique patients. *Appendix B, Table B–4: CHCF Case Review Sample Summary* clarifies that both nurses and physicians reviewed charts for 15 of those patients, for 91 reviews in total. Physicians performed detailed reviews of 30 charts, and nurses performed detailed reviews of 18 charts, totaling 48 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 43 patients. These generated 3,747 clinical events for review (*Appendix B, Table B–3: CHCF Event-Program*) that are documented in the case review's medical inspection tool. This 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 6 chronic care patient records, i.e., 3 diabetes patients and 3 anticoagulation patients (*Appendix B, Table B–1: CHCF Sample Sets*), the 76 unique patients sampled included patients with 370 chronic care diagnoses, including 32 additional patients with diabetes (for a total of 35) and 2 additional anticoagulation patients (for a total of 5) (*Appendix B, Table B–2: CHCF 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 was assessed for adequacy. The OIG's case review methodology and sample size matched other qualitative research. The empirical findings, supported by expert statistical consultants, showed adequate conclusions after 10 to 15 charts had undergone full clinician review. In qualitative statistics, this phenomenon is known as "saturation." The OIG asserts that the physician sample size of over 30 detailed reviews certainly far exceeds the saturation point necessary for an adequate qualitative review. With regard to reviewing charts from different providers, the 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 *CHCF 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 July to September 2016, deputy inspectors general and registered nurses attained answers to 92 objective medical inspection test (MIT) questions designed to assess the institution's compliance with critical policies and procedures applicable to the delivery of medical care. To conduct most tests, inspectors randomly selected samples of patients for whom the testing objectives were applicable and reviewed their electronic unit health records (eUHR). In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed health records for 426 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 July 25, 2016, field inspectors conducted a detailed onsite inspection of CHCF's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,716 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 CHCF'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 nine primary (clinical) and two secondary (administrative) quality indicators applicable to the institution for compliance testing:

- Primary indicators: *Access to Care*, *Diagnostic Services*, *Health Information Management (Medical Records)*, *Health Care Environment*, *Inter- and Intra-System Transfers*, *Pharmacy and Medication Management*, *Preventive Services*, *Specialized Medical Housing (OHU and CTC)*, 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 92 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 periods 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 CHCF, the OIG reviewed some of the compliance testing results, randomly sampled additional patients' records, and obtained CHCF 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, 12 of the OIG's primary indicators were applicable to CHCF. Of those 12 indicators, 7 were rated by both the case review and compliance components of the inspection, 3 were rated by the case review component alone, and 2 were rated by the compliance component alone.

The *CHCF Executive Summary Table* on page *ix* shows the case review and compliance ratings for each applicable indicator.

Summary of Case Review Results: The clinical case review component assessed 10 of the 12 primary (clinical) indicators applicable to CHCF. Of these 10 indicators, OIG clinicians rated none *proficient*, 7 *adequate*, and 3 *inadequate*.

The OIG physicians rated the overall adequacy of care for each of the 30 detailed case reviews they conducted. Of these 30 cases, 23 were *adequate*, and 7 were *inadequate*. In the 3,747 events reviewed, there were 874 deficiencies, of which 167 were 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 no adverse/sentinel events identified in the case reviews at CHCF during the OIG's inspection.

Summary of Compliance Results: The compliance component assessed 9 of the 12 primary (clinical) indicators applicable to CHCF. Of these nine indicators, OIG inspectors rated one *proficient*, three *adequate*, and five *inadequate*. This section of the report summarizes the results of those assessments. *Appendix A* details the test questions used to assess compliance for each indicator.

ACCESS TO CARE

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

Case Review Rating:
Adequate
Compliance Score:
Proficient
(89.0%)

Overall Rating:
Proficient

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 a *proficient* score. Case review focused on qualitative measures, while the compliance review focused on quantitative ones. Case review revealed some minor delays in the ability of patients to receive timely care from providers, while the compliance testing results found that most patients had ready access to the care that they required. The OIG's internal review process considered those factors that lead to both results and ultimately rated this indicator *proficient*.

Case Review Results

The OIG clinicians reviewed 1,886 provider and nurse encounters and identified 34 deficiencies relating to access to care, 11 of which were significant. The OIG clinicians rated the *Access to Care* indicator *adequate*.

Provider-to-Provider Follow-up Appointments

While CHCF's providers worked cohesively and diligently to provide access to care to the institution's high-risk population, the OIG clinicians still concluded that the institution was minimally staffed with providers. The low staffing levels resulted in providers who often had to provide coverage at other medical units when their colleagues in those units were absent. The provider movement between medical units compromised the continuity of patient care. Provider staffing levels are also discussed in the *Quality of Provider Performance* indicator.

The OIG identified the following significant deficiencies:

- In case 10, there was a four-day delay in provider follow-up for a patient with an acute exacerbation of chronic obstructive pulmonary disease.

- Also in case 10, there was a six-day delay for a follow-up visit with the correctional treatment center (CTC) provider.

- In case 32, the provider ordered a two-day follow-up after the patient's return from a hospitalization for emergency dialysis, but the follow-up was delayed four days. Fortunately, no harm occurred with the delay.

- In case 59, the patient's routine provider appointment for knee pain was delayed ten days.

Registered Nurse-to-Provider Referrals

The institution generally provided adequate and timely nurse-to-provider referrals. However, there were eight deficiencies, two of which were significant:

- In case 63, the nurse urgently referred a patient with a swollen and tender knee to a provider. The patient was seen two days late.

- In case 70, the nurse made an urgent provider referral for back pain. The patient was seen 12 days late.

Provider Follow-up After Specialty Service

The institution consistently provided patients with follow-up appointments after specialty services. More specifically, the OIG reviewed 427 consultative specialty services and discovered only five provider delays in care, two of which were significant:

- In case 13, the surgical follow-up after a three-toe amputation was delayed three weeks.

- In case 28, there was a three-week delay for a patient with sickle cell anemia to follow up with the hematologist (blood specialist).

Registered Nurse Sick Call Access

The California Health Care Facility provided excellent access for patients who submitted health care service request forms (sick call forms). Each housing unit had sick call forms visible and readily available with an appropriately labeled mailbox nearby for drop-off. Nursing also timely collected and reviewed the patients' sick call requests and made timely provider referrals when appropriate.

Follow-up After Hospitalization

The institution provided patients with adequate follow-up after hospitalizations. The OIG reviewed 134 hospitalization and outside emergency events, and only one significant deficiency was found:

- In case 6, the patient was not seen for eight days after a hospitalization for hepatic encephalopathy (confusion caused by severe liver disease).

Access to Specialty Services

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

Intra-System Transfers

Patients transferred into CHCF were seen by nurses and providers timely. The OIG clinicians reviewed eight transfer-in patients; all were seen by a provider within the required time frames.

Nurse Case Management

The OIG clinicians reviewed 53 encounters for 17 patients who were followed by nurse case managers for diabetes, end-stage liver disease, and dialysis. Patients were generally seen monthly to assess the status of their conditions. Two patients were followed for both diabetic and end-stage liver disease. The facility had developed multi-page forms, which included past and present laboratory values, medication changes, specialists' recommendations, future blood draws, and scheduled consults. As a result, documentation of patient status was thoroughly assessed and consistently documented.

Specialized Medical Housing

While other CDCR institutions generally only have one or two specialized medical housing units, CHCF's specialized medical housing comprised 12 CTCs and 14 OHUs. CHCF's provider access was adequate during and after admission to specialized medical housing. The OIG clinicians reviewed 43 OHU and CTC admissions with 2,075 medical and nursing encounters. Providers usually saw patients within appropriate time intervals. There were only three significant deficiencies:

- In case 10, two different providers' follow-up appointments with a patient with worsening chronic obstructive pulmonary disease were each delayed six days.

- In case 32, the two-day provider follow-up that was ordered for a patient receiving urgent dialysis occurred in six days.

Clinical Onsite Inspection

CHCF was composed of five yards. A Yard housed mental health crisis bed patients and a permanent inmate work crew. B Yard housed Department of State Hospitals' mental health patients. C Yard encompassed the 14 OHUs, while the D Yard encompassed the 12 CTCs. The outpatient E Yard housed patients in dormitory-like settings. Finally, dialysis patients were housed throughout the facility as appropriate to their medical needs.

In the 14 OHU buildings and the 12 CTC buildings, inspectors visited nursing stations and interviewed staff. Each building was wide with cell rows on two sides. The central area was extra

wide and contained one or more nursing stations that was surrounded by a broad counter which enclosed each station's four sides. In addition, custody had its own station near the nursing stations.

Sustainability of access to care was of great concern among the providers and managers. The institution was minimally staffed with providers who were available to perform medical evaluations, and morale suffered (also discussed in the *Quality of Provider Performance* indicator). The providers and ancillary staff maintained access to care, though sometimes sacrificing continuity of care, as patients were triaged but not consistently seen by their primary providers.

Clinician Summary

CHCF is a unique prison within the State of California. Its primary mission is to deliver health care to patients at medium and high medical risk, most of whom require special housing, as demonstrated by the institution's 12 CTCs and 14 OHUs. In fact, among the state's 35 prisons, CHCF had the highest number of patients at high medical risk (1,397). Further, based on its total population size, CHCF also had the highest percentage of patients at high medical risk (62 percent). At the time of the OIG's inspection, approximately 88 percent of the prison's population was classified as either medium or high medical risk; this equated to nearly 2,000 patients. These patients required frequent evaluations and appointments. Based on the OIG clinician's review, CHCF consistently provided adequate access to care for its patients.

Compliance Testing Results

The institution performed in the *proficient* range in the *Access to Care* indicator, with a compliance score of 89.0 percent. CHCF scored in the *proficient* range in the following test areas:

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

- All 16 patients sampled received a follow-up appointment with a provider within five days of discharge from a community hospital (MIT 1.007).

- Inspectors sampled 45 health care service request forms submitted by patients across all facility clinics. Nursing staff reviewed all patient request forms on the same day they were received. Nursing staff also completed a face-to-face triage encounter for all 45 patients within the required time frame (MIT 1.003, 1.004).

- Among 28 sampled patients who transferred to CHCF from other institutions and were referred to a provider based on nursing staff's initial health care screening, 26 were seen within the required time frame (93 percent). Two patients received their appointments one to two days late (MIT 1.002).

- Of the 15 patients sampled who were referred to and seen by a provider and for whom that provider subsequently ordered a follow-up appointment, 14 received their follow-up

appointment within the required time frame (93 percent). For one sampled patient, the provider never held a follow-up visit to re-evaluate the patient (MIT 1.006).

The institution performed in the *adequate* range in the following tests:

- Among 37 health care service request forms sampled on which nursing staff referred the patient for a provider appointment, 29 patients (78 percent) received an appointment within the required time frame. Seven appointments were between one and 17 days late, and one patient never received an appointment at all (MIT 1.005).

- To verify that patients' chronic care conditions were actively managed, inspectors reviewed recent provider appointments for 40 patients with chronic care conditions; 30 patients (75 percent) received their routine appointments within the required time frame. However, five patients' appointments were between 14 and 61 days late, and three patients' appointments were between 112 and 264 days late. In addition, two other patients did not receive an appointment at all (MIT 1.001).

CHCF performed in the *inadequate* range in the following test:

- Of the 18 sampled patients who received a high-priority or routine specialty service, only 11 (61 percent) received a follow-up appointment with a provider within the required time frame. Five patients received their specialty service follow-up appointments one to ten days late, and two patients never received an appointment at all (MIT 1.008).

Recommendations

No specific recommendations.

DIAGNOSTIC SERVICES

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.

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
62.2%

Overall Rating:
Inadequate

Case Review Results

The OIG clinicians reviewed 500 diagnostic events and found 47 deficiencies, 16 of which were significant. CHCF performed inadequately with regard to diagnostic services, and the OIG clinicians rated this indicator *inadequate*.

Radiology Services

CHCF performed poorly with retrieving radiology reports, notifying the patient, and scanning the reports into the patients' medical records. In multiple instances, the provider did not complete the Notification of Diagnostic Test Results (CDCR Form 7393) for an imaging study. This occurred in cases 8, 11, 13, 15, 17, 21, 25, and 33.

During the OIG's onsite inspection, CHCF leadership explained that the institution had stopped scanning radiology reports into the eUHR based on a directive from CCHCS headquarters. This directive erected a tremendous barrier to medical care. CHCF's failure to retrieve radiology reports increased the risk of a lapse in care by increasing the chance that a provider could overlook a seemingly missing report. Even if the ordering provider initially had reviewed the report, it would still not be readily available to any subsequent medical staff. Any nurse or provider caring for the patient in the coming months or years would face this barrier when attempting to review radiology reports that were missing from the eUHR. The institution's failure to retrieve and scan radiology reports into the eUHR occurred in cases 11, 20, 24, 25, 30, and 32. In addition, the following other significant deficiencies regarding radiology services occurred:

- In cases 7 and 10, the provider ordered the patient's chest x-rays, but the service was never scheduled.

- In case 34, a pulmonary consultant recommended the patient have a chest x-ray and a provider made the order, but the service was never completed.

Laboratory Services

The OIG clinicians identified significant laboratory deficiencies that included "stat" (immediate) test results that were not being provided timely to the institution's staff. Further, once the results were received, providers were only conducting a superficial review. More specifically:

- In case 13, several physicians reviewed but failed to address abnormally elevated liver levels (aminotransferases of 1281 and 1002) indicative of an acute hepatitis. Prior liver function tests had been normal.

- In case 15, on several occasions, the providers noted grossly abnormal ammonia levels but failed to address the findings.

- In cases 20 and 29, a stat blood draw was completed, but results were never scanned into the medical records.

- In case 23, the provider ordered a stat lactate level (test to determine presence of severe illness, such as shock) but inappropriately reviewed the laboratory results five days later. The laboratory results showed abnormally elevated lactate. The provider failed to address this important abnormality or question why the test was ordered. Fortunately, the patient did not have any severe illness at the time.

- In case 25, the provider reviewed laboratory results indicating an abnormal sodium level (155 mmol/L). However, the provider incorrectly noted that this result was within normal limits and unchanged from previous studies.

- In case 29, the provider failed to treat a symptomatic patient who had a critically high blood sugar level (826 mg/dl). The provider failed to re-evaluate the patient and inappropriately recommended a next-day follow-up. This case is also discussed in the *Quality of Provider Performance* indicator.

The OIG clinicians also identified the following other deficiencies related to laboratory services:

- In case 10, the provider ordered a urinalysis and urine culture; however, the laboratory did not receive the patient's sample.

- In case 13, OHU nurses failed to review recent laboratory results indicating an excess level of blood-thinning medication prior to administering the next dose.

- In case 14, a review of critically low blood glucose (20 mg/dl) did not occur for three days.

- In case 18, multiple laboratory tests were ordered for a kidney transplant evaluation, but the results were not scanned into the patient's medical records. While no harm came because of

this omission, there was potential harm by delaying or reducing the likelihood of a successful transplant.

- In case 28, scanning of a critical laboratory report into the medical records was delayed five months. Fortunately, no harm resulted.

- In case 31, an elevated blood glucose average was noted by the provider, but the test results were never scanned into the medical records.

Clinician Onsite Visit

The institution's providers were concerned that CHCF failed to track radiology reports. They had little confidence that an abnormal radiology report would be properly retrieved and forwarded to them for review. This process was purely dependent on the providers' actions. If the ordering provider was not present at the time of review, and the medical information was not effectively communicated, the imaging report, whether normal or abnormal, would remain within the imaging storage system (Radiology Information System or RIS) without an alert for review. This RIS system is separate from the main patient medical record storage system (eUHR).

The radiology technician also reported to the OIG clinicians that the institution's portable x-ray machine had not been functional for nearly nine months. This was one of the only two machines used to perform X-rays. The institution was currently using its fixed (non-portable) x-ray machine for 10 to 15 X-rays daily. Despite CHCF lacking the one machine, patients did not experience adverse effects or significant delays.

Clinician Summary

Diagnostic services are integral to the health care system. Providers are dependent on expedient results, and a process of notification is essential to maintaining patients' health. Providers need to be assured not only that their orders will be carried out, but also that results will be provided in a timely manner and not lost. Providers could not be so assured at CHCF. The institution had problems obtaining stat laboratory tests, which are essential to providers since the results often determine whether patients require a higher level of care or they can be managed by the providers within CHCF. When the OIG inquired of CHCF health care management regarding the poor delivery times for stat test results, the institution did not know the cause of the problem. Because of the identified system weaknesses, the OIG rated this indicator *inadequate*.

Compliance Testing Results

The institution received an *inadequate* compliance score of 62.2 percent in the *Diagnostic Services* indicator, which encompasses radiology, laboratory, and pathology services. For clarity, each type of diagnostic service is discussed separately.

Radiology Services

- Radiology services were performed within the required time frame for nine of ten sampled patients (90 percent), while only one patient's service was provided two days late. In a related area, the ordering provider properly evidenced a timely review of the corresponding diagnostic test results for only one of ten sampled patients (10 percent). Nine reports did not have required evidence that the reports were promptly reviewed by means of a provider's initials and timely review date. More specifically, providers' documented their initials and review date for only two of the nine reports, but these reviews occurred two and six days late. Seven other reports had no documented evidence of a provider review at all. After the results were received, providers communicated the test results to four of nine sampled patients within the required time frame (44 percent); two patients' communications occurred two and six days late, and there was no evidence that three other patients ever received their test results (MIT 2.001, 2.002, 2.003).

Laboratory Services

- Nine of the ten laboratory services sampled (90 percent) were timely performed. Also, the provider timely reviewed the corresponding diagnostic report, and the results were timely communicated to the patient. One patient did not receive his test on the date the provider ordered. For another patient, the provider reviewed the diagnostic report and communicated the results two days late (MIT 2.004, 2.005, 2.006).

Pathology Services

- CHCF received pathology reports within required time frames for seven of ten patients sampled (70 percent). One report was 16 days late and two reports were not scanned into the patients' medical records at all. Also, providers evidenced their review of the pathology results for only four of eight patients within the required time frames (50 percent). In one case, the provider reviewed the report three days late and in three other cases, providers did not evidence their report reviews by means of a signature and date. Finally, providers communicated the pathology results to only two of eight sampled patients within the required time frames (25 percent); results for six patients were communicated 2 to 14 days late (MIT 2.007,2.008, 2.009).

Recommendations

The OIG recommends CHCF do the following:

- Employ a formalized notification of diagnostic test results process for all imaging studies. Such a process would allow medical records to be printed out for all imaging reports and help to ensure they are presented along with the laboratory results to the individual provider. The provider should then receive and review all imaging reports and fill out the required

patient notification form. This form and the imaging report can then be scanned into the medical records and findings expeditiously communicated with the patient. This will help ensure the proper provider review of all ordered reports.

- Review the stat laboratory order process to improve the timely and consistent delivery of patients' test results to reviewing providers.

The OIG recommends CCHCF do the following:

- Implement a process with the outside radiology contractor services to communicate stat or significant abnormal results in manner that makes the notification process more pronounced than normal test result notification such as the radiology contractor making expedited and direct contact via phone or email with the ordering provider regarding abnormal results.

- To contribute to the review process and allow future providers access to the information, authorize institutions to scan imaging reports into the patient's main electronic medical record system, instead of the separate repository in Radiology Information System.

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 emergent 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. At CHCF, the institution's emergency treatment and triage area is known as the standby emergency medical services (SEMS).

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 rated the *Emergency Services* indicator *adequate*. Specifically, the OIG clinicians reviewed 116 urgent or emergent events and found 86 deficiencies, 18 of which were significant, in a variety of areas, including provider performance, nursing performance, and health information management. Health information management had 31 of the deficiencies, all minor. In general, CHCF performed adequately with BLS care and 9-1-1 call activation times. Case reviews showed that, generally, patients requiring urgent or emergent services received timely and adequate care.

Provider Performance

Based on the clinicians' case reviews, the SEMS providers timely evaluated patients. The providers generally made sound triage decisions and appropriately sent the patients to higher levels of care. However, there were four significant deficiencies identified that related to provider performance. These deficiencies are also discussed in the *Quality of Provider Performance* indicator.

- In case 13, the provider evaluated a patient with weakness, fever, and signs of serious infection in the foot. The provider suspected a seriously infected diabetic foot, yet incorrectly treated the patient with only an oral antibiotic prescription, instead of transfer to a higher level of care.

- In case 21, the provider failed to order aspirin for a patient with chest pain and an abnormal electrocardiogram.

- In case 25, the provider failed to assess the severity of a frail, diabetic patient with shortness of breath, low body temperature, and an abnormal chest x-ray indicative of a pneumonia. The provider took an unnecessary risk by only starting the patient on oral antibiotics in the OHU, instead of transferring him to a higher level of care.

- In case 29, the provider failed to provide treatment for a symptomatic patient with critically high blood sugar (826 mg/dl).

Nursing Performance

The nursing care during emergency medical responses was generally adequate. There were 42 deficiencies, of which 13 were significant, including the following notable examples:

- In case 2, the SEMS RN did not apply the AED (automated external defibrillator) per basic life support protocol to the unresponsive patient. The RN failed to assess the patient for signs of trauma and monitor for neurological changes and vital signs. The nursing documentation also did not include past medical history.

- In case 6, the SEMS RN failed to monitor the patient with an altered level of consciousness, wheezing, and abdominal pain prior to transferring him to the emergency room. The RN did not document the time the ambulance was called and illegibly signed chart entries.

- In case 7, the patient was transferred to the SEMS in respiratory distress and with a dangerously high blood pressure. The RN delayed consulting respiratory therapy for 30 minutes.

- In case 8, the patient was seen in the SEMS for treatment of stab wounds. The RN delayed calling the ambulance until 16 minutes after receiving the provider's order and failed to closely monitor the patient's status, with 43 minutes elapsing between vital sign checks. The RN failed to document the number, size, and description of the wounds. No documentation of the wound care was present in the patient's medical file.

- In case 9, the SEMS RN sent the patient back to outpatient housing following an electrocardiogram indicating changes consistent with a heart attack. The RN failed to contact the provider with these test results and request further treatment.

- In case 14, the patient fell and cut his forehead. Neither the RN first medical responder nor the SEMS RN checked the patient's blood glucose level. This is required for a patient with balance problems. When the patient was transferred to an outside emergency department, it was determined that the cause of the illness was low blood sugar. Upon the patient's return to the prison, the SEMS RN failed to recheck the patient's blood sugar and neurological status.

- In case 17, the patient was seen in the SEMS for difficulty breathing. The RN assessment was incomplete and incongruent. The patient's symptoms varied from page to page of the nursing progress notes, and vital signs were monitored only sporadically. The nurse failed to document the actions taken and to assess the patient's condition at discharge. Also, the RN's signature was illegible.

- In case 21, the patient had chest pain for almost three hours and had taken three nitroglycerin tablets without relief. The CTC RN did not assess the intensity of the chest pain and delayed transferring the patient to the SEMS for 45 minutes. This delayed care for the patient, who ultimately required transfer to a community hospital emergency room.

Emergency Medical Response Review Committee

The Emergency Medical Response Review Committee (EMRRC) met at least monthly to review "Code 3" (highest urgency) medical emergencies within 30 days of the emergency response. Nine cases reviewed were without deficiencies. Code 3 cases were thoroughly reviewed prior to the meeting, at which nursing and medical actions, timeliness, and clinical outcomes were evaluated. Overall, the OIG clinicians concluded that the committee's evaluations appropriately identified needed training. However, the OIG also concluded that CHCF's EMRRC failed to evaluate all unscheduled transfers out of the institution (including "Code 2," moderate urgency), as required by statewide policy. Because of its limited review process scope, the EMRRC inadequately monitored and evaluated the institution's emergency responses. When the OIG discussed the limited scope of the review process with members of CHCF management, they did not interpret CDCR policy to include reviews of Code 2 responses or all unscheduled transfers out of the institution. The OIG agrees that the current policy is vague and could be interpreted differently (as demonstrated here); however, best practices dictate that reviews for these types of responses be performed.

Onsite Clinician Inspection

The SEMS was centrally located at the institution. Medical staff were required to drive emergency response equipment from the SEMS to incident sites via a transport vehicle. The SEMS RNs frequently directed emergency medical services paramedics to respond directly to the scene when the patient required transfer to an outside hospital.

During their onsite visit, the OIG clinicians found the patient care environment in the SEMS to be appropriately staffed and containing necessary supplies and equipment for safe patient care. CCHCS had engineered an impressive workplace for providers to perform emergency care and frequent medical procedures. The elective procedures varied from simple incisional biopsies to lumbar punctures or thoracentesis (fluid removal between the lungs and chest wall). Sufficient workspace was available to perform these tasks efficiently.

There were two nurses (one medical responder and one SEMS RN) present in the SEMS during the visit. The medical responder's duties included going out to yards for any medical emergencies, while the SEMS RN remained in the SEMS for the duration of the shift. One or two providers were

onsite from 7:00am to 11:00pm weekdays and throughout the weekend for medical emergencies and urgent evaluations. The providers indicated to the OIG that better coverage of the SEMS would be with 24-hours-per-day, 7-days-per-week provider coverage. The providers noted that the frequency of after-hours nurse phone consults (between the weekday hours of 11:00pm to 7:00am) often resulted in sleepless nights for providers. They reported often being exhausted prior to returning for a full day's work.

Clinician Summary

The California Health Care Facility staff provided adequate emergency services to patients. Providers appropriately assessed and treated the institution's medically complex patient population during urgent or emergent events.

Recommendations for CCHCS

The OIG recommends the CCHCS revisit its emergency medical response post-event review procedure (P&P Volume 4, Ch.12.8) and modify the procedure to clearly articulate whether all Code 2 and unscheduled transfers out of the institution are subject to EMRRC reviews.

Recommendations for CHCF

The OIG recommends that, until such time that CCHCS revisits the policy cited immediately above, CHCF take a conservative and best practices approach, ensuring the EMRRC thoroughly reviews all Code 2 and unscheduled transfers out of the institution.

The OIG recommends that CHCF conduct a feasibility study of staffing the institution with provider coverage 24 hours a day, 7 days a week.

HEALTH INFORMATION MANAGEMENT (MEDICAL RECORDS)

Case Review Rating:
Adequate
Compliance Score:
Adequate
(78.2%)

Overall Rating:
Adequate

Health information management is a crucial link in the delivery of medical care. Medical personnel require accurate information in order to make sound judgments and decisions. This indicator examines whether the institution adequately manages its health care information. This includes determining whether the information is correctly labeled, 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.

Case Review Results

The OIG clinicians reviewed 3,747 events and found 217 deficiencies related to health information management, 13 of which were significant. The OIG clinicians rated this indicator *adequate*.

Hospital Records

There were few deficiencies regarding the transfer of hospital records to the facility. The documentation was timely and either scanned prior to physician review or reviewed by the provider within an appropriate time frame. When documentation was scanned prior to review, providers timely reviewed the documentation, as evidenced by their progress notes and orders. CHCF had a significant number of hospital transfers. Thus, the timely receipt of this medical information provided the patients seamless transfers of care. Only one deficiency was significant:

- In case 13, CHCF failed to retrieve or scan the hospital records into the eUHR.

Specialty Services

The OIG clinicians identified several cases in which specialty reports were scanned into the medical records without a provider signature (cases 13, 19, 21, 24, 25, 30, and 32). Significant deficiencies also occurred when specialty reports received late also resulted in delayed medical management. These issues are also discussed in the *Specialty Services* indicator.

- In case 9, a scanning delay of over one month occurred with a heart stress test report. While no harm resulted, there was a risk of harm by delayed management of heart disease.

- Also in case 23, the provider reviewed a liver ultrasound report; however, it was never scanned into the patient's medical record.

- In case 35, the provider reviewed an ultrasound test for liver scarring; however, it was never scanned into the patient's medical record.

Laboratory Reports

The following deficiencies related to laboratory services and they are also discussed in the *Diagnostic Services* indicator.

- In case 14, a review of a critically low blood glucose result (20 mg/dl) did not occur for three days.

- In case 18, multiple laboratory tests were ordered for a kidney transplant evaluation, but the results were not scanned into the medical records.

- In cases 20 and 29, a stat blood draw was completed, but results were never scanned into the medical records. At a later date, the labs were redrawn and finally reviewed.

- In case 28, scanning of a laboratory report into the eUHR was delayed five months.

- In case 31, the provider reviewed an elevated blood glucose test result; however, it was never scanned into the patient's medical records.

Scanning Performance

Incorrectly scanned documents can create delays or lapses in care by hindering providers' ability to find relevant clinical information. During the case review, the OIG clinicians identified 77 mislabeled or misfiled documents.

Legibility

Case review revealed 88 events with illegible documentation such as providers' and nurses' signatures.

Miscellaneous

In cases 6, 9, 12, and 19, an incorrect patient's information was scanned into the medical records. Some patients' records included more than one erroneous document.

Clinician Onsite Inspection

All clinics followed a standard morning huddle agenda, and staff discussed relevant information about patients with appointments or who required after-hours or offsite care. While onsite, the OIG clinicians witnessed clinical information discussed during daily morning huddles. Some clinics used large wall-mounted monitors to enable the care team to review laboratory results and other clinical data as a group. Various health care staff were interviewed regarding how information regarding after-hours and offsite medical care was handled. The OIG interviewed utilization management

staff, onsite and offsite specialty nurses, and members of the patient management unit (PMU), which performed receiving and release functions. All team members had reportedly been cross-trained to cover for staff absences.

Clinician Summary

The OIG clinicians identified cases in which specialty reports in patient's medical records lacked provider signatures or were not reviewed or scanned. This delayed medical management. Infrequently, scanning of some stat laboratory reports was beyond a time of usefulness or not scanned at all. Two percent of encounters had mislabeled patient records that had the potential to create dangerous situations. While a wide array of deficiencies were discovered, these findings were infrequent, so the OIG rated the case review portion of this indicator *adequate*.

Compliance Testing Results

The institution received an *adequate* compliance score of 78.2 percent in the *Health Information Management (Medical Records)* indicator, but performed well in the following areas:

- The institution's medical records staff scanned all 20 sampled dictated or transcribed provider progress notes into the patient's medical record within five calendar days (MIT 4.002).

- CHCF's medical records staff timely scanned all 20 sampled specialty service consultant reports and 20 sampled medication administration records into patients' medical records. In addition, 15 of 16 sampled hospital discharge reports (94 percent) were also timely scanned; one report was scanned nine days late (MIT 4.003, 4.004, 4.005).

- Inspectors reviewed eUHR files for 16 patients discharged back to CHCF after release from a community hospital. They found that providers reviewed the hospital discharge reports within three calendar days of discharge for 15 of those 16 patients (94 percent). One discharge report was reviewed seven days late (MIT 4.008).

- The institution scanned non-dictated provider progress notes, patients' Initial Health Screening forms (CDCR Form 7277), and Health Care Services Request forms (CDCR Form 7362) into the eUHR within required time frames for 10 of 11 documents sampled (91 percent). One of the sampled documents was scanned one day late (MIT 4.001).

CHCF displayed room for improvement in the following two areas:

- The institution scored zero in its labeling and filing of documents scanned into patients' eUHR. Examples of misfiled documents included medication reconciliation reports labeled as laboratory reports and, health care service requests labeled as progress notes. 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 inspection, inspectors identified 16 documents with labeling errors, 4 more than the maximum allowable errors (MIT 4.006).

- Reviewers inspected various medical documents such as hospital discharge reports, initial health screening forms, certain medication records, and specialty service reports to verify that clinical staff legibly documented their names on the forms. Fifteen of 32 samples, in which inspectors examined, showed compliance (47 percent). Seventeen of the sampled documents contained signatures that were too illegible to ascertain the clinician's identity (MIT 4.007).

Recommendation

The OIG recommends that the institution's records scanning staff receive additional training to help ensure that health care records are properly labeled and scanned into the correct patient's medical records. The institution should also assess whether existing quality control measures are adequate to monitor scanning accuracy, and ensure institution specific scanning procedures are documented and available to staff.

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 compliance testing results of the visual observations inspectors make at the institution during their onsite visit.

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(62.4%)

Overall Rating:
Inadequate

Compliance Testing Results

The institution received an *inadequate* compliance score of 62.4 percent in the *Health Care Environment* indicator, with the following six tests receiving scores in the *inadequate* range:

- CHCF appropriately cleaned, sanitized, and disinfected only 7 of 31 clinic locations tested (23 percent). In 19 clinics, staff did not sign cleaning logs to validate areas were properly cleaned; in four other clinics, staff did not clean every day during the 30-day review period, and one clinic did not maintain a cleaning log (MIT 5.101).

- Only 7 of 31 clinic locations met compliance requirements for maintaining essential core medical equipment and supplies (23 percent). The remaining 24 clinics were missing one or more items necessary to conduct a comprehensive exam. Missing items included a Snellen eye exam chart, an identified distance line for the Snellen chart, a nebulization unit, functional overhead lights, peak flow meters and disposable tips, glucose strips, hemoccult cards and a developer, lubricating jelly, tongue depressors, biohazard waste receptacles or plastic bags, and disposable paper for an exam table. Additionally, 2 of those 24 clinic locations had vital sign equipment with expired calibration stickers, and one of those clinic locations had expired glucose strips (MIT 5.108).

- Reviewers examined emergency medical response bags (EMRBs) to determine if the bags were inspected daily and inventoried monthly, and whether they contained all essential items. Only two of the seven EMRBs were compliant (29 percent). Five other EMRBs were missing one or more of the following: a CPR micro-mask, glucose gel, a large blood pressure cuff, a valve/regulator attached to portable oxygen, and a portable oxygen tank; one oxygen tank was not within the full pressure range. Staff did not complete monthly inventories of one of those EMRBs (MIT 5.111).

- OIG inspectors observed clinical staff such as providers, nurses, and phlebotomists to ensure they employed proper hand sanitation protocols during patient encounters. The staff at only 5 of 14 observed clinic locations followed required hand hygiene practices (36 percent). The

staff members at nine clinics did not consistently sanitize their hands before or after patient contact, before donning gloves, or after performing blood draws (MIT 5.104).

- Inspectors observed one or more exam rooms in 31 different clinical areas and found that only 14 clinical areas (45 percent) had appropriate space, configuration, supplies, and equipment to allow clinicians to perform a proper clinical exam. The 17 other clinics had one or more deficiencies, including nine clinics that had unlabeled or disorganized supply storage areas, four clinics with inaccurately labeled supply drawers, and four clinics with confidential records that were easily accessible by patients. Three clinics had exam tables or chairs that were torn or in disrepair, two clinics had supplies stored on the floor, and one clinic's exam room had an oto-ophthalmoscope that was not easily accessible to the exam table (*Figure 1*) (MIT 5.110).

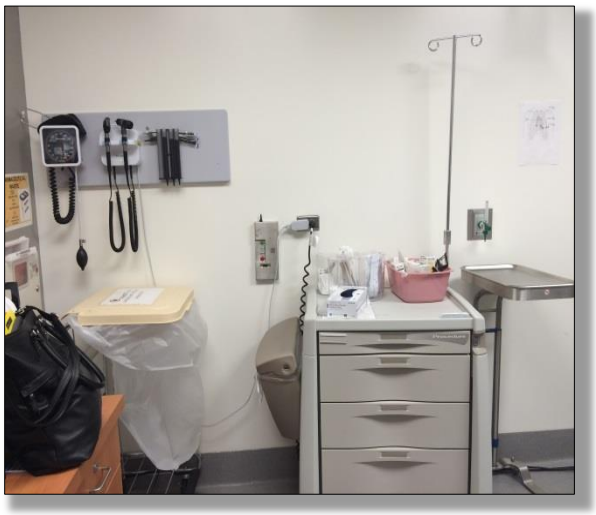

Figure 1: Inaccessible oto-ophthalmoscope that is not in close proximity to the exam table and unlabeled supply cabinet

- Inspectors found that 22 of 31 clinic locations (71 percent) followed adequate bulk medical supply storage and management protocols. However, inspectors noted various deficiencies at nine clinics that included four clinics with unlabeled bulk medical supplies; four clinics with supplies that were at subpar levels (*Figure 2*); and one clinic had personal food items stored in the medical supply area (MIT 5.107).

Figure 2: Empty supplies bins

CHCF scored in the *adequate* range in the following test area:

- Twenty-six of the 31 clinics observed (84 percent) had operable sinks and sufficient quantities of hand hygiene supplies. Patient restrooms at five clinics did not have disposable paper towels or soap (MIT 5.103).

The institution scored within the *proficient* range on the following four tests:

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

- Clinical health care staff properly disinfected and sterilized reusable invasive and non-invasive medical equipment in 30 of 31 clinic locations tested (97 percent). One clinic did not maintain an equipment sterilization log (MIT 5.102).

- CHCF followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste at 28 of 31 clinics observed (90 percent). Three clinics lacked sharps containers in all exam rooms (MIT 5.105).

- Clinic common areas at 28 of 31 clinics had an environment conducive to providing medical services (90 percent). Three clinics did not provide adequate visual or auditory privacy (MIT 5.109).

Other Information Obtained from Non-Scored Results

The OIG gathered information to determine if CHCF maintained its physical infrastructure in a manner that supported health care management's ability to provide adequate health care. The OIG did not score this question. According to health care managers, there were no concerns identified. During the OIG's inspection period, the only infrastructure project underway at CHCF was the construction of a new visiting center. The estimated completion date of this project was August 2017 (MIT 5.999).

Recommendation

The OIG recommends that CHCF health care management provide periodic training and refresher courses for all health care staff members regarding proper hand sanitation techniques and protocols. The OIG further recommends that managers periodically spot-check staff member's compliance as part of their probationary and annual performance evaluations.

INTER- AND INTRA-SYSTEM TRANSFERS

Case Review Rating:
Adequate
Compliance Score:
Adequate
(75.4%)

Overall Rating:
Adequate

This indicator focuses on the management of patients' medical needs and continuity of patient care during the inter- and intra-facility transfer process. The patients reviewed for *Inter- and Intra-System Transfers* include patients received from other CDCR facilities and patients transferring out of CHCF 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.

Case Review Results

The OIG clinicians reviewed 151 encounters related to the *Inter- and Intra-System Transfers* indicator, including 14 cases of patients transferring into CHCF from other institutions, and 3 cases of patients transferring out of CHCF to other institutions. In total, the clinicians discovered forty-three deficiencies. Ten of the deficiencies were significant and all ten related to post-hospitalization events. The OIG rated the case review portion of this indicator *adequate*.

Transfers In

There were 11 minor deficiencies regarding patients transferring into CHCF. Deficiencies regarding access to care, health information management, nursing, and provider care are discussed in those corresponding indicators.

Transfers Out

Two minor deficiencies occurred with two patients transferring out of CHCF; all were due to incomplete nursing documentation of significant medical information on the patient's health care transfer information form.

- In case 41, the RN neglected to fully complete the transfer-out forms. The forms did not include a scheduled gender identity disorder referral, did not address the history of suicide attempts or whether the patient was on suicide precautions, and did not indicate that the patient was on heat-sensitizing medications (requiring avoidance of the sun or extreme

temperatures). The OIG clinicians considered this deficiency minor because other records were available for providers to ascertain the missing information.

- In case 42, the RN failed to adequately document on the transfer form the need for a physical therapy evaluation and pending primary care appointments.

Hospitalizations

The OIG clinicians examined 134 events related to patients returning to CHCF from a community hospitalization or emergency department. These events represent some of the institution's highest-risk encounters for two reasons. These patients are usually of higher acuity since they have just been hospitalized for a severe illness or injury. They are also at risk due to potential lapses in care that can occur during the hand-off from the community hospital back to the institution. CHCF's SEMS nurses processed hospital-discharged patients when those patients returned to the institution. In the majority of cases, registered nurses appropriately reviewed the discharge medications and plans of care and obtained physician orders. Of the 30 hospitalization deficiencies, ten were significant and were attributed to a range of programs: nursing and provider care, pharmacy, medical records, and appointments. The following are some of the significant deficiencies identified:

- In case 1, nurses failed to initiate seizure precautions such as padded bed rails for three months. They also failed to obtain provider orders for a helmet to protect the patient's head during seizures.

- In case 8, the SEMS RN failed to give an ordered tetanus vaccine for a patient with multiple stab wounds.

- In case 13, following the patient's hospitalization for amputation of a gangrenous toe, the SEMS RN failed to assess the surgical site for bleeding, describe the pulse or skin temperature, and document the wound dressing. The nurse also failed to obtain provider orders for wound care.

- Also in case 13, a nurse failed to clarify an unusual order for insulin with the provider.

- Also in case 13, health care staff failed to retrieve and scan hospital records.

- In case 23, after the patient returned from the hospital, nurses failed to obtain and administer needed chronic care medications from the institution's Omnicell (electronic medication storage). This resulted in a three-day delay of chronic care medications.

- In case 28, the SEMS provider ordered a next-day follow-up for a patient who had been hospitalized for a sickle cell anemia crisis and dehydration from acute diarrhea. The provider saw the patient four days late.

- In case 32, the provider failed to promptly order a vascular surgery follow-up visit after the patient underwent surgery for dialysis catheter placement.

Clinician Onsite Visit

At CHCF, patient intake occurred in the Facility Shared Services (FSS) building. Designated nurses reviewed patients' health care transfer information forms, medication reconciliation forms, medication administration records, patient summary, and any medical equipment or supplies that came with the patient. The nurses then met and interviewed the patient to complete the Initial Health Screening form (CDCR Form 7277) and identify any special needs, such as a lower bunk or urgent referrals to mental health or to SEMS for immediate evaluation. Finally, the nurses obtained medication orders from a designated provider who was also responsible for reviewing transfer information and who ordered the initial provider visit.

Compliance Testing Results

CHCF obtained an *adequate* score of 75.4 percent in the *Inter- and Intra-System Transfers* indicator and scored in the *proficient* range in the following two test areas:

- Inspected transfer packages for four patients who transferred out of the institution included all ordered medications and related documentation (MIT 6.101).

- For 26 of the 27 sampled patients who transferred to CHCF from another CDCR facility, nursing staff signed and dated the assessment and disposition portion of the initial health screening forms on the same day the form was completed (96 percent). One health screening form did not include the completion of all required questions (MIT 6.002).

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

- Twenty-five sampled patients who transferred into CHCF from another CDCR facility had an existing medication order. Twenty-one of those patients received their medications within the required time frame (84 percent). Four patients received their medications one to four days late (MIT 6.003).

- Nursing staff completed 23 of 30 sampled initial health screening forms on the same day patients transferred into CHCF from other CDCR institutions (77 percent). Nursing staff did not properly complete the initial health screening form for four patients. Three other forms were partially or completely missing from the eUHR (MIT 6.001).

CHCF showed room for improvement in the following area:

- Among 20 patients who transferred out of CHCF to another CDCR institution, CHCF staff listed only four patients' pending scheduled specialty service appointments on their health

care transfer information forms (20 percent). On the remaining 16 forms, nursing staff did not notate the patient's pending specialty service appointments (MIT 6.004).

Recommendations

No specific recommendations.

PHARMACY AND MEDICATION MANAGEMENT

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(69.9%)

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.

Case Review Results

The OIG clinicians evaluate pharmacy and medication management as secondary processes as they relate to the quality of clinical care provided. Compliance testing is a more targeted approach and is heavily relied upon for the overall rating for this indicator. During case review, 27 deficiencies related to pharmacy and medication management were noted, 14 of which could have caused harm to patients. The case review portion of this indicator was rated *inadequate*.

Nursing Medication Errors

- In case 1, the medication nurse failed to provide the weekly ciprofloxacin (antibiotic) dose. The patient was unavailable the day the medication became available and nursing did not timely follow-up with the patient. The patient did not receive the medication until the next week, resulting in a 14-day lapse.

- Also in case 1, the specialized medical housing unit nurse failed to check the patient's blood glucose level and identify why the evening insulin was not given. The next morning, the patient's blood glucose level was very high.

- In case 13, the nurse failed to clarify important questions regarding the correct dose and timing of new insulin orders.

- In case 23, after the patient returned from the hospital, nurses failed to obtain and administer needed chronic care medications from the institution's Omnicell. This oversight resulted in a three-day delay of medication receipt. This deficiency was discussed in the *Inter- and Intra-System Transfers* indicator.

- Also in case 23, the nurses failed to administer the evening doses of rifaximin (tuberculosis medication) for two weeks.

Pharmacy Errors

- In case 13, the patient did not receive the second dose of vancomycin (antibiotic) as recommended by the hospital physicians and ordered by the provider for osteomyelitis (bone infection).

Medication Continuity

In the majority of cases reviewed, patients received their medications timely and as prescribed. There were, however, four significant deficiencies regarding medication continuity:

- In case 7, the pharmacy did not update the medication administration records (MARs) to reflect new dosing guidelines for administering furosemide (diuretic). Nurses frequently did not document the patient's blood pressure on the MAR as required.

- In case 24, the pharmacy failed to dispense furosemide as ordered.

- In case 29, the pharmacy delayed the ordered discontinuance of insulin for three days.

Anticoagulant Medication

At CHCF, patients' anticoagulation medications were adjusted by the institution's anticoagulation clinic, which was managed by a chief physician & surgeon. The clinic was run well, and communication between the providers was good. Most cases involved appropriate changes of warfarin (blood thinner) dosing. However, there were three significant deficiencies noted:

- In cases 24 and 28, the patients were at high risk for blood clots. The provider failed to add a fast-acting temporary blood thinner while the more slow-acting medication was being initiated. This could have potentially resulted in further blood clots.

- In case 24, the pharmacy failed to review the physician's order to discontinue all prior warfarin orders. When the new lowered dose was ordered, the patient incorrectly received both warfarin doses.

Clinician Onsite Visit

During the onsite visit, the OIG met with CHCF providers, nurses, and pharmacy staff regarding specific case review findings. In addition, while onsite, the OIG discovered that when providers prescribed changes for chronic care keep-on-person medications, the older, unused medications collected from patients were routinely inappropriately disposed of. More specifically, the nurses did not always return unused medications to the pharmacy, as required by medication disposal policy. One of the medication line nurses in an outpatient unit informed the OIG that they simply placed the medications in the clinic's medical waste receptacle without a formal disposal record.

Clinician Summary

The OIG case review rated the *Pharmacy and Medication Management* indicator *inadequate.*

Compliance Testing Results

The institution received an *inadequate* compliance score of 69.9 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 66.6 percent, which fell into the *inadequate* range. The institution scored poorly in the following areas:

- For 23 of 39 patients sampled (59 percent), the institution timely and correctly administered all required chronic care medications and followed proper protocols when patients refused or were "no shows" to receive their medications. The remaining 16 sampled patients had one or more qualifying periods of missed medications and they did not always timely receive a medication counseling referral form, medication counseling, or both (MIT 7.001).

- Among 30 sampled patients at CHCF who had transferred from one housing unit to another, 18 (60 percent) received their prescribed medications without interruption; 12 patients did not receive their medications by the next dosing interval after the transfer occurred (MIT 7.005).

- CHCF provided hospital discharge medications within required time frames to 10 of 16 patients sampled who had returned from a community hospital (63 percent). For four patients, discharge medications were one to three days late, and two patients did not receive their discharge medications at all (MIT 7.003).

CHCF scored in the *adequate* range on the following test:

- The institution timely administered or delivered new medication orders to 34 of the 40 patients sampled (85 percent). Two patients received their medications one and six days late, and four patients did not receive their new medications at all (MIT 7.002).

Observed Medication Practices and Storage Controls

For this sub-indicator, the institution received an average score of 63.7 percent, scoring in the *inadequate* range on the following three tests:

- Among 30 clinic and medication line storage locations sampled, non-narcotic medications that required refrigeration were properly stored in only three (10 percent); the OIG inspectors considered the remaining 27 locations deficient because they did not have an area designated for return-to-pharmacy medications in their refrigerators (MIT 7.103).

- Non-narcotic medications that did not require refrigeration were properly stored at only 18 of the 36 applicable clinics and medication line storage locations inspected (50 percent). The 18 other clinics had one or more deficiencies. Nine clinics had internal and external medications stored in the same area. Eight clinics did not have designated areas for return-to-pharmacy medications. Five clinics had open, multi-use medication vials that nurses did not label with the dates they first opened the containers. Finally, two clinics had stored medications past their expiration dates (MIT 7.102).

- The OIG interviewed nursing staff and inspected narcotics storage areas at 27 applicable clinic and medication line locations to assess narcotics security controls. Only 15 clinic locations (56 percent) had strong controls in place. During the 30-day review period, nursing staff did not consistently complete narcotics control log entries as required by policy. In ten clinics, logbooks were missing required signatures. In two clinics, nurses did not complete a required physical narcotics inventory at every shift change. Additionally, in one of those ten locations, nursing staff also did not immediately update the narcotics log after administering a narcotic medication (MIT 7.101).

The institution performed in the *adequate* range on the following tests:

- Nursing staff at five of the six medication preparation and administration locations inspected followed proper hand hygiene protocols during the medication preparation and administration process (83 percent). However, nursing staff at one location did not always sanitize their hands prior to initially donning protective gloves or between subsequent glove changes (MIT 7.104).

- Five of six inspected medication administration areas (83 percent) demonstrated appropriate administrative controls and protocols. However, at one location, OIG inspectors observed a

prohibited nursing practice when a nurse distributed medications previously prepared by another nurse (MIT 7.106).

CHCF scored in the *proficient* range on the following test:

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

Pharmacy Protocols

For this sub-indicator, the institution received an average score of 80.0 percent, scoring 100 percent in the following test areas:

- CHCF's main pharmacy and satellite pharmacies followed general security, organization, and cleanliness management protocols; properly stored and monitored non-refrigerated and refrigerated or frozen medications; and maintained adequate controls and properly accounted for narcotic medications (MIT 7.107, 7.108, 7.109, 7.110).

CHCF scored in the *inadequate* range on the following test:

- CHCF's pharmacist in charge neither completed any of the 30 sampled medication error follow-up reports, nor shared the monthly medication error statistics report with the applicable quality improvement committees (MIT 7.111).

Non-Scored Tests

- In addition to the OIG's testing of reported medication errors, inspectors follow up on any significant medication errors found during the case reviews or compliance testing to determine whether the errors were properly identified and reported. The OIG provides those results for information purposes only. At CHCF, 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 prescribed KOP rescue asthma inhalers and nitroglycerin medications. Inspectors identified one patient to whom this test applied. The patient stated he had physical possession of his prescribed rescue medication (MIT 7.999).

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:
Adequate
(83.0%)

Overall Rating:
Adequate

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 *adequate* range in the *Preventive Services* indicator with a compliance score of 83.0 percent. Three test areas scored in the *proficient* range, with one receiving a score of 100 percent:

- The institution was compliant in offering annual influenza vaccinations to all 30 sampled patients during the most recent influenza season (MIT 9.004).

- CHCF offered colorectal cancer screenings to 29 of 30 sampled patients subject to the annual screening requirement (97 percent). For one patient, there was no evidence in the eUHR either that health care staff offered a colorectal cancer screening test within the previous 12 months or that the patient had a normal colonoscopy within the last ten years (MIT 9.005).

- Inspectors tested whether the institution timely offered vaccinations for influenza, pneumonia, and hepatitis to patients who suffered from chronic care conditions. At CHCF, 26 of 27 sampled patients (96 percent) received all recommended vaccinations at required intervals. For one patient, inspectors could not locate documented evidence of hepatitis A nor hepatitis B vaccinations (MIT 9.008).

The following test areas received scores in the *inadequate* range:

- Inspectors sampled nine patients taking tuberculosis (TB) medications to test for timely administration. Six of the nine patients (67 percent) received all required doses of their medication during the most recent three-month period. Three patients were out of compliance including one patient who missed three separate doses of medication, and two other patients who did not receive required visits with a provider when they refused their medication doses. In a related area, health care staff completed required monitoring for only

five of seven patients taking TB medications (71 percent). For two patients, there was no eUHR evidence that staff completed required signs and symptoms monitoring (MIT 9.001, 9.002).

- Inspectors sampled 30 patients to determine whether they received a TB screening within the last year. Of those 30 patients, 15 were classified as Code 22 (requiring a TB skin test in addition to a signs and symptoms check), and the other 15 were classified as Code 34 (subject only to an annual signs and symptoms check). Only 20 of the 30 screenings (67 percent) were adequate. Inspectors identified the following deficiencies related to the other ten TB screenings (MIT 9.003):

    - Among the 15 patients classified as Code 22, eight patients had insufficient screenings. They included four instances where an LVN or licensed psychiatric technician, rather than an RN, public health nurse, or primary care provider, read the patient's skin test result (as required by CCHCS policy in place at the time of the screening). Two instances occurred where nursing staff neglected to document either the test's start or end time and the inspector could not determine whether the nurse completed the test within the required 72 hours. Finally, inspectors noted one instance where nursing staff did not complete a patient's TB test at all.

    - Among the 15 patients classified as Code 34, nursing staff did not properly complete the history and symptoms section of the screening form for two patients.

Recommendations

No specific recommendations.

QUALITY OF NURSING PERFORMANCE

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

Overall Rating:
Adequate

The *Quality of Nursing Performance* indicator is a qualitative evaluation of the institution's nursing services. The evaluation is completed entirely by OIG nursing clinicians within the case review process, and, 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 health service request forms 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 Standby Emergency Medical Services (SEMS) or related to emergency medical responses are reported under the *Emergency Services* indicator.

Case Review Results

The OIG nursing clinicians rated the *Quality of Nursing Performance* at CHCF *adequate.* CHCF is predominantly a specialized medical housing environment. While most state facilities' medical units are primarily outpatient settings, the majority of CHCF patients resided in specialized medical units. The OIG evaluated 1,127 nursing encounters, 161 of which were in the outpatient setting; 826 nursing encounters relating to specialized medical housing were also reviewed, but are reported in the *Specialized Medical Housing* indicator.

Among the 161 outpatient nursing encounters reviewed, 56 were for sick call requests, 19 were for nursing case management (including diabetic and end-stage liver disease patients), six were for RN quarterly comprehensive case management assessment, ten were for education, seven were for abnormal blood sugar levels, and six were for wound care. In total, OIG clinicians identified 28 deficiencies related to outpatient nursing services, all were minor.

Nursing Sick Call

Clinicians reviewed 56 sick calls and found 11 deficiencies. Most sick call RNs appropriately assessed the patients' complaints and provided necessary interventions for patients presenting to the outpatient nursing clinics. The quality of nursing performance was sometimes affected by poor assessments, failure to see patients face-to-face, and failure to adequately review medication administration records for contraindications to patient care. The following notable deficiencies were identified:

- In cases 8, 48, 56, 63, 71, 73, and 75, objective assessments were inadequate or incomplete.
- In cases 8 (on three separate occasions), 70, 71, and 74, nurses failed to perform face-to-face assessments for patients with medical symptoms.
- In case 13, nurses twice documented the incorrect foot.
- In case 16, nurses failed to thoroughly and consistently document daily wound care.
- In case 64, the nurse failed to communicate recent abnormal laboratory results with the provider for a patient on a blood thinner when a new order may have been required.

Wound Care Program

CHCF employed two specially trained wound care RNs. One of them was available for interview while the OIG clinicians were onsite. These wound care nurses received provider orders to perform patient wound care. They were certified because of a week-long training course that enabled them to evaluate and appropriately treat wounds. Treatment regimens were selected from the CDCR wound care procedures. The procedures were written in the form of a provider order, which required a provider's signature.

The wound care nurses' time was ineffectively used because the nurses would often wait for their patients to finish showering or receiving other treatments (rather than treat other patients who were ready and then circling back to treat those patients who were initially unavailable). Poor communication led to this time management problem. The interviewed wound care nurse indicated that they also required additional time to push their wound care supply carts from unit to unit because each unit did not stock all needed specialty wound care supplies. Delays in wound care also occurred when unit nurses consciously neglected to conduct interim wound assessments because they anticipated that a specialty wound care nurse would eventually make weekly rounds to perform the task.

Clean Procedure Room

The institution's clean procedure room was used for minor surgical procedures, such as spinal taps. CHCF had infection control policies and procedures in place for the room. The RN in charge of procedures indicated that the institution was current on all infection control training. However, the training was an informal process without a written program. This RN was also credentialed in infection control and confident that the workers knew and understood the importance of the clean room. The OIG was concerned about the lack of a consistent, formal training program to ensure compliance with these standards during times the credentialed nurse was absent.

Medication Administration

Medication administration was generally timely and reliable and is further discussed in the *Pharmacy and Medication Management* indicator.

Emergency Care

Emergency nursing care is discussed in the *Emergency Services* indicator.

Inter- and Intra-System Transfers

Nursing care for transfers is discussed in the *Inter- and Intra-System Transfers* and *Diagnostic Services* indicators.

Clinician Onsite Visit

The nurses in outpatient clinic settings were active participants in primary care team morning huddles. Providers, sick call nurses, medication line nurses, and schedulers attended the morning huddles, which included discussions about hospitalized patients, SEMS visits, on-call physician reports, mental health concerns, and any other issues related to current patients and the day's clinic. Laboratory results and other pertinent patient data were projected onto a large screen monitor for all participants to observe. Staff members participated in team discussions when they had additional patient information to share.

During the OIG's onsite visit, nursing staff indicated that there were no major barriers to initiating communication with nursing supervisors, providers, and custody officers regarding patient care needs. Yard clinic nurses were knowledgeable about their patients, and some went beyond their daily sick call visits to check on patients they were concerned about. The receiving and release nurses demonstrated clear knowledge of processes established to assess the health care status of incoming patients, and they provided necessary care while the patients remained in the clinic area. Utilization management, specialty nurses, and support staff developed communication systems and backup systems to ensure providers closely followed hospitalized patients and those with specialty appointments. Nurses were enthusiastic about their assignments and working conditions. The nursing staff believed they provided quality nursing care to the patients and felt supported by the supervising nurses and chief nursing executive. Nurses in all areas reported good working

relationships with providers and custody staff. The OIG commends CHCF's nursing staff for their knowledge about assigned patients, specific processes, procedures for their individual assignments, and the institution-wide nursing communication practices.

The OIG clinicians interviewed the nurse educators about programs to enhance and improve care for patients. An all-day training course on palliative care was held the last day the OIG was onsite in preparation for the opening of a 60-bed palliative care unit. Twenty staff members were scheduled to receive education for this program, including travelling to CDCR's California Medical Facility to observe hospice care.

CHCF employed medical assistants (MAs). MAs have general medical knowledge, including medical terminology, clinical knowledge including nursing and laboratory procedures, and some computer skills. MAs receive extensive training on computer use and CDCR software, which regularly integrates custody, nursing, and medical records. MAs were ideally assigned as nursing unit clerks at CHCF.

CHCF received a grant to begin an LVN-to-RN program in association with a local college. LVNs who were current employees of CDCR and who had completed nursing prerequisites may apply for acceptance into the program. It was scheduled to be a "20-20" program, for each 20 hours of work the LVN would receive 20 hours of classroom instruction, until the course is completed. At least three known LVNs were expected to apply for this program.

Recommendations

The OIG recommends CHCF provide training in the following areas:

- The requirement of face-to-face assessments for patients who present with medical symptoms.
- Focused subjective and objective nursing assessments for each medical complaint based on both the patient's current complaints and his past health history.
- Documentation of accurate, legible nursing notes according to subjective, objective, assessment, plan, and education (SOAPE) note format requirements, including a legible signature and the time of the encounter.
- Enhanced communication between wound care nurses and unit nurses for conservation of time and increased productivity.

The OIG further recommends that CHCF do the following:

- Formalize its infection control training for all staff who work in procedure clinics.

QUALITY OF PROVIDER PERFORMANCE

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

Case Review Rating:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

Case Review Results

The OIG clinicians reviewed 767 medical provider encounters and identified 184 deficiencies related to provider performance. Of the 182 deficiencies, 69 were significant. The numbers of provider encounters and of deficiencies at CHCF were vastly greater than those of other inspected institutions were. However, the proportion of significant deficiencies among the events was in line with other intermediate institutions that received *adequate* provider ratings. CHCF provided medical care to patients with severe long-term needs, and its providers generally performed adequately with CDCR's most complex medical patients. CHCF had 14 OHUs, 12 CTCs, and one outpatient facility. Approximately 80 percent of the provider encounters reviewed involved care within the specialized medical housing units. Providers frequently made sound medical decisions while adapting to the challenges of a developing medical institution. Emergency care was appropriate and the providers worked well with receiving institutions for a seamless transfer of care. Occasionally, providers failed to properly review the medical information that was returned with the patient. OIG clinicians rated this indicator *adequate*.

Assessment and Decision-Making

Eighteen of the significant deficiencies involved both superficial assessments and a misjudging of the seriousness of medical conditions. The OIG found multiple errors attributable to the lack of continuity of care and the sometimes poor communication with nursing staff. Others causes for errors were due to the historical absence of a palliative care provider, a wound care provider specialist, and a preoperative policy within the institution. The OIG identified the following significant deficiencies:

- In case 6, the provider was consulted about a patient with shortness of breath. The provider appropriately ordered laboratory tests and a chest x-ray, but failed to have the patient evaluated within an appropriate time frame.

- In case 11, prior to hospitalizing the patient on several occasions for various ailments, providers failed to review the POLST (Physician Orders for Life-Sustaining Treatment) for

a patient with advanced dementia. The POLST had indicated that the patient desired comfort care only.

- In case 13, significant deficiencies occurred on several encounters:
    - The provider ordered oral levofloxacin (antibiotic) for suspected foot osteomyelitis with findings of gangrene and exposed bone. The provider failed to emergently transfer the patient to a higher level of care for this serious bone infection. In addition, the provider inappropriately ordered a follow-up in 28 days. Finally, the oral antibiotics were inadequate for this patient who required intravenous treatment.
    - The provider failed to address an elevated blood pressure of 175/78 (mm/Hg).
    - Upon the patient's return from the hospital, the provider failed to perform an adequate exam and assessment. The provider incorrectly dictated a normal physical exam after the patient returned from a partial foot amputation and a recent angiogram (blood vessel imaging). The provider also failed to assess the patient's diabetes mellitus.
    - Another provider inappropriately documented that the patient had a normal skin and extremity exam after another surgical procedure when, in fact, the patient had a recent below-the-knee amputation and a new bedsore.
    - The provider failed to evaluate the leg cellulitis (skin infection) discovered during hospitalization and failed to review the prior day's nurse's note documenting the presence of gangrene in the toes.
    - After nurse communication of the finding, the provider inappropriately waited five days to perform an evaluation of the gangrenous wound.
- In case 14, the provider incorrectly ordered a routine, not an urgent, computerized tomography (CT) scan of the chest, abdomen, and pelvis to rule out malignancy.
- Also in case 14, the provider failed to order a cardiology follow up for a patient with a significant new finding of heart failure.
- In case 15, the provider failed to pursue a POLST to indicate a change in code status when the patient requested to be a DNR (do not resuscitate). The POLST was delayed four months.
- In case 17, the providers failed to evaluate the patient in a preoperative clinic to assess risk with laboratory tests and a chest x-ray prior to surgical intervention. In addition, the provider failed to discuss with cardiology abnormal electrocardiogram (EKG) changes noted one day prior to surgery.

- In case 19, the provider reviewed the colonoscopy report indicating an inadequate exam because of poor patient preparation, which had occurred for the third time in less than five months. The provider ordered the fourth colonoscopy without additional action to ensure the patient adequately prepared for the exam. This delayed the patient's anemia workup.

- In case 20, the provider noted the patient had a symptomatic slow heart rate of 43 beats per minute, but failed to examine his heart or order an EKG.

- In case 21, the provider discontinued the patient's aspirin and clopidogrel (medications to prevent heart attacks) without documenting a reason. The patient had developed blockage of an artery to the heart four days prior and was sent to the hospital with chest pain the day after the medications were discontinued.

- In case 23, the provider failed to discontinue the long-acting insulin when intermediate insulin was started. This led to both insulins inappropriately being used for two months. Fortunately, no harm came to the patient from this incident.

- In case 24, the provider failed to evaluate an elderly patient with shortness of breath, an abnormal lung exam, and dizziness. A chest x-ray was ordered without appropriate follow-up. The provider failed to document this encounter.

- Also in case 24, the provider underestimated the risk for this patient with pneumonia. X-rays had suggested pneumonia in both lungs of this elderly diabetic patient, but he was only given an oral antibiotic (azithromycin) and discharged back to the dorm.

- In case 25, the provider evaluated a urinalysis suggestive of a urinary tract infection. The provider ordered a quinolone (antibiotic) for 30 days. The provider failed to review the prior urine cultures, which all showed that the patient had resistance to quinolones.

Review of Records

Medical information from an institution sending patients to CHCF is crucial, but CHCF lacked a process to highlight the recommendations of the sending institutions to help CHCF's receiving providers. The OIG noted 20 significant deficiencies during the review of records. Pertinent findings missing from either the specialty or hospital consultants can lead to increased risk of harm. Other significant review of records deficiencies are discussed in the *Specialty Services* indicator. The following were some of the notable deficiencies in this area:

- In case 7, the provider failed to promptly order new cholesterol and blood pressure medications recommended by the hospital physician for a patient with a new diagnosis of heart failure. This resulted in a three-day delay of receipt of the new medications.

- In case 8, on several occasions, the provider failed to thoroughly review the documentation of the poor ACAT score (tool to assess the management of asthma). This failure led to delayed management of poorly controlled asthma.

- In case 13, several providers failed to address elevated liver blood tests (aminotransferases of 1281 and 1002) indicative of acute hepatitis even though prior liver function tests were normal. The providers also failed to monitor thyroid function when starting amiodarone (heart medication), which has thyroid-related side effects.

- In case 13, the provider superficially reviewed the discharge summary and continued long-acting insulin twice a day instead of the recommended once a day.

- In case 14, the provider evaluated the patient after a recent hospitalization for an acute mental change caused by liver disease. In addition, the provider failed to address the low blood glucose episodes during the prior weeks. The provider also failed to address the concerning discharge diagnosis of a heart attack.

- In case 16, the provider incorrectly assessed that a patient had been previously taking the medications levetiracetam (seizure medication), clopidogrel (blood thinner), glargine insulin (diabetes), and minoxidil (blood pressure medication). However, the patient had not previously been on these medications. The provider inappropriately ordered unnecessary and potentially harmful medications.

- In case 21, the provider failed to document the nursing referral involving a patient with chest pain that did not resolve after four nitroglycerin tablets.

- In case 22, the provider superficially reviewed the respiratory therapy note documenting a patient with frequent episodes of shortness of breath. The patient was not provided with a rescue inhaler for his chronic obstructive lung disease.

- Also in case 22, the provider failed to review a nurse's note documenting the patient drinking his own urine. This resulted in a delayed patient evaluation for advanced dementia.

- In case 24, the provider reviewed recent hospital records and failed to document that a pulmonary embolism (blood clot in the lung) and a deep vein thrombosis (blood clot in the leg) had been discovered and that the patient was being treated with warfarin.

- Also in case 24, the provider failed to review duplicate prescriptions of blood-thinning medications ordered the day prior. This medication error resulted in the patient receiving a higher dose of warfarin for two additional days.

- In case 26, the providers, on several occasions, failed to thoroughly review the chronic care medications and continue the prescriptions for calcitriol (vitamin D) for hypocalcemia (low blood calcium). This case is also discussed in the *Diagnostic Services* indicator.

- In case 32, the provider failed to address the hospital's recommendations. This resulted in a ten-day delay in referral to vascular surgery.

- In case 34, the provider failed to review the prior progress note that ordered a chest x-ray. The imaging study was not reviewed until four months later.

Emergency Care

The providers mostly made appropriate decisions during emergencies. However, case review did identify four significant deficiencies that occurred in emergency care. Although these deficiencies were concerning, they were the exception to the well-managed emergency care provided by providers at CHCF. These cases are also discussed in the *Emergency Services* indicator.

- In case 13, the provider evaluated a patient with weakness, fever, and signs of serious infection in the foot. The provider suspected a seriously infected diabetic foot, yet incorrectly treated the patient with only a prescription of an oral antibiotic, instead of transfer to a higher level of care.

- In case 21, the provider failed to order aspirin for a patient with chest pain and an abnormal EKG.

- In case 25, the provider failed to assess the severity of a frail, diabetic patient with shortness of breath, low body temperature, and an abnormal chest x-ray indicative of a pneumonia. The provider took an unnecessary risk by only starting the patient on oral antibiotics in the OHU, instead of transferring him to a higher level of care.

- In case 29, the provider failed to provide treatment for a symptomatic patient with a critically high blood sugar level (826 mg/dl).

Chronic Care

The OIG noted 25 significant deficiencies in chronic care. The majority of the deficiencies involved the care of patients with diabetes mellitus and hepatitis C liver disease. Diabetic care was not followed closely enough within the huddles to help the providers develop dynamic treatment plans. In addition, hepatitis C treatment protocols were used too infrequently for this now curable disease.

- In case 6, the provider, on multiple occasions, noted critically high blood sugar levels (400 to 500 mg/dl) without episodes of hypoglycemia. However, the provider failed to change the patient's diabetic regimen.

- Also in case 6, the providers failed to evaluate and consider treatment for the patient with hepatitis C cirrhosis and a hepatitis C fibrosis score of 10 (treatment is strongly considered with scores of greater than 3.25). In addition, the positron emission tomography (PET) scan further supported treatment of the patient's hepatitis, as the result displayed no evidence of malignancy.

- In case 9, on several occasions, the provider failed to appropriately review and order follow-up on a patient with poorly controlled diabetes.

- In case 10, the provider failed to document why he discontinued a warfarin medication prescribed by a prior provider.

- In case 13, the provider failed to address the poorly controlled diabetes in a patient with coronary artery disease and a poorly healed amputation.

- In case 14, a provider inappropriately ordered two doses of regular insulin within a short amount of time. This increased the risk of a low blood sugar reaction.

- In cases 17 and 34, the providers incorrectly documented that patients on dialysis did not qualify for hepatitis C treatment. There are new treatments offered by the state to treat hepatitis C for patients with severe kidney disease.

- In case 19, the provider inappropriately renewed atenolol when the patient required a different blood pressure medication to lower blood pressure in the esophagus veins caused by liver disease.

- In case 23, the provider incorrectly prescribed glucose tablets three times a day to a diabetic requiring insulin.

- Also in case 23, the provider used a cloned note, identical to a previous note, including the vital signs from the previous note.

- Also in case 23, the provider inappropriately assessed a patient with poorly controlled diabetes. The finger stick blood glucose levels were not reviewed, and the diabetic medications were not modified.

- In case 24, the provider failed to provide enoxaparin (fast-acting blood thinner) to a patient with a recent pulmonary embolism and inadequate blood levels of warfarin (long-acting blood thinner).

- In case 25, prior to an elective surgery, the provider failed to obtain a cardiology consultation to help follow and reduce the risk for an additional heart injury for a patient who experienced a recent heart attack.

- In case 28, the provider failed to start enoxaparin for a patient at high risk of blood clots. The patient also had prolonged periods with inadequate levels of warfarin.

- In case 29, the provider noted diabetes mellitus was poorly controlled with an elevated fasting glucose and no hypoglycemic episodes, but no medication adjustment was ordered to improve diabetic control.

- In case 31, three-times-daily blood glucose levels showed poor control (ranged from 89 to 399 mg/dl), but the provider failed to order an average blood glucose sooner than the two months required if no treatment was to be provided. In addition, the provider failed to increase the long acting insulin or add a standard regular insulin dose before the noon meal and during the evening, which may have improved glucose control.

- Also in case 31, the patient refused a chronic care appointment. The provider should have briefly reviewed the patient's chart and rescheduled the appointment accordingly for a patient with worsening diabetes. The patient was not scheduled to see a primary provider for eight additional weeks. This delay resulted in a failure to meet the annual diabetic eye exam requirement.

- In case 35, the providers inappropriately documented that the patient with chronic hepatitis C and cirrhosis was not a candidate for hepatitis C treatment.

Documentation Quality

Documentation was generally appropriate. Dependence on cloned notes was a concern but was understandable due to the significant medical documentation within progress notes and frequent evaluations. However, two significant deficiencies in documentation occurred:

- In case 7, the provider relied on a cloned physical exam from prior progress notes. This dependence, on several occasions, resulted in the failure to document the presence of a newly inserted dialysis catheter.

- As described previously, in case 23, the provider used a cloned note, identical to a previous note, including the vital signs from the previous note.

Onsite Inspection

The morning meeting was collegial and professionally managed by the executive staff. Morning huddles were comprehensive, and the staff were aware of the prior night's activities and patients' medical issues. The transfer of information was fluid, yet a vital component was missing. Discussion with the providers revealed ignorance about the nurses' documentation of medical events. No comparison between the providers' on-call notes and the nurses' findings regarding patients' ailments occurred prior to scanning of the documentation. This inconsistency, on occasion, led to discordance in documentation of patients' acute health concerns.

The providers at CHCF appreciated the challenge of the medically complex patient population. They eagerly discussed the multiple diagnoses and provided up-to-date medical management while being minimally staffed with providers. With minimal staffing, providers had to provide coverage to other medical units for their colleagues when they took time off, compromising continuity of care. The providers interviewed by the OIG were disheartened by the amount of paperwork that accompanied these complex patients and expressed that nearly half of total work time spent with patients was used to fill out the various forms needed to comply with state mandates. Providers reported paperwork to be the most frustrating part of their duties. This had led many of them to consider other employment opportunities. As previously highlighted on page 2 of this report, physician retention has continually plagued CHCF.

The OIG's evaluation of CHCF premises revealed a clean and well-conceived infrastructure. The facilities were state-of-the-art, and medical equipment was readily available. Yet, the OIG identified that the CTC and OHU providers rarely documented their patients' rehabilitation potential. This may have been due to the lack of adequate physical therapy consultants. At the time of review, there were only two contract physical therapists and a part-time occupational therapists hired to manage the institution's patient population. Communication between the therapists and the providers was rare. Because of these factors, there was a backlog of over 250 patient appointments.

The physician executive staff consisted of three chief physician & surgeons and a chief medical executive. They were all highly receptive to their staff and were appreciated by the providers. They reported that staffing had improved, but recruiting and retention help from CCHCS was needed to maintain the current number of providers. The majority of the providers' deficiencies related to superficial reviews were attributed to necessary workaround solutions to triage these medically complex patients when there was a shortfall of providers and a surplus of documentation. In addition to managing the medical needs of this institution, the executive staff's challenging goal was to retain and increase the provider staff. Many at CHCF expressed concern about maintaining effectiveness with the upcoming implementation of the new Electronic Health Record System (EHRS). This additional transition stress and the required learning curve with the new system may greatly reduce provider efficiency as it did when implemented at other CDCR institutions. With the minimal provider staffing and the high medical acuity patient population, the medical providers at CHCF and the OIG expressed concern about the patient care in the near future at CHCF.

Conclusion

The OIG reviewed 30 clinical cases and found 23 *adequate* and 7 *inadequate*. The providers were an intelligent and impressive group of physicians in this new and complex institution. Their deficiencies were closely linked to the shortfalls of the institution, specifically the minimal provider staffing model. The providers were unable to provide continuity of care, and this resulted in superficial reviews of medical information and delays in treatment with chronic care patients. The medical staff was stretched to the limit, and provider fatigue was apparent. Still, the providers found a way to manage these complex patients. The OIG rated the *Quality of Provider Performance* indicator at CHCF *adequate*.

Recommendations

The OIG recommends that CHCF do the following:

- Develop changes to decrease the providers' workload. Improving time management of the providers would help mitigate identified deficiencies such as lack of careful medical record review. For example:
    - Add scribe positions to support the efficiency in providers' workload. This is a relatively low cost solution to dramatically increase the provider's productivity and decrease the need for them to fully complete some types of state mandated paperwork.
    - Remove barriers to recruitment of new providers, and fill the current vacancies.
- Increase the number physical therapy staff (either within the institution or as outpatient consultants).
- Recruit or assign a provider wound care specialist, such as with telemedicine, to work closely with the nurse wound care specialists.
- Include the assignment of a specially trained palliative care provider to work in the institution's planned 60-bed palliative care unit to help evaluate and manage complex patients who have serious ailments.
- Develop a preoperative management protocol with a documentation workflow to optimize and clear patients to undergo surgery or other procedures in a timely and safe manner.

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. California Health Care Facility is a medical facility with 14 active Outpatient Housing Units (OHUs) and 12 active Correctional Treatment Centers (CTCs).

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(74.4%)

Overall Rating:
Adequate

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

Case Review Results

CHCF's medical facility included 14 OHUs housing approximately 460 patients, as well as 12 CTCs housing about 350 patients. The OHUs are designated housing areas within state institutions providing supportive services for patients requiring limited assistance with daily living activities or short-term observations. The CTCs provided inpatient health services to patients who need professionally supervised health care that cannot be provided on an outpatient basis. The specialized medical housing at CHCF consisted of medically complex patients transferred from other institutions for closer medical management. CDCR recognizes that high-risk and clinically complex patients are at an exponentially higher risk for adverse health outcomes than the average patient is, and they require assessment that is more intensive, frequent monitoring, and treatment planning services to mitigate risk. CHCF was equipped and trained to manage the high volume of medically complex patients. The staffing had vacancies, which challenged those providers tasked with caring for these patients. The OIG reviewed 2,075 encounters for the *Specialized Medical Housing* indicator, including 353 dialysis encounters. There were 459 deficiencies, with 79 significant. The OIG clinicians rated the indicator *adequate*. However, as discussed below, they also identified deficient areas that need improvement in both nursing and provider care.

Provider Performance

Provider performance in the OHUs and CTCs is more completely discussed in the *Quality of Provider Performance* indicator. The clinicians provided adequate care within the specialized medical housing units. A provider rounded daily in one to two of the OHUs or CTCs, treating the urgent needs of the patients as well as addressing the scheduled appointments within the facility.

The providers were highly adaptive to the needs of the patients and were often enthusiastic about the medical management of these complex patients.

Nursing Performance

Performance of OHU and CTC nursing staff was adequate. The majority of nursing encounters reviewed demonstrated appropriate patient-specific nursing assessment, interventions, and documentation. The majority of the deficiencies involved nursing staff's inadequate assessment, failure to intervene, and failure to notify the provider. Of the 231 deficiencies in nursing services, 28 were significant and placed the patient at risk of, or actually caused, harm.

- In case 1, a patient was previously hospitalized for uncontrolled seizures and nurses failed to initiate seizure safety precautions or obtain provider orders for a seizure helmet. The patient was found on the floor and unresponsive twice because of uncontrolled seizures.

- In case 10, nurses inserted an intravenous line without a provider order. In addition, this patient with a swallowing disorder had to be evaluated by his provider after a choking episode because nurses did not follow recommendations from the speech therapist. The recommendations were for nurses to give medications with "honey-thick" liquids or jelly, to help the patient safely swallow.

- In case 12, the patient developed a new bedsore because nurses failed to implement prevention measures such as changing the patient's position every two hours.

- In case 13, nurses doing wound care did not document nor notify the provider of the wound deterioration but instead waited for the weekly wound care nurse to notify the provider. In addition, days before surgery for a three-toe amputation, nurses did not monitor the patient's condition or document the appearance of his gangrenous toes.

- Also in case 13, after a patient reported that he had just fallen out of bed, nurses failed to put the bed's side rails up. In addition, nurses did not reassess the patient's safety needs or implement plans for his safety. Two weeks later, the patient was found on the floor on two different occasions.

- In case 14, nurses failed to immediately notify the provider of the patient's dangerously low blood sugar level (37 mg/dl), failed to reassess blood sugar levels or the patient's condition, failed to inform the next watch of the patient's change in condition, and failed to document the SEMS RN's instructions for care.

- Also in case 14, the nurse failed to contact the provider immediately to report the patient's significant change in mental status, that included confusion, and inability to follow directions. Nurses failed to reassess the patient's condition while he was in this state, which caused an 80-minute delay in admission to the SEMS and a further delay in admission to the outside hospital emergency room.

- In case 15, the patient had difficulty breathing and vomited ten times in one night. The nurse failed to assess the patient's temperature, symptoms of breathing difficulty, lung sounds, vomiting, bowel movements, or swelling of the legs. In addition, the nurse failed to notify the provider of the new symptoms.

- In case 21, when the patient requested to see his provider for testicular pain, the nurse did not assess the patient's level of pain, did not document the patient's description of the pain, and did not refer the patient to the provider.

- In case 23, nurses failed to notify the SEMS provider of changes in the patient's condition following a radiology procedure. The patient had difficulty walking, swelling and tenderness in his legs, weakness, and all-over body pain.

- Also in case 23, the diabetes nurse case manager failed to identify for a month that the patient received both a long-acting insulin and an intermediate-acting insulin, when the long-acting should have been discontinued.

- In case 24, nurses failed to emergently notify a provider when a patient with significant respiratory disease had shortness of breath, a very low blood oxygen level, decreased breath sounds, and wheezing.

- In case 25, an elderly, fragile patient had severe weight loss. Upon the patient's admission to the CTC, the nurse failed to weigh him, document multiple wounds, obtain wound care orders, document his mental status, assess the skin surrounding a urinary catheter, document urine output, assess the blood oxygen level, initiate thorough nursing care plans, and contact the provider for diet orders.

- In case 48, the nurse inappropriately advised a diabetic patient to apply ice or heat to his feet to relieve pain. As the patient had decreased sensation in his feet, these treatments had the potential to cause additional injuries.

Clinician Onsite Inspection

Nurses working in the OHUs and CTCs had visual access to all patient rooms. All the specialized medical housing units were essentially identical, and patient rooms were on both sides of a long, rectangular open room. In the center of most buildings were two nursing units and a similar unit for custody. Providers had offices that were nurse accessible within these buildings. Custody also provided ready access to caregivers and patients. All patient care staff had access to computers, and meeting rooms had large monitors for sharing patient information during huddles or for training.

Clinician Summary

The California Health Care Facility provided adequate care to OHU and CTC patients. The large number of medically complex patients was mostly well managed, with relatively low numbers of significant deficiencies.

Compliance Testing Results

The institution received an *inadequate* score of 74.4 percent in the *Specialized Medical Housing* indicator, which focused on the institution's CTCs and OHUs. CHCF displayed the need for improvement in the following test areas:

- Providers completed subjective, objective, assessment, plan, and education (SOAPE) notes at required intervals for only 17 of the 39 sampled patients (44 percent); the 22 others were completed one to 19 days late (MIT 13.004).

- Providers evaluated 17 of 27 sampled patients within 24 hours of each patient's admission to a specialized medical housing unit (63 percent); one patient was evaluated more than 24 hours later, and there was no eUHR evidence found that the other nine patients were seen at all (MIT 13.002).

CHCF scored in the *adequate* range on the following test:

- Providers completed history and physical examinations at required intervals for 35 of 44 patients sampled (80 percent); untimely exams occurred from one to three days late for four patients, and five patients never received an exam at all (MIT 13.003).

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

- Nursing staff completed an initial assessment of all 44 sampled patients on the same day of their admission to the specialized medical housing unit (MIT 13.001).

- CHCF had properly functioning call systems in 18 of the 21 areas observed (86 percent). In three of the OHUs observed, staff did not always conduct or document evidence of daily testing of the call system. In a related area, knowledgeable staff at all inspected housing units stated that urgent or emergent staff access to patient cells was timely at one minute or less, and CHCF management did not identify any concerns related to this reported response time (MIT 13.101).

Recommendations

The OIG recommends CHCF leadership develop processes to protect patients with recurrent medical problems, such as bedsores and uncontrolled seizures.

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
(69.8%)

Overall Rating:
Inadequate

Case Review Results

The OIG clinicians reviewed 363 events related to specialty services, the majority of which were consultations and procedures. Ninety-one deficiencies were found in this category, 15 of which were significant. The OIG case review rated specialty services *inadequate*.

Access to Specialty Services

Most serious deficiencies were attributed to insufficient access to specialty consults. Greater than a third of the serious deficiencies occurred with urgent consults. In the following cases, specialty services contributed to delays of care:

- In case 6, the gastroenterology consult for an urgent endoscopic ultrasound (imaging of the digestive tract) was delayed more than six weeks.
- In case 13, an urgent podiatry consult never occurred.
- Also in case 13, the patient underwent a three-toe amputation and the orthopedic follow-up visit was delayed three weeks.
- Also in case 13, an urgent cardiology consultation was delayed two weeks.
- In case 19, a liver ultrasound was ordered but still not completed after seven months.
- In case 27, a patient suffered from blood clots in the leg, and the provider ordered a monitoring ultrasound to occur in four weeks. The ultrasound occurred but was not scanned into the eUHR. The provider did not have a two week follow up appointment to review the results. These results appear to have been missed until a consulting hematologist reviewed the report two months later.

- In case 33, the vascular consult for increasing leakage of blood from an artery was delayed two weeks.

Nursing Performance

Of the 363 encounters reviewed for specialty services, 45 were nursing encounters, with 30 nursing deficiencies noted. Although none was significant, most represented a repeated failure to adequately assess patients returning from outside specialty visits. Some documentation deficiencies were for incomplete, erroneous, or illegible records. Nurses failed to assess patients returning after colonoscopies, cryotherapy (freezing of skin lesions), toe amputations, wound repairs, new dialysis access, or intravenous lines. In addition, nurses failed to monitor the blood sugar levels of diabetic patients sent out while fasting for a procedure, who returned after the noon meal. Nursing care of patients returning from outside appointments was inadequate.

Onsite Specialty Procedure Clinics

During the onsite visit, 55 patients were seen in a shared clinic for orthopedic devices and optometry. A vaccine clinic also occurred that day. Various specialty clinics took place throughout the week. The frequency of specialty clinics varied from twice weekly (optometry), to monthly (infectious disease, audiology, and gastroenterology).

Provider Performance

Significant deficiencies involving missing and delayed consult notes and inadequate provider review included the following:

- In case 6, the provider erroneously dictated that the positron emission tomography (PET) report was not completed when it had been in the eUHR for 20 days prior to the provider's evaluation.

- Also in case 6, the provider failed to review several recent documents, including a recent gastroenterology consultant note recommending an endoscopic ultrasound and another provider's urgent gastroenterology consult request for an ultrasound.

- In case 20, the provider failed to review the oncologist's recommendation for a computerized tomography (CT) scan of the neck and thorax to determine the effectiveness of chemotherapy. This resulted in an imaging delay of three months. Fortunately, this did not harm the patient.

- In case 21, the provider failed to address the cardiologist's recommendation of a carotid ultrasound. On the physical exam, the consultant noted a carotid bruit (abnormal carotid finding that can indicate blockage).

Health Information Management

Health information management pertaining to specialty care exhibited deficiencies of delayed or unscanned records in the electronic medical record. In addition, deficiencies occurred in the transfer of specialty information from consultant to provider. The following were some notable deficiencies:

- In case 9, a scanning delay of over one month occurred with a heart stress test report.
- Also in case 23, the liver ultrasound was reviewed by the provider but was never scanned into the medical records.
- In case 35, the fibroscan (ultrasound for liver scarring) was reviewed by the provider, but was not scanned into the medical records.

These significant deficiencies are also discussed in the *Health Information Management* indicator.

Onsite Inspection

Specialty services are vital to an institution when the provider identifies patients requiring higher level of care with outside medical consultants. This institution had many patients requiring this care. The specialty services at CHCF and the providers were disconnected. During the OIG's inspection, consultant reports and access to care were delayed in multiple instances. The providers and specialty services failed to communicate the need for providing specialty and hospital recommendations in an easily retrievable and concise manner. This resulted in multiple deficiencies of superficial reviews related to specialty service documentation.

The lack of adequate physical therapy posed an additional barrier to assessing and rehabilitating many patients residing in the OHU and CTC. The OIG noted a backlog of over 250 patient appointments, with no solution identified by the institution. This is also discussed in the *Quality of Provider Performance* indicator.

Clinician Summary

While providers did an adequate job identifying and initially referring patients to specialty services when needed, issues with delays in specialist follow-ups were identified that negatively affected patient care. There were also delays in the retrieval of specialty reports and failure of the providers to adequately recognize and address specialty recommendations. Therefore, this indicator was rated *inadequate.*

Compliance Testing Results

The institution received an *inadequate* compliance score of 69.8 percent in the *Specialty Services* indicator, receiving low scores in the following specific test areas:

- Inspectors noted that specialists' reports were timely reviewed by a provider following routine specialty service appointments for only 7 of the 14 samples reviewed (50 percent); five reports were reviewed between one and eight days late, and two reports were not found in the eUHR (MIT 14.004).

- When an institution approves or schedules a patient for a specialty service appointment and then transfers that patient to another institution, policy requires that the receiving institution ensure a patient's appointment occurs within a specified time frame. At CHCF, only 11 of the 20 sampled patients (55 percent) received their specialty service appointments timely. Nine patients did not receive their appointments timely including three patients whose appointments occurred between one and 32 days late, four patients who never received their appointment at all, and two other patients who experienced both problems (MIT 14.005).

- For 10 of the 15 patients sampled, high-priority specialty service appointments occurred within 14 calendar days of the provider's order (67 percent); five patients received services from one to 15 days late (MIT 14.001).

- CHCF timely received and providers timely reviewed the specialist's reports for 10 of 15 patients sampled who received high-priority services (67 percent). The institution received the specialist's report for three patients from 3 to 11 days late and did not receive two reports at all. The provider reviewed the specialist's report for one patient four days late (MIT 14.002).

- When CHCF denied a provider's request for a specialty service, providers did not always communicate the denial to the patient within the required time frame, so that the patient could timely consider alternate treatment strategies. Of the 20 denials sampled, 14 patients (70 percent) received a timely notification while six patients did not. Two patients' service denial notifications were 2 and 18 days late, and four other patients never received the required notification (MIT 14.007).

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

- When patients did not meet certain minimum criteria to receive a requested specialty service, CHCF's health care management is required to notify the requesting physician within a required time frame. Based on the OIG's review, the institution timely made those notifications for 16 of 20 denials sampled (80 percent); there were four untimely denials that were issued one to seven days late (MIT 14.006).

CHCF scored in the *proficient* range in the following test area:

- For all 15 patients sampled, routine specialty service appointments timely occurred within 90 calendar days of the provider's order (MIT 14.003).

Recommendation

The OIG recommends the institution review its current processes related to specialty services to help improve problematic areas such as timeliness of patient appointments, and providers' ability to accurately address consultant recommendations. One of the process improvements could include the utilization management nurse highlighting during huddles the consultant recommendations for the specialty return patients. This should help to facilitate communication with the primary care team.

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 CHCF.

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 CHCF in July 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
(62.0%)

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 received an *inadequate* compliance score of 62.0 percent in the *Internal Monitoring, Quality Improvement, and Administrative Operations* indicator, with *inadequate* scores in the following test areas:

- None of the 12 sampled incident packages reviewed by the institution's Emergency Medical Response Review Committee included all required documentation. Specifically, the Emergency Medical Response Review Event Checklist forms were not completed. As a result, the institution scored a zero for this test area (MIT 15.007).

- CHCF staff completed medical emergency response drills for the three watches inspectors reviewed but did not complete all required forms for any of them, resulting in a score of zero (MIT 15.101).

- CHCF improved or reached targeted performance objectives for only one of seven quality improvement initiatives identified in its 2015 Performance Improvement Work Plan, resulting in a score of only 14 percent. For six of the initiatives, either the work plans did not document the progress made for some of the objectives identified, the institution failed to either improve upon or reach targeted objective levels, or both deviations occurred (MIT 15.005).

- The institution completed six of the ten initial patient death reports sampled within the required time frames (60 percent). Four reports were not timely or correctly submitted. Specifically, staff did not complete death report notifications for two patients by noon of the next business day following the deaths; for two other deaths, the chief medical executive did not sign the death reports as required by policy (MIT 15.103).

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

- Inspectors reviewed six recent months of Quality Management Committee (QMC) meeting minutes and confirmed that CHCF's QMC met monthly in all six months reviewed. In addition, the QMC evaluated program performance and took action when improvement opportunities were identified in five of those months (83 percent). Only one month's meeting minutes were inadequate. Specifically, the committee's December 2015 meeting did not identify improvement opportunities (MIT 15.003).

The institution scored a *proficient* 100 percent in each of the following test areas:

- CHCF's QMC took adequate steps to ensure the accuracy of its Dashboard data reporting. Further, staff documented discussions of data validation methodologies used when evaluating data, the results of data analysis, and the methodologies used to train staff who collected Dashboard data (MIT 15.004).

- CHCF processed inmate medical appeals timely for all 12 of the most recent months. In addition, the institution's second-level medical appeal responses addressed the patient's initial complaint in all ten appeals sampled (MIT 15.001, 15.102).

- The institution's local governing body (LGB) met at least quarterly and exercised responsibility for the quality management of patient health care during the most recent 12-month period (MIT 15.006).

Other Information Obtained from Non-Scored Areas

- The CCHCS' Death Review Committee (DRC) is required to complete a death review summary report within 30 to 60 days of an inmate's death, depending on whether the death was expected or unexpected. To allow for expeditious corrective action, the DRC should also issue the report to the institution's CEO within seven calendar days of report completion. At CHCF, all ten sampled deaths were expected and the reports should have been completed within 30 calendar days of death; however, none was timely completed. All ten reports were completed between 31 and 147 days late (61 to 177 days after death). In addition, once the reports were completed, the DRC did not always timely forward the completed reports to CHCF's CEO so that needed corrective action could be immediately pursued. The DRC untimely notified the CEO for nine of the ten completed reports. The lateness ranged between one and 14 days late (between 8 and 21 days after the DRC finalized the report) (MIT 15.996).

- Inspectors met with the CEO to inquire about CHCF's protocol for tracking routine medical appeals. Inspectors found that management received a Monthly Appeal Activity Report and a Monthly CEO Health Care Appeals Report from the appeals coordinator. These reports contained breakdowns of appeals categorized by topic and prioritized by number received.

Management utilized these reports to track appeal trends. When management identified a problem area, a quality improvement team was appointed to review the issue and make a recommendation (MIT 15.997).

- Non-scored data gathered regarding CHCF's practices for implementing local operating procedures (LOPs) indicated that the institution had an effective process in place for developing LOPs. The CEO stated the institution had an LOP committee that met on a monthly basis and worked to adhere as closely as possible to statewide policies. Each department supervisor was responsible for identifying and developing an LOP if it was necessary, and supervisors consulted with subject matter experts as needed. At the time of the OIG's inspection, CHCF had implemented 48 of the 49 applicable LOPs relating to core topical areas recommended by the clinical experts who helped develop the OIG's medical inspection compliance program (MIT 15.998).

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

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
(52.5%)

Overall Rating:
Inadequate

Compliance Testing Results

The institution received an *inadequate* compliance score of 52.5 percent in the *Job Performance Training, Licensing, and Certifications* indicator, scoring in the *inadequate* range on the following five tests:

- The pharmacist in charge did not have a system in place to monitor Drug Enforcement Agency (DEA) registrations for CHCF's providers who prescribed controlled substances. As a result, the institution scored a zero in this test area (MIT 16.106).

- During the most recent 12 months, CHCF did not ensure that all newly hired nurses timely received an employee orientation course. While all new nurses received training, two nurses received the training 41 and 69 days late. As a result, the institution scored a zero in this test area (MIT 16.107).

- Only one of five nurse supervisors sampled completed the required number of monthly performance reviews for their subordinate nurses (20 percent). Four nurse supervisors each completed some reviews, but not the minimum number of required reviews. In addition, one of these nurses also failed to address the "well-performed" and "needs improvement" aspects of their subordinate nurse's performance review (MIT 16.101).

- CHCF staff timely and properly completed only 10 of 30 provider clinical performance evaluations (33 percent). For the 20 providers who were deemed to be out of compliance, deficiencies consisted of the following: in two instances, evaluations were not signed or dated by the evaluator; in seven instances, probationary reports were untimely or not completed; and in 11 instances, annual evaluations were untimely, incomplete, or not completed at all (MIT 16.103).

- OIG inspectors examined records to verify that all CHCF providers, nurses, and custody staff members were current with their emergency response certifications and inspectors found that only the providers and nurses were fully compliant (67 percent). The inspectors identified where four correctional officers had expired certifications (MIT 16.104).

While CHCF scored poorly in the areas above, it received *proficient* scores in the following test areas:

- All providers were current with their professional licenses, and nursing staff and the pharmacist in charge were current with their professional licenses and certification requirements (MIT 16.001, 16.105).

- All ten nurses sampled were current on their clinical competency validations (MIT 16.102).

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.

What is HEDIS?

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 California Health Care Facility, nine HEDIS measures were selected and are shown in the following *CHCF Results Compared to State and National HEDIS Scores* table. Multiple health plans publish their HEDIS performance measures at the state and national levels. The OIG has provided selected results for several health plans in both categories for comparative purposes.

Results of Population-Based Metric Comparison

Comprehensive Diabetes Care

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. They included diabetes monitoring, patients under good HbA1c diabetic control, patients under poor HbA1c diabetic control, blood pressure monitoring control, and dilated eye exams.

When compared statewide, CHCF significantly outperformed Medi-Cal in all five diabetic measures selected. Further, CHCF outperformed the Kaiser Permanente, Southern California region, in four of five diabetic measures, trailing in only diabetic patient blood pressure control by 6 percentage points. CHCF also outperformed Kaiser's, Northern region, in three of the five measures. However, CHCF scored 3 and 7 percentage points lower than Kaiser, Northern region, in conducting dilated eye exams and in diabetic patient blood pressure control, respectively.

When compared nationally, CHCF significantly outperformed Medicaid, Medicare, and commercial health plans (based on data obtained from health maintenance organizations) in all five of the diabetic measures. The institution scored better than the U.S. Department of Veterans Affairs (VA) in two of the four applicable measures (HbA1c testing and Poor HbA1c Control); and CHCF matched the VA in blood pressure control, but was outscored by 12 percentage points in conducting dilated eye exams. In general, CHCF performed well with its overall management of diabetes.

Immunizations

Comparative data for immunizations was only fully available for the VA and partially available for Kaiser, Medicare, and commercial health plans. With respect to administering influenza shots to adults aged 18 to 64, influenza shots for adults 65 and older, and pneumococcal vaccinations, CHCF significantly outperformed all other reporting entities; however, despite these comparatively good scores, the institution's CHCF's scores were still adversely affected by patient refusals, a factor that negatively affected the instruction's comparable score.

Cancer Screening

For this measure, colorectal cancer screening data for Medi-Cal and Medicaid was not available. With respect to colorectal cancer screening, CHCF performed better than Medicare and commercial health plans. CHCF's score was between 7 and 9 percentage points lower than Kaiser's, statewide, and the VA's. However, CHCF's low score was again directly attributable to patient refusals. Had the refusals not occurred, the institution would have had a nearly perfect score and the highest score compared to all reporting statewide and national health plans.

Summary

Overall, based on the institution's comparative HEDIS results, CHCF's performance reflected an adequate chronic care program, including comprehensive diabetes care, as well as an adequate immunization program. For colorectal cancer screening, the institution's performance demonstrated room for improvement. Overall, the institution's comparable scores for immunizations and cancer screenings could be further improved by implementing patient education measures to help reduce the rate of refusals.

CHCF Results Compared to State and National HEDIS Scores

Clinical Measures	California				National			
	CHCF Cycle 4 Results[1]	HEDIS Medi-Cal 2015[2]	HEDIS Kaiser (No. CA) 2015[3]	HEDIS Kaiser (So.CA) 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]	**12%**	39%	18%	24%	44%	31%	25%	19%
HbA1c Control (<8.0%)[6]	**75%**	49%	70%	62%	47%	58%	65%	-
Blood Pressure Control (<140/90)	**78%**	63%	84%	85%	62%	65%	65%	78%
Eye Exams	**78%**	53%	69%	81%	54%	56%	69%	90%
Immunizations								
Influenza Shots - Adults (18–64)	**81%**	-	54%	55%	-	50%	-	58%
Influenza Shots - Adults (65+)	**82%**	-	-	-	-	-	72%	76%
Immunizations: Pneumococcal	**95%**	-	-	-	-	-	70%	93%
Cancer Screening								
Colorectal Cancer Screening	**73%**	-	80%	82%	-	64%	67%	82%

1. Data was collected in September 2016 (for the management of diabetes measures) and July 2016 (for all other measures) by reviewing medical records from a sample of CHCF'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 plans, 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 plans were based on data received from various health maintenance organizations.

5. The Department of Veterans Affairs (VA) data was obtained from the VA's website, www.va.gov.
For the Immunizations: Pneumococcal measure only, the data was obtained from the *VHA Facility Quality and Safety Report - Fiscal Year 2012 Data*.

6. For this measure, the entire applicable CHCF population was tested.

7. For this measure only, a lower score is better. For Kaiser, the OIG derived the Poor HbA1c Control indicator using the reported data for the <9.0% HbA1c control indicator.

APPENDIX A — COMPLIANCE TEST RESULTS

California Health Care Facility Range of Summary Scores: 52.50% - 88.96%	
Indicator	**Compliance Score (Yes %)**
Access to Care	88.96%
Diagnostic Services	62.16%
Emergency Services	Not Applicable
Health Information Management (Medical Records)	78.16%
Health Care Environment	62.44%
Inter- and Intra-System Transfers	75.39%
Pharmacy and Medication Management	69.91%
Prenatal and Post-Delivery Services	Not Applicable
Preventive Services	82.95%
Quality of Nursing Performance	Not Applicable
Quality of Provider Performance	Not Applicable
Reception Center Arrivals	Not Applicable
Specialized Medical Housing (OHU, CTC, SNF, Hospice)	74.36%
Specialty Services	69.76%
Internal Monitoring, Quality Improvement, and Administrative Operations	61.96%
Job Performance, Training, Licensing, and Certifications	52.50%

Reference Number	*Access to Care*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
1.001	**Chronic care follow-up appointments:** Was the patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter?	30	10	40	75.00%	0
1.002	**For endorsed patients received from another CDCR institution:** If the nurse referred the patient to a provider during the initial health screening, was the patient seen within the required time frame?	26	2	28	92.86%	2
1.003	**Clinical appointments:** Did a registered nurse review the patient's request for service the same day it was received?	45	0	45	100.00%	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?	45	0	45	100.00%	0
1.005	**Clinical appointments:** If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter?	29	8	37	78.38%	8
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?	14	1	15	93.33%	30
1.007	**Upon the patient's discharge from the community hospital:** Did the patient receive a follow-up appointment within the required time frame?	16	0	16	100.00%	0
1.008	**Specialty service follow-up appointments:** Do specialty service primary care physician follow-up visits occur within required time frames?	11	7	18	61.11%	12
1.101	**Clinical appointments:** Do patients have a standardized process to obtain and submit health care services request forms?	4	0	4	100%	0
Overall percentage:					**88.96%**	

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?	1	9	10	10.00%	0
2.003	**Radiology:** Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	4	5	9	44.44%	1
2.004	**Laboratory:** Was the laboratory service provided within the time frame specified in the provider's order?	9	1	10	90.00%	0
2.005	**Laboratory:** Did the primary care provider review and initial the diagnostic report within specified time frames?	9	1	10	90.00%	0
2.006	**Laboratory:** Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	9	1	10	90.00%	0
2.007	**Pathology:** Did the institution receive the final diagnostic report within the required time frames?	7	3	10	70.00%	0
2.008	**Pathology:** Did the primary care provider review and initial the diagnostic report within specified time frames?	4	4	8	50.00%	2
2.009	**Pathology:** Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	2	6	8	25.00	2
Overall percentage:					**62.16%**	

Emergency Services	Scored Answers
Assesses reaction times and responses to emergency situations.	**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 patient encounter date?	10	1	11	90.91%	0
4.002	Are dictated / transcribed documents scanned into the eUHR within five calendar days of the patient encounter date?	20	0	20	100.00%	0
4.003	Are specialty documents scanned into the eUHR within the required time frame?	20	0	20	100.00%	0
4.004	Are community hospital discharge documents scanned into the eUHR within three calendar days of the patient date of hospital discharge?	15	1	16	93.75%	0
4.005	Are medication administration records (MARs) scanned into the eUHR within the required time frames?	20	0	20	100.00%	0
4.006	During the eUHR review, did the OIG find that documents were correctly labeled and included in the correct patient's file?	0	12	12	0.00%	0
4.007	Did clinical staff legibly sign health care records, when required?	15	17	32	46.88%	0
4.008	**For 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	1	16	93.75%	0
Overall percentage:					**78.16%**	

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	24	31	22.58%	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?	30	1	31	96.77%	0
5.103	**Infection Control:** Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	26	5	31	83.87%	0
5.104	**Infection control:** Does clinical health care staff adhere to universal hand hygiene precautions?	5	9	14	35.71%	17
5.105	**Infection control:** Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	28	3	31	90.32%	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?	22	9	31	70.97%	0
5.108	**Clinical areas:** Do clinic common areas and exam rooms have essential core medical equipment and supplies?	7	24	31	22.58%	0
5.109	**Clinical areas:** Do clinic common areas have an adequate environment conducive to providing medical services?	28	3	31	90.32%	0
5.110	**Clinical areas:** Do clinic exam rooms have an adequate environment conducive to providing medical services?	14	17	31	45.16%	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?	2	5	7	28.57%	24
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:					**62.44%**	

Reference Number	*Inter- and Intra-System Transfers*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
6.001	**For endorsed patients received from another CDCR institution or COCF:** Did nursing staff complete the initial health screening and answer all screening questions on the same day the patient arrived at the institution?	23	7	30	76.67%	0
6.002	**For endorsed patients received from another CDCR institution or COCF:** When required, did the RN complete the assessment and disposition section of the health screening form; refer the patient to the TTA, if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening?	26	1	27	96.30%	3
6.003	**For endorsed patients received from another CDCR institution or COCF:** If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption?	21	4	25	84.00%	5
6.004	**For patients transferred out of the facility:** Were scheduled specialty service appointments identified on the Health Care Transfer Information Form 7371?	4	16	20	20.00%	0
6.101	**For patients transferred out of the facility:** Do medication transfer packages include required medications along with the corresponding Medication Administration Record (MAR) and Medication Reconciliation?	4	0	4	100.00%	2
Overall percentage:					**75.39%**	

Reference Number	*Pharmacy and Medication Management*	Scored Answers				
		Yes	No	Yes + No	Yes %	N/A
7.001	Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows?	23	16	39	58.97%	1
7.002	Did health care staff administer or deliver new order prescription medications to the patient within the required time frames?	34	6	40	85.00%	0
7.003	**Upon the patient's discharge from a community hospital:** Were all medications ordered by the institution's primary care provider administered or delivered to the patient within one calendar day of return?	10	6	16	62.50%	0
7.004	**For patients received from a county jail:** Were all medications ordered by the institution's reception center provider administered or delivered to the patient within the required time frames?	Not Applicable				
7.005	**Upon the patient's transfer from one housing unit to another:** Were medications continued without interruption?	18	12	30	60.00%	0
7.006	**For en route patients who lay over at the institution:** If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption?	Not Applicable				
7.101	**All clinical and medication line storage areas for narcotic medications:** Does the institution employ strong medication security controls over narcotic medications assigned to its clinical areas?	15	12	27	55.56%	10
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?	18	18	36	50.00%	1
7.103	**All clinical and medication line storage areas for non-narcotic medications:** Does the institution properly store non-narcotic medications that require refrigeration in assigned clinical areas?	3	27	30	10.00%	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	1	6	83.33%	31

Reference Number	*Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.105	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when preparing medications for patients?	6	0	6	100.00%	31
7.106	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when distributing medications to patients?	5	1	6	83.33%	31
7.107	**Pharmacy:** Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and satellite pharmacies?	2	0	2	100.00%	0
7.108	**Pharmacy:** Does the institution's pharmacy properly store non-refrigerated medications?	2	0	2	100.00%	0
7.109	**Pharmacy:** Does the institution's pharmacy properly store refrigerated or frozen medications?	2	0	2	100.00%	0
7.110	**Pharmacy:** Does the institution's pharmacy properly account for narcotic medications?	2	0	2	100.00%	0
7.111	**Pharmacy:** Does the institution follow key medication error reporting protocols?	0	30	30	0.00%	0
7.998	**For Information Purposes Only:** During eUHR compliance testing and case reviews, did the OIG find that medication errors were properly identified and reported by the institution?	Information Only				
7.999	**For Information Purposes Only:** Do patients in isolation housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications?	Information Only				
Overall percentage:					**69.91%**	

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

Reference Number	*Preventive Services*	Scored Answers				
		Yes	**No**	**Yes + No**	**Yes %**	**N/A**
9.001	**Patients prescribed TB medications:** Did the institution administer the medication to the patient as prescribed?	6	3	9	66.67%	2
9.002	**Patients prescribed TB medications:** Did the institution monitor the patient monthly for the most recent three months he or she was on the medication?	5	2	7	71.43%	4
9.003	**Annual TB Screening:** Was the patient screened for TB within the last year?	20	10	30	66.67%	0
9.004	Were all patients offered an influenza vaccination for the most recent influenza season?	30	0	30	100.00%	0
9.005	**All patients from the age 50 through the age of 75:** Was the patient offered colorectal cancer screening?	29	1	30	96.67%	0
9.006	**Female patients from the age of 50 through the age of 74:** Was the patient offered a mammogram in compliance with policy?	Not Applicable				
9.007	**Female patients from the age of 21 through the age of 65:** Was the patient offered a pap smear in compliance with policy?	Not Applicable				
9.008	Are required immunizations being offered for chronic care patients?	26	1	27	96.30%	3
9.009	Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	Not Applicable				
Overall Percentage:					**82.95%**	

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

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

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

Reference Number	*Specialized Medical Housing (OHU, CTC, SNF, Hospice)*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	**For all higher-level care facilities:** Did the registered nurse complete an initial assessment of the patient on the day of admission, or within eight hours of admission to CMF's hospice?	44	0	44	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 patient within 24 hours of admission?	17	10	27	62.96%	17
13.003	**For OHU, CTC, & SNF only:** Was a written history and physical examination completed within 72 hours of admission?	35	9	44	79.55%	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 patient at the minimum intervals required for the type of facility where the patient was treated?	17	22	39	43.59%	5
13.101	**For OHU and CTC Only:** Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter patient's cells?	18	3	21	85.71%	0
Overall percentage:					**74.36%**	

Reference Number	*Specialty Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	Did the patient receive the high priority specialty service within 14 calendar days of the PCP order?	10	5	15	66.67%	0
14.002	Did the PCP review the high priority specialty service consultant report within three business days after the service was provided?	10	5	15	66.67%	0
14.003	Did the patient receive the routine specialty service within 90 calendar days of the PCP order?	15	0	15	100.00%	0
14.004	Did the PCP review the routine specialty service consultant report within three business days after the service was provided?	7	7	14	50.00%	1
14.005	**For endorsed patients received from another CDCR institution:** If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames?	11	9	20	55.00%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	16	4	20	80.00%	0
14.007	Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame?	14	6	20	70.00%	0
Overall Percentage:					**69.76%**	

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 patient 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?	Not Applicable				
15.003	Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified?	5	1	6	83.33%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	1	0	1	100.00%	0
15.005	For each initiative in the Performance Improvement Work Plan (PIWP), has the institution performance improved or reached the targeted performance objective(s)?	1	6	7	14.29%	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?	4	0	4	100.00%	0
15.007	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	0	12	12	0.00%	0
15.101	Did the institution complete a medical emergency response drill for each watch and include participation of health care and custody staff during the most recent full quarter?	0	3	3	0.00%	0
15.102	Did the institution's second-level medical appeal response address all of the patient's appealed issues?	10	0	10	100.00%	0
15.103	Did the institution's medical staff review and submit the initial patient death report to the Death Review Unit in a timely manner?	6	4	10	60.00%	0
15.996	**For Information Only:** Did the CCHCS Death Review Committee submit its patient death review summary to the institution timely?	Information Only				
15.997	**For Information Only:** Identify the institution's protocols for tracking medical appeals.	Information Only				
15.998	**For Information Only:** Identify the institution's protocols for implementing health care local operating procedures.	Information Only				

Reference Number	*Internal Monitoring, Quality Improvement, and Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.999	**For Information Only:** Identify the institution's health care staffing resources.	Information Only				
Overall Percentage:					**61.96%**	

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?	39	0	39	100.00%	0
16.101	Does the institution's supervising registered nurse conduct periodic reviews of nursing staff?	1	4	5	20.00%	0
16.102	Are nursing staff who administer medications current on their clinical competency validation?	10	0	10	100.00%	0
16.103	Are structured clinical performance appraisals completed timely?	10	20	30	33.33%	3
16.104	Are staff current with required medical emergency response certifications?	2	1	3	66.67%	0
16.105	Are nursing staff and the pharmacist in charge current with their professional licenses and certifications?	5	0	5	100.00%	1
16.106	Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	0	1	1	0.00%	1
16.107	Are nursing staff current with required new employee orientation?	0	1	1	0.00%	0
Overall Percentage:					**52.50%**	

APPENDIX B — CLINICAL DATA

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

Table B-2: California Health Care Facility Chronic Care Diagnoses	
Diagnosis	**Total**
Anemia	17
Anticoagulation	5
Arthritis/Degenerative Joint Disease	16
Asthma	10
COPD	16
Cancer	6
Cardiovascular Disease	32
Chronic Kidney Disease	30
Chronic Pain	26
Cirrhosis/End-Stage Liver Disease	9
Coccidioidomycosis	2
DVT/PE	2
Deep Venous Thrombosis/Pulmonary Embolism	3
Diabetes	35
Gastroesophageal Reflux Disease	16
Gastrointestinal Bleed	3
HIV	1
Hepatitis C	30
Hyperlipidemia	27
Hypertension	48
Mental Health	13
Rheumatological Disease	1
Seizure Disorder	5
Sickle Cell Anemia	1
Sleep Apnea	6
Thyroid Disease	10
	370

Table B-3: California Health Care Facility Event — Program	
Program	**Total**
Diagnostic Services	500
Emergency Care	116
Hospitalization	134
Intra-System Transfers In	14
Intra-System Transfers Out	3
Not Specified	4
Outpatient Care	538
Specialized Medical Housing	2,075
Specialty Services	363
	3,747

Table B-4 California Health Care Facility Review Sample Summary	
	Total
MD Reviews Detailed	30
MD Reviews Focused	0
RN Reviews Detailed	18
RN Reviews Focused	43
Total Reviews	91
Total Unique Cases	76
Overlapping Reviews (MD & RN)	15

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

California Health Care Facility			
Quality Indicator	**Sample Category (number of samples)**	**Data Source**	**Filters**
Access to Care			
MIT 1.001	Chronic Care Patients (40)	Master Registry	• Chronic care conditions (at least one condition per 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) (45)	MedSATS	• Clinic (each clinic tested) • Appointment date (2–9 months) • **Randomize**
MIT 1.007	Returns from Community Hospital (16)	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 (4)	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 (11)	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	(20)	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	(16)	OIG Q: 4.008	• Community hospital discharge documents • First 20 IPs selected
MIT 4.005	(20)	OIG Q: 7.001	• MARs • First 20 IPs selected
MIT 4.006	(12)	Documents for any tested patient	• Any misfiled or mislabeled document identified during OIG compliance review (12 or more = No)
MIT 4.007	Legible Signatures & Review (32)	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 (16)	Inpatient claims data	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • **Randomize** (each month individually) • First 5 patients from each of the 6 months (if not 5 in a month, supplement from another, as needed)
Health Care Environment			
MIT 5.101-105 MIT 5.107–111	Clinical Areas (31)	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 (6)	OIG inspector onsite review	• R&R IP transfers with medication

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Pharmacy and Medication Management			
MIT 7.001	Chronic Care Medication (40)	OIG Q: 1.001	*See* ***Access to Care*** • At least one condition per patient—any risk level • **Randomize**
MIT 7.002	New Medication Orders (40)	Master Registry	• Rx count • **Randomize** • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns from Community Hospital (16)	OIG Q: 4.008	• See ***Health Information Management (Medical Records)*** *(returns from community hospital)*
MIT 7.004	RC Arrivals – Medication Orders *N/A at this institution*	OIG Q: 12.001	• See ***Reception Center Arrivals***
MIT 7.005	Intra-Facility Moves (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 (0)	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 (37)	OIG inspector onsite review	• Identify and inspect onsite clinical areas that prepare and administer medications
MITs 7.107-110	Pharmacy (2)	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 (1)	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 *N/A at this institution*	OB Roster	• Delivery date (2–12 months) • **Most recent** deliveries (within date range)
	Pregnant Arrivals *N/A at this institution*	OB Roster	• Arrival date (2–12 months) • **Earliest** arrivals (within date range)

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Preventive Services			
MITs 9.001–002	TB Medications (11)	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 *N/A at this institution*	SOMS	• Arrival date (at least 2 yrs prior to inspection) • Date of birth (age 52–74) • **Randomize**
MIT 9.007	Pap Smear *N/A at this institution*	SOMS	• Arrival date (at least three yrs prior to inspection) • Date of birth (age 24–53) • **Randomize**
MIT 9.008	Chronic Care Vaccinations (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 *N/A at this institution*	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • **Randomize**
Specialized Medical Housing			
MITs 13.001–004	CTC (44)	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 (20)	MedSATS	• Arrived from (other CDCR institution) • Date of transfer (3–9 months) • **Randomize**
MIT 14.006-007	Denials (14)	InterQual	• Review date (3–9 months) • **Randomize**
	(6)	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 (0)	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) (7)	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 (10)	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.996	Death Review Committee (10)	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 (39)	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 (33)	OIG Q:16.001	• All required performance evaluation documents
MIT 16.104	Medical Emergency Response Certifications (all)	Onsite certification tracking logs	• All staff o Providers (ACLS) o Nursing (BLS/CPR) o 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

April 12, 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 California Health Care Facility (CHCF) conducted from July 2016 to October 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
Scott Heatley, M.D., Ph.D., CCHP, Chief Physician and Surgeon, OIG
Penny Horper, R.N., MSN, CPHQ, Nurse Consultant Program Review, OIG
Yulanda Mynhier, Director, Health Care Policy and Administration, CCHCS
Roscoe Barrow, Chief Counsel, CCHCS Office of Legal Affairs, CCHCS
R. Steven Tharratt, M.D., MPVM, FACP, Director, Health Care Operations, CCHCS
Renee Kanan, M.D., Deputy Director, Medical Services, CCHCS
Jane Robinson, R.N., Deputy Director, Nursing Services, CCHCS
Eureka Daye, Ph.D., Regional Health Care Executive, Region (I), CCHCS
Jasdeep Bal, M.D., Regional Deputy Medical Executive, Region (I), CCHCS
Phillip Mallory, R.N., Regional Nursing Executive, Region (I), CCHCS
Raul Recarey, Chief Executive Officer, CHCF
Annette Lambert, Deputy Director (A), Quality Management, Clinical Information and Improvement Services, CCHCS
Dawn DeVore, Staff Services Manager II, Program Compliance Section, CCHCS