

California Health Care Facility Medical Inspection Results Cycle 5



April 2019

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Service ♦ Transparency**

Office of the Inspector General CALIFORNIA HEALTH CARE FACILITY Medical Inspection Results Cycle 5

Roy W. Wesley
Inspector General

Bryan B. Beyer
Chief Deputy Inspector General

Shaun R. Spillane
Public Information Officer



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FOREWORD

Pursuant to California Penal Code Section 6126 et seq., which assigns the Office of the Inspector General (OIG) responsibility for oversight of the California Department of Corrections and Rehabilitation (CDCR), the OIG conducts a comprehensive inspection program to evaluate the delivery of medical care at each of CDCR's 35 adult prisons. The OIG **explicitly** makes no determination regarding the constitutionality of care in the prison setting. That determination is left to the Receiver and the federal court. The assessment of care by the OIG is just one factor in the court's determination whether care in the prisons meets constitutional standards.

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

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

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

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EXECUTIVE SUMMARY

The OIG completed the Cycle 5 medical inspection of the California Health Care Facility (CHCF) in February 2019. The vast majority of our inspection findings were based on CHCF's health care delivery between February 2017 and December 2017. Our policy compliance inspectors performed an onsite inspection in November 2017. After reviewing the institution's health care delivery, our case review clinicians performed an onsite inspection in October 2018 to follow up on their initial findings.

OVERALL RATING:

Inadequate

Our clinician team, consisting of expert physicians and nurse consultants, reviewed cases (patient medical records) and interpreted our policy compliance results to determine the quality of health care the institution provided. Our compliance team, consisting of registered nurses, monitored the institution's compliance with its medical policies by answering a predetermined set of policy compliance questions.

Our clinician team reviewed 75 cases that contained 1,977 patient-related events. Our compliance team tested 87 policy questions by observing CHCF's processes and examining 400 patient records and 1,527 data points. We distilled the results from both the case review and compliance testing into 13 health care indicators, and have listed the individual indicators and ratings applicable for this institution in the *CHCF Executive Summary Table* on the following page. Our experts made a considered and measured opinion that the overall quality of health care at CHCF was *inadequate*.

CHCF Executive Summary Table

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

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

Expert Clinician Case Review Results

Our expert clinicians reviewed cases of patients with many medical needs and included a review of 1,977 patient care events.¹ The vast majority of our case review covered the period between July 2017 and December 2017. As depicted on the executive summary table on page *iv*, we rated 10 of the 13 indicators applicable to CHCF. Of those ten applicable indicators, we rated two adequate and eight inadequate. When determining the overall adequacy of care, we paid particular attention to the clinical nursing and provider quality indicators, as adequate health care staff can sometimes overcome suboptimal compliance or performance with processes and programs. However, the opposite is not true; inadequate health care staff cannot provide adequate care, even though the established processes and programs may be adequate. We identified inadequate medical care based on the risk of significant harm to the patient, not the actual outcome.

Program Strengths — Clinical

- CHCF’s Emergency Medical Response Review Committee (EMRRC) identified deficiencies effectively, while emergency nurse supervisors provided suitable staff training.

Program Weaknesses — Clinical

- CHCF could not meet the institution’s demand for medical services because of ongoing problems with access to care. The institution often delayed provider follow-ups, especially in the correctional treatment centers (CTCs) and outpatient housing units (OHUs).
- CHCF did not provide adequate specialty service follow-ups. Follow-up appointments requested by specialists often occurred late.
- CHCF provider performance regressed significantly since Cycle 4. Providers repeatedly failed to make sound assessments and accurate diagnoses. Poor provider assessments and misdiagnoses frequently occurred throughout the case reviews, especially in the CTCs and the OHUs.
- CHCF providers did not sufficiently review diagnostic or laboratory reports. This finding was partly due to understaffing at the institution, which created a heavier workload for providers.
- CHCF providers performed poorly in addressing hospital discharge recommendations and new discharge diagnoses for patients.

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

- CHCF nursing performance also regressed since Cycle 4. The nurses made incomplete assessments for patients in all areas of the institution. This problem was especially notable for patients returning from an offsite hospital.
- CHCF nurses did not consistently ensure medication continuity for patients during the transfer-in and transfer-out processes.
- CHCF medication processes did not ensure medication continuity for the institution's patients. Patients often did not receive medications either timely or correctly.

Compliance Testing Results

Of the 13 health care indicators applicable to CHCF, our compliance inspectors² evaluated 10. Of these, we rated one *adequate* and nine *inadequate*. The vast majority of our compliance testing concerned medical care that occurred between February 2017 and November 2017. Within those ten indicators, 87 individual compliance questions generated 1,527 data points that tested CHCF's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.³ Those 87 questions are detailed in *Appendix A — Compliance Test Results*.

Program Strengths — Compliance

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

- The institution's specialized medical housing unit had properly working call buttons, and medical staff were able to enter patient rooms during emergent events in a timely manner.
- CHCF's nursing staff performed well in completing initial assessments on the same day patients were admitted to specialized medical housing.
- Providers at CHCF performed well in completing history and physical evaluations within 24 hours of a patient's admission to the correctional treatment center (CTC).

Program Weaknesses — Compliance

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

- Patients did not receive their ordered chronic care medications, hospital discharge medications, and newly ordered medications within the specified time frames.

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 wherein CCHCS policies and procedures did not specifically address an issue.

- Providers at CHCF did not always communicate diagnostic services results to patients in a timely manner.
- CHCF did not perform well in ensuring that approved specialty services were provided timely.
- The institution did not provide chronic care, specialty services, nursing referrals, and hospital discharge follow-up appointments within required time frames.
- CHCF performed poorly in managing patients on tuberculosis (TB) medications. Patients were not appropriately referred to a provider after missing several doses or refusing TB medications. In addition, the institution did not complete TB monitoring at required intervals.
- CHCF nurses often did not properly account for narcotic medication at medication line locations based on the record maintained by the licensed nursing staff.

Recommendations

The OIG recommends the following:

- The chief executive officer (CEO) and the chief support executive (CSE) should ensure that all CHCF providers have access to and show proficiency using the radiology information system (RIS) to retrieve and review offsite radiology reports. Alternatively, CHCF can scan offsite radiology reports directly into the EHRS medical record, which would be a more efficient method of enabling providers to review offsite reports. During this inspection, we found that a majority of CHCF providers did not review offsite radiology reports because they were inaccessible.
- The CEO and the CSE should identify and fix the processes that resulted in X-rays and laboratory tests being delayed or that were not completed, which we identified during this inspection.
- The CSE and the chief nurse executive (CNE) should rectify the problems we found whereby standby emergency medical services (SEMS) nurses did not consistently collect and process laboratory specimens when those tests were performed during weekends.
- All CHCF executives should analyze why the processing of diagnostic and specialty reports was delayed and attempt to correct the situation to alleviate future occurrences. We found delays with both the initial retrieval, and the providers' review, of those reports.
- The CNE should train and improve the clinical performance of nurses in multiple areas. The training should focus on making thorough assessments, recording complete

documentation, and administering all medications correctly. We found errors in these areas throughout the institution.

- The CEO, the CNE, and the pharmacist-in-charge (PIC) should analyze why problems occurred with pharmacy and nursing processes, and adjust these processes to correct problems we found with medication administration and medication continuity.
- The chief medical executive (CME) should improve the hiring, training, and monitoring processes the institution used to ensure sufficient provider quality. We found serious problems with providers' assessments, misdiagnoses, review of records, and chronic care performance. Most CHCF staff attributed these problems to severe provider understaffing during this review period.
- The CEO and the CNE should adjust specialty scheduling processes to ensure that patients who require urgent or short-interval specialty follow-ups receive them. During this inspection, we found that delayed specialty follow-ups occurred more frequently with urgent or expedited follow-up orders.

Population-Based Metrics

In general, CHCF performed very well compared to other health plans as measured by population-based metrics. In comprehensive diabetes care, CHCF outperformed most state and national health care plans in the five diabetic measures. However, CHCF scored lower than four health care plans regarding diabetic eye exams.

With regard to immunization measures, CHCF scored higher than all other health care plans for influenza immunizations in both younger and older adults. However, the institution's score for pneumococcal immunizations was mixed, exceeding the score for one health care plan, but scoring lower than one other health care plan. CHCF's colorectal cancer screening scores were higher than all other health plans.

CHCF may improve its score for diabetic eye exams by reducing the number of refusals through educating patients on the benefits of this preventive service.

INTRODUCTION

Pursuant to California Penal Code Section 6126 et seq., which assigns the Office of the Inspector General (OIG) responsibility for oversight of the California Department of Corrections and Rehabilitation (CDCR), and at the request of the federal Receiver, the OIG developed a comprehensive medical inspection program to evaluate the delivery of medical care at each of CDCR's 35 adult prisons. The OIG conducted a clinical case review and a compliance inspection, ensuring a thorough, end-to-end assessment of medical care within CDCR.

California Health Care Facility (CHCF) was the 35th medical inspection of Cycle 5. During the inspection process, the OIG assessed the delivery of medical care to patients using the primary clinical health care indicators applicable to the institution. The *Administrative Operations* indicator is secondary because it does not reflect the actual clinical care provided.

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 (CCHCS). 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 14 licensed correctional treatment centers (CTCs), which provided inpatient medical care, diagnostic evaluation, and treatment. There were also 12 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 also had multiple outpatient clinics in E facility 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.

Based on staffing data the OIG obtained from CCHCS as identified in the following *CHCF Health Care Staffing Resources as of November 2017* table, CHCF’s vacancies among nursing staff were 143.6 positions in November 2017, and nursing supervisors had 20.4 vacancies. At the time of the OIG’s inspection, CHCF had 26 nursing staff on extended leave.

CHCF Health Care Staffing Resources as of November 2017

	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff**	Total
Authorized Positions	8.0	41.0	75.4	1,017.6	1,142.0
Filled by Civil Service	8.0	22.0	55.0	874.0	959.0
Vacant	0.0	19.0	20.4	143.6	183.0
Percentage Filled by Civil Service	100.0%	53.7%	72.9%	85.9%	84.0%
Telemed					
Filled by Telemed	0.0	3.0	0.0	0.0	3.0
Percentage Filled by Telemed	0.0%	7.3%	0.0%	0.0%	0.3%
Registry					
Filled by Registry	0.0	7.4	0.0	16.1	23.5
Percentage Filled by Registry	0.0%	18.0%	0.0%	1.6%	2.1%
Total Filled					
Total Filled Positions	8.0	32.4	55.0	890.1	985.5
Total Percentage Filled	100.0%	78.9%	72.9%	87.5%	86.3%
Appointments in Last 12 Months					
Appointments in Last 12 Months	0.0	5.0	7.0	106.0	118.0
Redirected Staff	0.0	0.0	0.0	2.0	2.0
Staff on Extended Leave^	0.0	1.0	0.0	26.0	27.0
Adjusted Total					
Adjusted Total: Filled Positions	8.0	31.4	55.0	862.1	956.5
Adjusted Total: Percentage Filled	100.0%	76.5%	72.9%	84.7%	83.8%

* Executive Leadership includes Chief Physician & Surgeon.

** Nursing Staff includes Senior Psychiatric Technician/Psychiatric Technician.

^ In Authorized Positions.

Note: The OIG did not validate the CHCF Health Care Staffing Resources data.

As of November 6, 2017, the Master Registry for CHCF showed that the institution had a total population of 2,338. Within that total population, 42.7 percent was designated as high medical risk, Priority 1 (High 1), and 23.5 percent was designated as high medical risk, Priority 2 (High 2). Patients’ assigned risk levels are based on the complexity of their required medical care related to their specific diagnoses, frequency of higher levels of care, age, and abnormal laboratory results and procedures. High 1 has at least two high-risk conditions; High 2 has only one. Patients at high medical risk are more susceptible to poor health outcomes than those at medium or low medical risk. Patients at high medical risk also typically require more health care services than do patients with lower assigned risk levels. The table on the following page illustrates the breakdown of the institution’s medical risk levels at the start of the OIG medical inspection.

CHCF Master Registry Data as of November 6, 2017

Medical Risk Level	Number of Patients	Percentage
High 1	999	42.7%
High 2	550	23.5%
Medium	646	27.6%
Low	143	6.1%
Total	2,338	100%

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OBJECTIVES, SCOPE, AND METHODOLOGY

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

To maintain a metric-oriented inspection program that evaluates medical care delivery consistently at each state prison, the OIG identified 15 indicators (14 primary (clinical) indicators and one secondary (administrative) indicator) of health care to measure. The primary quality indicators cover clinical categories directly relating to the health care provided to patients, whereas the secondary quality indicator addresses the administrative functions that support a health care delivery system. The *CHCF Executive Summary Table* on page *iv* of this report identifies these 15 indicators.

The OIG rates each of the quality indicators applicable to the institution under inspection based on case reviews conducted by OIG clinicians and compliance tests conducted by OIG registered nurses. The case review results alone, the compliance test results alone, or a combination of both these information sources may influence an indicator's overall rating. For example, the OIG derives the ratings for the primary quality indicators *Quality of Nursing Performance* and *Quality of Provider Performance* entirely from the case review done by clinicians, while the ratings for the primary quality indicators *Health Care Environment* and *Preventive Services* are derived entirely from compliance testing done by registered nurse inspectors. As another example, primary quality indicators such as *Diagnostic Services* and *Specialty Services* receive ratings derived from both sources.

The OIG does not inspect for efficiency or cost-effectiveness of medical operations. Consistent with the OIG's agreement with the Receiver, this report only addresses the quality of CDCR's medical operations and its compliance with quality-related policies. 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, the OIG does not include specific identifying details related to any such cases in the 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 are not necessarily indicative of deficient medical care delivery.

CASE REVIEWS

The OIG added case reviews to the Cycle 4 medical inspections at the recommendation of its stakeholders, which continues in the Cycle 5 medical inspections. The following exhibit provides definitions that describe this process.

Exhibit 1. Case Review Definitions

Case = Sample = Patient

An appraisal of the medical care provided to one patient over a specific period, which can comprise detailed or focused case reviews.

Detailed Case Review

A review that includes all aspects of one patient's medical care assessed over a six-month period. This review allows the OIG clinicians to examine many areas of health care delivery, such as access to care, diagnostic services, health information management, and specialty services.

Focused Case Review

A review that focuses on one specific aspect of medical care. This review tends to concentrate on a singular facet of patient care, such as the sick call process or the institution's emergency medical response.

Case Review Event

A direct or indirect interaction between the patient and the health care system. Examples of direct interactions include provider encounters and nurse encounters. An example of an indirect interaction includes a provider reviewing a diagnostic test and placing additional orders.

Case Review Deficiency

A medical error in procedure or in clinical judgment. Both procedural and clinical judgment errors can result in policy non-compliance, elevated risk of patient harm, or both.

Adverse Deficiency

A medical error that increases the risk of, or results in, serious patient harm. Most health care organizations refer to these errors as *adverse events*.

The OIG’s clinicians perform a retrospective case review of selected patient files to evaluate the care given by an institution’s primary care providers and nurses. Retrospective case review is a well-established review process used by health care organizations that perform peer reviews and patient death reviews. Currently, CCHCS uses retrospective case review as part of its death review process and in its pattern-of-practice reviews. CCHCS also uses a more limited form of retrospective case review when performing appraisals of individual primary care providers.

Patient Selection for Retrospective Case Reviews

Because retrospective case review is time consuming and requires qualified health care professionals to perform it, the OIG must carefully select a sample of patient records for clinician review. Accordingly, the group of patients the OIG targeted for case review carried the highest clinical risk and utilized the majority of medical services. The majority of patients selected for retrospective case review were high-utilizing patients with chronic care illnesses who were classified as high or medium risk. The reason the OIG targeted these patients for review is twofold:

1. The goal of retrospective case review is to evaluate all aspects of the health care system. Statewide, high-utilization patients consume medical services at a disproportionate rate. Between October 2011 and March 2012, 9 percent of the total statewide adult patient population was classified as high-risk and accounted for more than half of CCHCS’ pharmaceutical, specialty, community hospital, and emergency costs.⁴ This disproportionate utilization of health care resources was consistent with that observed in the general U.S. population. Based on the 2010 Medical Expenditure Panel Survey data, 5 percent of the U.S. population accounted for 50 percent of health care costs.⁵ By May 2018, the proportion of high-risk patients had increased to 13.6 percent of the statewide adult patient population.⁶
2. Selecting this target group for case 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- and medium-risk patients for detailed case review, the OIG clinical experts made the following three assumptions:

⁴ Twenty-first Tri-Annual Report of the Federal Receiver’s Turnaround Plan of Action for May 1 – August 31, 2012, Appendix 6, *High-Risk Patient Performance Report – Appropriate Placement in the CCHCS Primary Care Environment*, August 2012; <https://www.clearinghouse.net/chDocs/public/PC-CA-0018-0097.pdf> (accessed 3-28-19).

⁵ S. B. Cohen, *The Concentration and Persistence in the Level of Health Expenditures Over Time: Estimates for the U.S. Population, 2009–2010* (Rockville, MD: Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, 2012); https://meps.ahrq.gov/data_files/publications/st392/stat392.shtml (accessed 9-10-18).

⁶ CCHCS Public Dashboard, Statewide, May 2018; <https://cchcs.ca.gov/wp-content/uploads/sites/60/2018/08/Public-Dashboard-2018-05.pdf> (accessed 9-10-18).

1. If the institution is able to provide adequate clinical care to the most challenging patients with multiple complex and interdependent medical problems, it is more likely to provide 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 cases generated during death reviews, sentinel events (unexpected occurrences involving death or serious injury, or risk thereof), and hospitalizations are more likely to comprise high-risk patients.

Benefits and Limitations of Targeted Subpopulation Review

Because the patients selected utilize the broadest range of services offered by the health care system, the OIG's retrospective case review provides adequate data for a qualitative assessment of the most vital system processes (referred to as "primary quality indicators"). Retrospective case 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 institution's ability to *respond* with adequate medical care to this subpopulation is a crucial and vital indicator of how the institution provides health care to its whole patient population. Simply put, if the institution's medical system does not *respond* adequately 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 medical *conditions* or *outcomes* from the retrospective case reviews to the general population. For example, if the high-risk diabetic patients reviewed have poorly controlled diabetes, one cannot conclude that all the diabetics' conditions are poorly controlled. Similarly, if the high-risk diabetic patients under review have poor outcomes, one cannot conclude that the entire diabetic population is having similarly poor outcomes. The OIG does not extrapolate *conditions* or *outcomes*, but instead extrapolates the institution's *response* for those patients needing the most care because the *response* yields valuable system information.

In the above example, if the institution responds by providing appropriate diabetic monitoring, medication therapy, and specialty referrals for the high-risk patients reviewed, then it is reasonable to infer that the institution is also responding appropriately to all the diabetics in the prison. However, if these same high-risk patients needing monitoring, medications, and referrals

are not getting those needed services, it is likely that the institution is not providing appropriate diabetic services.

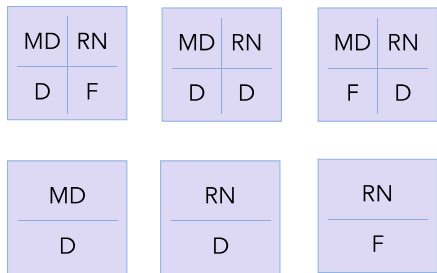
Case Review Sampling Methodology

Using a pre-defined case review sampling algorithm, OIG analysts apply various filters to each institution’s patient population. The various filters include medical risk status, number of prescriptions, number of specialty appointments, number of clinic appointments, and other health-related data. The OIG uses these filters to narrow down the population to those patients with the highest utilization of medical resources (see Chart 1, below). To prevent selection bias, the OIG ensures that the same clinicians who perform the case reviews do not participate in the sample selection process.

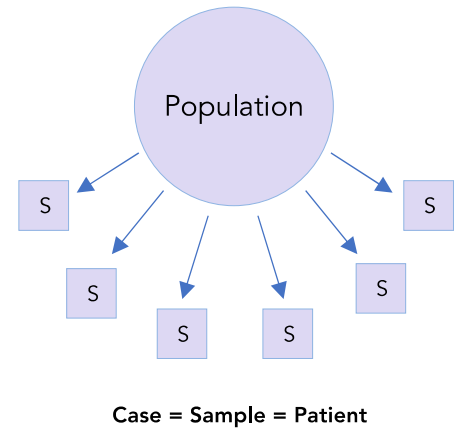
Chart 1. Case Review Sample Selection

Sample Selection

Analysts apply filters to the **population** to obtain **samples (S)** with high utilization. Six permutations, or arrangements, of case review types are possible for each sample.



MD = Provider
 RN = Registered Nurse
 D = Detailed Review
 F = Focused Review



The OIG’s case sample sizes matched those of other qualitative research. The empirical findings, supported by expert statistical consultants, showed adequate conclusions after 10 to 15 cases had undergone comprehensive, or detailed, clinician review. In qualitative statistics, this phenomenon is known as “saturation.” The OIG found the Cycle 4 medical inspection sample size of 30 for detailed physician reviews far exceeded the saturation point necessary for an adequate qualitative review. At the end of Cycle 4 inspections, the OIG re-analyzed the case

review results using half the number of cases; there were no significant differences in the ratings. To improve inspection efficiency while preserving the quality of the inspection, the OIG reduced the number of the samples for Cycle 5 medical inspections to the current levels. For most basic institutions, the OIG samples 20 cases for detailed physician review. For intermediate institutions and several basic institutions with larger high-risk populations, the OIG samples 25 cases. For California Health Care Facility, the OIG samples 30 cases for detailed physician review.

Breadth of Case Reviews

As indicated in *Appendix B, Table B-1: CHCF Sample Sets*, the OIG clinicians evaluated medical records for 75 unique cases. *Appendix B, Table B-4: CHCF Case Review Sample Summary* clarifies that both nurses and physicians reviewed 23 of those cases, for 98 case reviews in total. Physicians performed detailed reviews of 30 cases, and nurses performed detailed reviews of 21 cases, totaling 51 detailed case reviews. Physicians and nurses also performed a focused review of an additional 47 cases. These reviews generated 1,977 case review events (*Appendix B, Table B-3: CHCF Event – Program*).

While the sampling method specifically pulled only 6 chronic care cases, i.e., 3 diabetes cases and 3 anticoagulation cases (*Appendix B, Table B-1: CHCF Sample Sets*), the 75 unique cases sampled included 426 chronic care diagnoses, including 43 additional cases with diabetes (for a total of 46) and 11 additional anticoagulation cases (for a total of 14) (*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 OIG did assess for adequacy the overall operation of the institution’s system and staff.

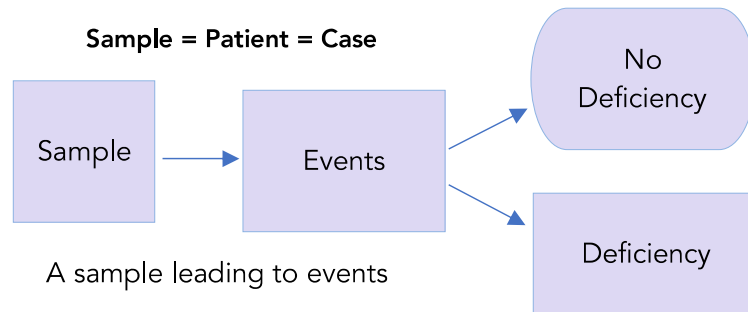
Case Review Testing Methodology

A physician, a nurse consultant, or both clinician inspectors review each case. The OIG clinician inspector can perform one of two different types of case review: detailed or focused (see Exhibit 1, page 6, and Chart 1, previous page). As the OIG clinician inspector reviews the medical record for each sample, the inspector records pertinent interactions between the patient and the health care system. These interactions are also known as case review *events*. When an OIG clinician inspector identifies a medical error, the inspector also records these errors as case review *deficiencies*. If a deficiency is of such magnitude that it caused, or had the potential to cause, serious patient harm, then the OIG clinician records it as an *adverse deficiency* (see Chart 2, next page).

Chart 2. Case Review Testing and Deficiencies

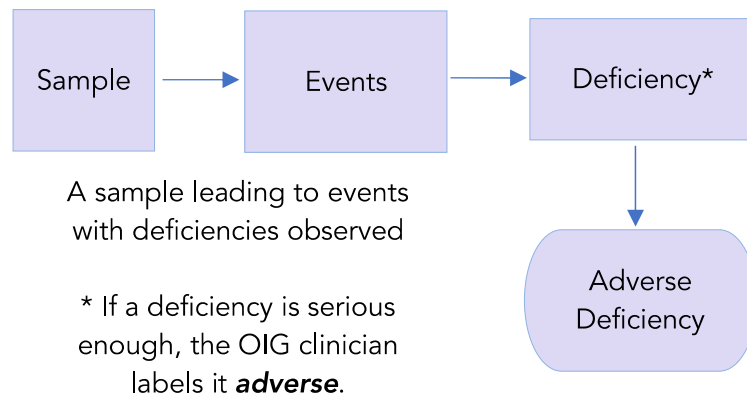
Case Review Testing

The OIG clinicians examine the chosen samples, performing a **detailed case review** or a **focused case review**, to determine the events that occurred.



Deficiencies

Not all events lead to deficiencies (medical errors); however, if there are errors, then the OIG clinicians determine whether any are **adverse**.



When the OIG clinician inspectors have reviewed all cases, they analyze the deficiencies. OIG inspectors search for similar types of deficiencies to determine if a repeating pattern of errors existed. When the same type of error occurs multiple times, the OIG inspectors identify those errors as findings. When the error is frequent, the likelihood is high that the error is regularly recurring at the institution. The OIG categorizes and summarizes these deficiencies in one or more health care quality indicators in this report to help the institution focus on areas for improvement.

Additionally, the OIG physicians also rate each of the detailed physician cases for adequacy based on whether the institution met the patient's medical needs and if it placed the patient at significant risk of harm. The cumulative analysis of these cases gives the OIG clinicians

additional perspective to help determine whether the institution is providing adequate medical services or not.⁷

Based on the collective results of clinicians' case reviews, the OIG clinicians rated each quality indicator *proficient* (excellent), *adequate* (passing), or *inadequate* (failing). A separate confidential *CHCF Supplemental Medical Inspection Results: Individual Case Review Summaries* report details the case reviews the 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

Our registered nurse inspectors obtained answers to 87 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 medical records. In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed health records for 400 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 November 27, 2017, registered nurse 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 1,527 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*.

⁷ Regarding individual provider performance, the OIG did not design the medical inspection to be a focused search for poorly performing providers; rather, the inspection assesses each institution's systemic health care processes. Nonetheless, while the OIG does not purposefully sample cases to review each provider at the institution, the cases usually involve most of the institutions' providers. Providers should only escape OIG case review if institutional managers assigned poorly performing providers the care of low-utilizing and low-risk patients, or if the institution had a relatively high number of providers.

Scoring of Compliance Testing Results

After compiling the answers to the 87 questions for the ten indicators for which compliance testing was applicable, the OIG compliance team derived a score for each quality indicator by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Based on those results, the OIG assigned a rating to each quality indicator of *proficient* (greater than 85 percent), *adequate* (between 75 percent and 85 percent), or *inadequate* (less than 75 percent).

OVERALL QUALITY INDICATOR RATING FOR CASE REVIEWS AND COMPLIANCE TESTING

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

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

POPULATION-BASED METRICS

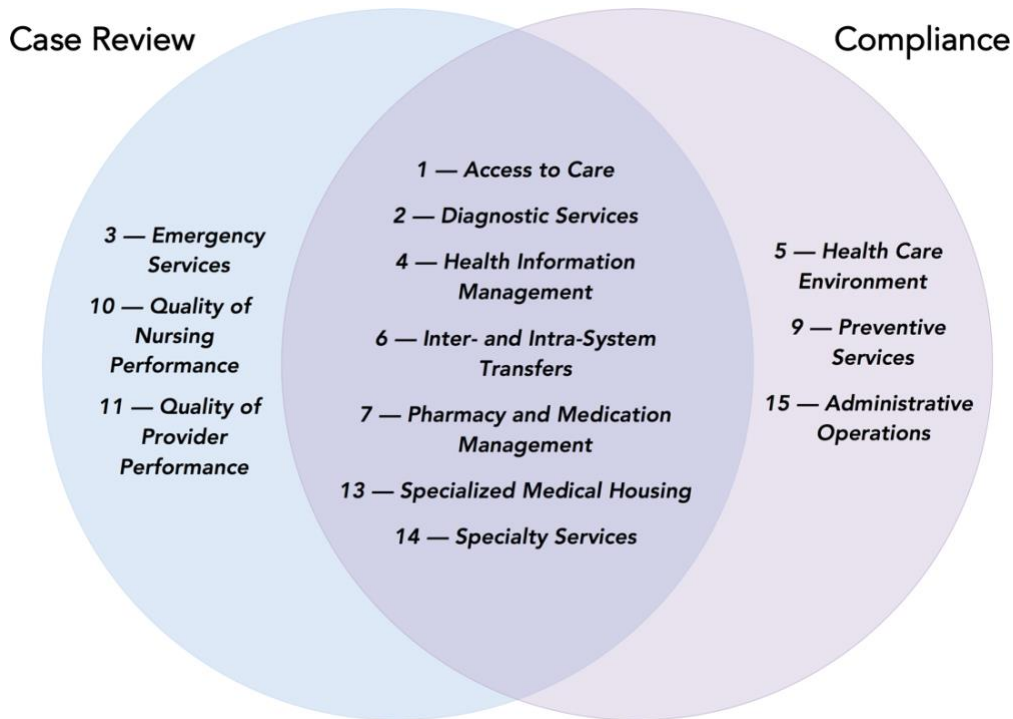
The OIG identified a subset of Healthcare Effectiveness Data Information Set (HEDIS) measures applicable to the CDCR patient population. To identify outcomes for CHCF, the OIG reviewed some of the compliance testing results, randomly sampled additional patients' records, and obtained CHCF data from the CCHCS Master Registry. The OIG compared those results to HEDIS metrics reported by other statewide and national health care organizations.

MEDICAL INSPECTION RESULTS

The OIG’s case review and clinician teams use quality indicators to assess the clinical aspects of health care. The *CHCF Executive Summary Table* on page *iv* of this report identifies the 13 indicators applicable to this institution. The following chart depicts their union and intersection:

Chart 3. Inspection Indicator Review Distribution

The *Administrative Operations* indicator is a secondary indicator; therefore, the OIG did not rely upon this indicator when determining the institution’s overall score. Based on the analysis and results in all the primary indicators, the OIG experts made a considered and measured opinion that the quality of health care at CHCF was *inadequate*.



The *Administrative Operations* indicator is a secondary indicator; therefore, the OIG did not rely upon this indicator when determining the institution’s overall score. Based on the analysis and results in all the primary indicators, the OIG experts made a considered and measured opinion that the quality of health care at CIM was *inadequate*.

Summary of Case Review Results: The clinical case review component assessed 10 of the 12 primary (clinical) indicators applicable to CHCF. Of these ten indicators, OIG clinicians rated two *adequate* and eight *inadequate*.

The OIG physicians rated the overall adequacy of care for each of the 30 detailed case reviews they conducted. Of these 30 cases, 13 were *adequate* and 17 were *inadequate*. In the 1,977 events reviewed, there were 665 deficiencies, 250 of which were considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

Adverse Deficiencies Identified During Case Review: Adverse deficiencies are medical errors that markedly increased the risk of, or resulted in, serious patient harm. Medical care is a complex and dynamic process with many moving parts, subject to human error even within the best health care organizations. All major health care organizations typically identify and track adverse deficiencies for quality improvement. Adverse deficiencies are not typically representative of medical care delivered by the organization. The OIG normally identifies adverse deficiencies for the dual purposes of quality improvement and the illustration of problematic patterns of practice found during the inspection. Because of the anecdotal nature of these deficiencies, the OIG cautions against drawing inappropriate conclusions regarding the institution based solely on adverse deficiencies. The OIG identified eight adverse deficiencies in the case reviews at CHCF:

- In case 1, the patient had an intestinal bleed and low platelet levels. The hospital physician recommended stopping the patient's clopidogrel (a blood thinning medication that decreases platelet function) and prescribing aspirin instead. While the providers prescribed aspirin to the patient, they failed to stop the patient's clopidogrel. They prescribed both of the blood-thinning medications, which significantly increased the patient's risk of bleeding again. We also discuss this case in the *Quality of Provider Performance* and *Specialized Medical Housing* indicators.
- Also in case 1, the patient had low blood levels (anemia). By July 2017, the patient's blood levels had decreased to a critically low level. None of the providers reviewed this abnormal laboratory result. As a result, they did not address the patient's critically low blood level until he had dialysis several days later. The following week, the patient's blood level decreased even further. Again, none of the providers acted immediately to address the patient's dangerously severe anemia. We also discuss this case in the *Quality of Provider Performance* indicator.
- Again in case 1, several providers did not thoroughly review the medical record and did not recognize the patient's irregular heart rhythm on two separate electrocardiograms (EKGs). In failing to diagnose the patient's irregular heart rhythm, the providers significantly increased the patient's risk of having a stroke or developing a blood clot in his lungs. We also discuss this case in the *Specialized Medical Housing* indicator.
- In case 7, the nurse failed to check the unresponsive patient for the presence of a pulse or breathing. Because of this error, the emergency staff did not start CPR immediately. The OHU nurse also requested 9-1-1 activation, but failed to direct a specific person to perform the task, resulting in a delay in contacting EMS. When the nurses noted a pulse, they stopped CPR, but did not check the patient for breathing. The nurses also failed to

restart CPR immediately when the patient's heart stopped beating again. We also discuss this case in the *Emergency Services* and the *Specialized Medical Housing* indicators.

- In case 8, the patient explained to the provider that in the event of his demise, he did not want medical staff to perform heroic life-saving measures (i.e., CPR). The provider failed to enter an order that reflected his wishes. Nurses did not ensure that those orders were entered. When the patient's condition deteriorated, medical staff performed CPR and other emergency measures on the patient despite the patient's most recent desire to withhold those interventions.
- In case 9, the patient had abdominal distention, lethargy, and confusion. A provider ordered an emergency abdominal X-ray, which revealed the patient had a small bowel obstruction. However, the provider was offsite and failed to inform the on-call physician that this X-ray was pending. As a result, a provider never checked the abdominal X-ray. The patient died five-hours later. The providers may have prevented this patient's death if a provider had known of the patient's bowel obstruction and had promptly sent the patient to an outside hospital for further management. We also discuss this case in the *Specialized Medical Housing* indicator.
- In case 17, the patient was taking a blood thinning medication, and the provider inappropriately added aspirin, another blood thinning medication. Consequently, the patient developed nasal and rectal bleeds.
- In case 23, the patient had an aggressive bacterial infection in his right leg. CHCF staff did not retrieve or scan his wound culture report for more than three weeks. The report showed the bacteria was resistant to multiple antibiotics, including the antibiotic ordered by the patient's provider. This delay in critical health information transmission also delayed the needed change in the patient's antibiotic treatment. We also discuss this case in the *Diagnostic Services* indicator.

Summary of Compliance Results: The compliance component assessed 10 of the 13 indicators applicable to CHCF. Of these ten indicators, OIG inspectors rated one *adequate* and nine *inadequate*. The results of those assessments are summarized within this section of the report. Each section of this report summarizes the results of those assessments, whereas *Appendix A* provides the details of the test questions used to assess compliance for each indicator.

1 — ACCESS TO CARE

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

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(68.2%)
Overall Rating:
Inadequate

Case Review Results

We reviewed 410 provider, nursing, specialty, and outside hospital encounters that required follow-up appointments, and identified 86 deficiencies relating to access to care. Of the 86 deficiencies, 57 were significant and placed the patient at an elevated risk of harm. Poor health care access affected all aspects of health care delivery at CHCF. The case review rating for the *Access to Care* indicator was *inadequate*.

Provider-to-Provider Follow-up Appointments

CHCF performance in this area remained relatively unchanged from Cycle 4. Failure to ensure appointment availability can cause lapses in care. The OIG clinicians reviewed 88 outpatient provider encounters and identified five deficiencies in cases 12, 22, 23, and 78. In these cases, follow-up appointments occurred late. The following are two examples of such delays:

- In case 22, the provider ordered a next-day follow-up for the patient to evaluate a right testicular mass. The follow-up did not occur for seven days, which was a significant lapse in care as the patient could have had an undiagnosed testicular cancer or an untreated infection.
- In case 78, the patient had a rash and right lower extremity swelling. The on-call provider requested a two-day follow-up, but the appointment did not occur.

RN Sick Call Access

CHCF performed satisfactorily with sick call access. The OIG clinicians reviewed 122 RN sick call encounters and identified only one significant deficiency:

- In case 26, a nurse received a patient's sick call requesting an urgent examination of a lower extremity ulcer. However, the nurse evaluation did not occur until four days later.

RN-to-Provider Referrals

Sick call nurses assess patients and make referrals to a provider when needed. CHCF performed poorly with these appointments, as we found seven significant deficiencies in cases 21, 24, 25, 52, 104, and 107. The following examples show missed or delayed nurse-requested provider appointments:

- In case 24, a nurse requested a patient follow-up with a provider in 14 days to assess an open head wound. However, the appointment never occurred.
- In case 52, a nurse requested a same-day provider appointment because the patient had testicular pain. However, the appointment did not occur until four days later.
- In case 107, the patient complained of right-sided neck pain. Although the nurse requested a one-day follow-up with the provider, the appointment did not occur until seven days later.

Provider Follow-Up After Specialty Service

CHCF failed to consistently provide patients with provider follow-up appointments after receiving specialty services. We reviewed 166 specialty diagnostic and consultative services and found many instances in which follow-ups were delayed or did not occur. This pattern of delayed follow-ups markedly increased the risk of lapses or delays in patient care. We found these deficiencies in cases 5, 10, 15, 25, 28, 30, 32, and in the following cases:

- In case 18, the provider requested an urgent appointment with an endocrinologist (a doctor who treats hormonal imbalances) because the patient had uncontrolled diabetes. After the patient returned from his endocrinology appointment, the nurse requested a 14-day follow-up with his provider. This appointment did not occur for nearly two months, which increased the patient's risk of developing diabetic complications.
- In case 22, the patient returned after he had received an urgent urological procedure. The provider requested a follow-up in three days. This appointment occurred 15 days outside the requested time interval, which resulted in a significant delay in the patient's medical care.
- In case 23, the patient had scarring of his cornea (the clear front surface of the eye) resulting from a viral infection. The onsite eye doctor recommended an urgent referral to an ophthalmologist (a specialty surgeon who diagnoses and treats eye diseases). The nurse requested a three-day follow-up with the patient's provider to process this urgent recommendation, but that appointment occurred 22 days later (19 days late), a delay that meant an ophthalmologist did not see the patient for nearly one month. This lapse in care was significant as the patient's eye infection could have worsened and caused blindness.

Intra-System Transfers

Nurses assessed newly transferred patients correctly and typically referred them to a provider timely. We reviewed three transfer-in patients and found no deficiencies with access to care in this area.

Follow-up After Hospitalization

CHCF performance in patient follow-ups after hospitalizations was sufficient, similar to that observed during Cycle 4. We reviewed 53 hospitalization and outside emergency events, and identified only one deficiency with access to care in this area:

- In case 26, the patient returned from an outside emergency department after he was diagnosed with a lower extremity infection. Per CCHCS policy, a provider should have seen the patient within five days. This follow-up occurred 13 days later (8 days late), which increased the patient's risk of developing complications due to his infection.

Follow-up After Urgent or Emergent Care

CHCF demonstrated substandard performance when scheduling provider follow-ups after patients returned from the standby emergency medical services (SEMS) unit. The OIG reviewed 64 urgent or emergent encounters, 25 of which required a provider follow-up. We identified deficiencies in three cases: 24, 29, and the following case:

- In case 18, the patient had an abnormal EKG that showed he was having a possible cardiac event. SEMS staff initially monitored the patient and then released him back to his general housing unit. The SEMS provider requested a 14-day follow-up for additional evaluation. This follow-up did not occur for approximately five weeks, resulting in a significant lapse in care because this patient demonstrated risk factors for a heart attack, and a provider did not see him for more than a month.

Specialized Medical Housing

CHCF performed poorly with provider access both during and after admission to the correctional treatment center (CTC) and outpatient housing unit (OHU). Providers did not always see their patients in the CTC and OHU within appropriate time intervals. CHCF possessed a license waiver that allowed its providers to see patients every seven days once a provider was in place who designated the patient as a long-term-care (LTC) patient in the CTC. Despite the allowance granted by this waiver, we found that providers still did not see their patients within the seven-day interval and often saw the patients every two to three weeks instead. The OIG clinicians reviewed six CTC admissions with 375 CTC provider encounters. We identified this pattern of delay for both OHU and CTC patients in cases 4, 5, 9, 14, 16, 17, 19, 29, and 35.

Specialty Access

CHCF performed poorly ensuring patients received appropriate access to specialty services. We discuss this performance further in the *Specialty Services* indicator.

Clinician Onsite Inspection

Problems with access to care were primarily due to a lack of providers. We discuss this problem further in the *Quality of Provider Performance* indicator. As noted in that indicator, we found 19 provider vacancies out of the 45 designated positions during our review period. This lack of providers posed significant challenges for the institution to provide sufficient care quality.

CHCF also converted to the electronic health record system (EHRS) on July 11, 2017, which contributed to the significant backlog of patients. During this process, CHCF scheduled fewer patients for each provider because providers were learning and adapting to this new system. This meant that on average, most providers saw only eight patients per day. The institution gradually increased the number of patients scheduled to 14 patients in C yard, approximately 8 to 14 patients in D yard, and 14 patients in E yard.

At the time of the onsite inspection, CHCF reduced the patient backlog throughout the institution by using telemedicine providers and registry providers (temporary physicians).

Case Review Conclusion

CHCF experienced problems providing patients with sufficient access to care during the review period. We identified a significant backlog of patients during this review period. Although implementing the EHRS exacerbated this backlog, CHCF providers saw more patients as they became accustomed to the new system. CHCF also took steps to improve these access issues by recruiting telemedicine providers and new registry physicians. While the OIG acknowledges this institution's ongoing efforts to improve access to care, many of these improvements either occurred late or after this review period. Therefore, the results of these changes are not reflected in the Cycle 5 rating. The OIG rated this indicator *inadequate*.

Compliance Testing Results

The institution performed in the *inadequate* range, with a score of 68.2 percent in the *Access to Care* indicator. The following tests received scores in the *inadequate* range:

- We sampled 25 patients with chronic care conditions and found that 14 (56.0 percent) received timely provider follow-up appointments. Three patients' follow-up appointments were two to six days late. Four patients' follow-up appointments were 45 to 76 days late. One patient's follow-up appointment was 135 days late. For the remaining three patients, a follow-up appointment never occurred (MIT 1.001).

- Among 25 patients sampled who transferred into CHCF and whom nurses referred to a provider based on their initial health screening, only 9 were seen timely (36.0 percent). For 15 patients, provider appointments occurred between 4 and 82 days late. One patient's provider visit never occurred at all (MIT 1.002).
- We sampled 21 health care services request forms on which the nurse referred the patient for a provider appointment. Thirteen patients (61.9 percent) received a timely appointment. Four patients received their appointments between 4 and 18 days late. Two patients received their appointments 40 and 79 days late, and two other patients did not receive a provider visit at all (MIT 1.005).
- Of the seven applicable sampled patients whom nursing staff referred to a provider and for whom the provider subsequently ordered follow-up appointments, five patients (71.4 percent) received timely follow-up appointments. For two patients, follow-up appointments occurred one and 66 days late (MIT 1.006).
- We tested 25 patients discharged from a community hospital to determine whether they received provider follow-up appointments at CHCF within five calendar days of returning to the institution. Thirteen patients (52.0 percent) received a timely provider follow-up appointment. Twelve patients received their appointments between one and 66 days late (MIT 1.007).
- Of 24 sampled patients who received a high-priority or routine specialty service, 12 of them (50.0 percent) received a timely provider follow-up appointment with a CHCF provider. Of those 12 patients who did not receive a timely follow-up appointment, 5 patients' high-priority specialty service follow-up appointments were one to 45 days late; 2 patients' routine specialty service follow-up appointments were 9 and 30 days late; and the remaining 5 patients' routine specialty services follow-up appointments never occurred (MIT 1.008).

Three tests received scores in the *proficient* range:

- We reviewed 30 health care services request forms (CDCR Form 7362) submitted by patients across all facility clinics. Nursing staff reviewed this form for 28 patients on the same day the forms were collected (93.3 percent). For two patients, nursing staff reviewed this form one day beyond the required time frame (MIT 1.003).
- Nursing staff timely completed face-to-face triage encounters for 28 of 30 sampled patients (93.3 percent). For one patient, nursing staff failed to complete documentation in the Subjective, Objective, Assessment, Plan, and Education (SOAPE) format. For the remaining patient, a face-to-face encounter never occurred (MIT 1.004).
- Patients had access to health care services request forms at all six housing units we inspected (MIT 1.101).

2 — *DIAGNOSTIC SERVICES*

This indicator addresses several types of diagnostic services. Specifically, it addresses whether radiology and laboratory services were timely provided to patients, whether primary care providers timely reviewed results, and whether providers communicated results to the patient within 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
(62.8%)
Overall Rating:
Inadequate

Case Review Results

We reviewed 368 diagnostic events and found 63 deficiencies, of which 31 were significant. Of those 63 deficiencies, we found 50 related to health information management and 13 related to the noncompletion of ordered tests. For health information management, we considered test reports that were never retrieved or reviewed just as severe of a problem as tests that were not performed. The case review rating for this indicator was *inadequate*.

Test Completion

As we found in Cycle 4, CHCF continued to perform poorly with most diagnostic services. CHCF often did not perform diagnostic services promptly. The institution also failed to consistently perform diagnostic tests the providers ordered. Not completing diagnostic tests is a serious deficiency that might lead to lapses in medical care. We found noncompleted laboratory tests or diagnostic scans in cases 1, 5, 16, 18, 24, and 108. We discuss the following examples for quality improvement purposes:

- In case 16, the provider ordered an urgent, same-day chest X-ray to evaluate an elderly patient with shortness of breath and cough. However, the chest X-ray was not performed until four days later. This delay placed the patient at risk of having an undiagnosed and untreated lung infection.
- In case 24, the provider ordered laboratory tests to further monitor the patient's hepatitis C (a viral liver infection). CHCF never performed these tests, which potentially delayed the patient's hepatitis C treatment.
- In case 108, the patient had right leg swelling and pain that caused concern for a blood clot in his leg. While the provider did order an urgent ultrasound within two days, CHCF never completed this diagnostic scan. This failure placed the patient at risk of developing a stroke or cardiac arrest from an undiagnosed blood clot.

We also found that SEMS nurses on the weekends often did not perform needed laboratory tests. In cases 19, 22, and 29, during a weekend, the provider ordered urgent laboratory tests. The nurses neither collected the specimens nor performed the tests. We also discuss these errors in the *Emergency Services* indicator.

Health Information Management

CHCF performed poorly in retrieving and scanning diagnostic reports. We found delays in scanning diagnostic and laboratory reports as well as failing to retrieve and scan in cases 5, 10, 22, 23, 34, and 35. These failures increased the risk of patient harm because pertinent information was unavailable to subsequent providers. We provide the following examples for quality improvement purposes:

- In case 22, clinical staff evaluated an elderly patient in the SEMS unit for lightheadedness. Although staff performed an EKG, this diagnostic test was not scanned into the EHRS. This lapse in medical care was significant because this pertinent information was unavailable to subsequent providers.
- In case 23, the patient had a dangerous bacterial infection of his right leg. His wound culture showed bacteria resistant to multiple antibiotics, including the antibiotic the provider had ordered. This report was not retrieved or scanned into the EHRS for more than three weeks, delaying a change in the patient's antibiotic treatment.
- In case 35, the patient had a slow-growing brain tumor. Although the patient had a magnetic resonance imaging (MRI) scan, the results were not available in the EHRS or the radiology information system-picture archive and communication system (RIS-PACS). This was a significant lapse in medical care because the MRI scan was not available to guide the patient's treatment plan.

We also found that CHCF providers failed to sign diagnostic or laboratory reports in cases 1, 2, 11, 14, 16, 18, 19, 26, 28, 30, 31, 32, and 34. CHCF providers also did not consistently review diagnostic and laboratory results promptly. We identified delays in test review in cases 12, 15, 17, 18, 19, 21, 23, and 30.

Clinician Onsite Inspection

We learned that although reports generated from onsite radiology tests flowed directly into the EHRS for the providers to review, the reports from offsite radiology tests were scanned into the radiology information system (RIS) instead. Unfortunately, we discovered that a majority of the providers could not access the radiology reports from the RIS. As a result, these providers could not review multiple offsite diagnostic reports. To efficiently review these offsite radiology reports and to provide necessary patient care, the providers strongly recommended that the institution should scan these offsite reports directly into the EHRS. The OIG agrees that while the most efficient method would be for the institution to scan the reports directly into the EHRS,

we recommend that CHCF should at least ensure the providers have access to the RIS and can show proficiency retrieving offsite radiology reports.

Case Review Conclusion

During this review period, CHCF performed poorly in most aspects of diagnostic services that involved laboratory services. We identified deficiencies in the collecting and processing of diagnostic tests ordered by providers. Also, we found a pattern whereby providers did not review laboratory and diagnostic reports. A majority of providers had difficulty accessing offsite radiology reports in the RIS. Because of these problems, we rated this indicator *inadequate*.

Compliance Testing Results

The institution received an *inadequate* compliance score of 62.8 percent in the *Diagnostic Services* indicator, which encompasses radiology, laboratory, and pathology services. For clarity, each type of diagnostic service is discussed separately below:

Radiology Services

- CHCF timely performed radiology services for nine of ten sampled patients (90.0 percent). For one patient, the institution provided radiology services two days late (MIT 2.001). Providers timely reviewed the corresponding diagnostic services reports for only two of ten patients (20.0 percent). For eight patients, we found no evidence the providers reviewed their reports at all (MIT 2.002). Providers timely communicated the diagnostic results to only three of ten patients (30.0 percent). Of the remaining seven, for three patients, providers communicated the results between 3 to 26 days late; and for four patients, providers did not communicate the results at all (MIT 2.003).

Laboratory Services

- CHCF timely performed all ten sampled laboratory services, and providers also reviewed the laboratory results promptly (MIT 2.004, 2.005). Providers timely communicated the results to only two of the nine sampled patients (22.2 percent). For six patients, the written communication received from the provider failed to identify the specific laboratory test referenced. For the remaining patient, the provider did not communicate the result at all (MIT 2.006).

Pathology Services

- The institution received final pathology reports in a timely manner for seven of ten sampled patients (70.0 percent). For two patients, the institution received the reports 10 and 20 days late; and for one other patient, the institution did not obtain the final pathology report (MIT 2.007). Providers properly showed evidence of their review of the pathology results for eight of nine patients (88.9 percent). One report was reviewed one day late (MIT 2.008). Finally, while providers timely communicated the pathology results to four of the nine patients (44.4 percent), for five patients, providers communicated the pathology results between one and 20 days late (MIT 2.009).
-

3 — *EMERGENCY SERVICES*

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

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

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

Case Review Results

We reviewed 64 urgent/emergent events and found 44 deficiencies in various aspects of urgent and emergent medical care. We found eight significant deficiencies that occurred in cases 3, 10, 11, 19, 22, and 27. The case review rating for the *Emergency Services* indicator was *adequate*.

CPR Response

We reviewed eight CPR events. Two CPR events occurred in the outpatient yard (E yard). During these events, custody staff promptly notified medical staff and began CPR. First medical responders (FMRs) from the SEMS unit arrived on scene in a timely manner, and custody officers and nurses worked together to provide coordinated resuscitation attempts. Six other CPR events occurred in the specialized medical housing areas where CTC and OHU nurses usually responded quickly and intervened appropriately in emergency CPR situations. One OHU event occurred during which the CPR response was subpar. The institution should use the following exception for quality improvement purposes:

- In case 7, the nurse failed to check the unresponsive patient for the presence of a pulse and respiration. Because of this error, emergency staff did not start CPR promptly. The OHU nurse also requested 9-1-1 activation, but failed to direct a specific person to perform the task, resulting in a delay in contacting EMS. When the nurses noted a pulse, they stopped CPR, but did not check the patient for breathing. The nurses also failed to restart CPR immediately when the patient's heart stopped beating again. We also discuss this case in the *Specialized Medical Housing* indicator.

Provider Performance

CHCF providers generally made appropriate assessments and created proper treatment plans when patients presented emergently to the SEMS unit. The providers were frequently available for immediate consultation. The following two case examples were not representative of most SEMS provider care, but should be used for quality improvement purposes:

- In case 3, a provider evaluated the patient for a seizure, but did not perform a head or neurological examination to assess for possible head trauma.
- In case 11, the patient with multiple cardiac risk factors complained of chest pain and became unresponsive during dialysis. When a provider subsequently evaluated the patient in the SEMS unit, the provider did not consider heart disease as a possible explanation for the patient's symptoms and did not address the patient's elevated blood pressure.

CHCF providers did not consistently document their SEMS assessments and decision-making in cases 10, 11, 19, 28, 34, and the following:

- In case 12, the patient had a cardiac arrest, and a SEMS provider performed appropriate clinical interventions; however, the provider did not document the emergent event.

Nursing Performance

SEMS nurses usually conducted appropriate assessments and interventions, and notified providers promptly. Most deficiencies were minor and occurred in cases 10, 19, 22, 27, and 29. Nonetheless, there was room for improvement in this area. The following examples illustrated some of these concerns:

- In case 10, the patient was short of breath, and his oxygen saturation level was very low. He was also wheezing and coughing up bloody sputum. The nurse gave the patient a low dose of oxygen, but failed to check whether the patient's breathing improved. Almost one hour later, the patient remained in respiratory distress and was sent to the hospital.
- In case 27, the patient had severe abdominal pain. The nurse did not monitor the patient's condition while awaiting his transfer to a community hospital.
- In cases 19, 22, and 29, during a weekend, the provider ordered urgent laboratory tests. The nurses neither collected the specimens nor performed the tests. We also discussed this issue in the *Diagnostic Services* indicator.

Nursing Documentation

While SEMS nurses assessed and intervened appropriately during emergent events, they usually failed to record accurate sequential timelines and other pertinent information concerning the event. We identified poor nursing documentation, mostly discrepancies in recording timelines of emergent events, as well as incomplete documentation of nursing care. These deficiencies occurred in cases 1, 3, 5, 9, 10, 11, 12, 13, 23, 27, 29, and 30.

Emergency Medical Response Review Committee

The Emergency Medical Response Review Committee (EMRRC) met regularly and discussed emergent events. The committee properly identified clinical deficiencies and provided nursing training when deficiencies were identified.

Clinician Onsite Inspection

In most California state prisons, medical staff typically deliver urgent medical care in an unlicensed triage and treatment area (TTA). Unlike most prisons, the SEMS unit at CHCF is a California state-licensed emergency care area. SEMS medical providers are physically present in the unit 16 hours each weekday and are “on-call” overnight. Providers are also present for a full 24 hours on both weekend days. Registered nurses (RNs), licensed vocational nurses (LVNs), and certified nursing assistants (CNAs) staff the SEMS unit during each shift.

During our onsite inspection, the SEMS unit had four bays; each was spacious, well-stocked, and was fully visible from the nurse’s station. The staff explained that one RN and one LVN were always ready to respond to emergencies in the housing units and clinics. They also explained that in addition to urgent and emergent care, the SEMS staff evaluated patients after they returned from specialty appointments, community emergency departments, and offsite hospitalizations. In all, the staff reported an average of 700 SEMS patient encounters each month.

Case Review Conclusion

CHCF provided appropriate emergency care. The EMRRC successfully identified care deficits, and SEMS supervisors trained their staff appropriately. However, we found that nurse and provider documentation discrepancies affected the ability to thoroughly assess the sequence of events, an area that could be improved. Nonetheless, clinically significant problems were relatively rare, and we rated the *Emergency Services* indicator *adequate*.

4 — **HEALTH INFORMATION MANAGEMENT**

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

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(63.8%)
Overall Rating:
Inadequate

Case Review Results

The OIG clinicians reviewed 1,977 events and found 99 deficiencies related to health information management. Of those 99 deficiencies, 32 were significant. The case review rating for this indicator was *inadequate*.

Hospital Records

We reviewed 53 offsite emergency department and hospital visits. CHCF staff timely retrieved hospital records, scanned them into the medical record, and reviewed them appropriately. We found no deficiencies in this area.

Specialty Services

CHCF performed adequately concerning specialty reports. The institution retrieved specialty reports and scanned them into the medical record promptly. However, we identified a pattern in which CHCF staff scanned specialty reports into the EHRS without evidence of review. We also discuss these findings in the *Specialty Services* indicator.

Diagnostic Reports

CHCF performed poorly with its diagnostic report processing. We found delays in scanning diagnostic and laboratory reports, and noted the institution’s failure in retrieving and scanning these reports in cases 5, 10, 22, 23, 34, and 35. Most CHCF providers could not access or review offsite radiology reports because they did not have functioning access to the RIS. We discussed these findings in the *Diagnostic Services* indicator.

Urgent/Emergent Records

CHCF providers usually performed sufficiently when documenting their SEMS encounters with patients. However, we noted room for improvement in this area. The *Emergency Services* indicator provides additional details.

Scanning Performance

CHCF performed poorly in this area. We identified mistakes in the document scanning process in which documents were either mislabeled or misfiled (filed in the wrong chart). Erroneously scanned documents can create delays or lapses in care by hindering providers' ability to find relevant clinical information. We found mislabeled or misfiled documents in the electronic unit health record (eUHR) and the EHRS in cases 2, 4, 9, 17, 21, 23, 25, 42, 43, 47, 48, 58, 99, and 104.

Legibility

Legibility was not an issue after CHCF transitioned to the EHRS. CHCF required all onsite staff to type or dictate their entries into the EHRS after the transition.

Clinician Onsite Inspection

The OIG clinicians observed clinical information transmission during the morning huddles. All units used a standardized CCHCS huddle agenda. Staff displayed clinical information on a large monitor for ease of information dissemination and discussion. They also reviewed and renewed expiring medications during the morning huddle. Despite using the standard CCHCS huddle agenda, however, the quality of the huddles varied significantly among different units. Some teams were unfamiliar with their patients or the care being delivered. These teams were only superficially aware of important after-hours clinical information, and they used the huddles primarily as a scheduling tool only. However, in other huddles, care teams were fully cognizant of their patients' care needs. Besides ensuring appropriate appointment scheduling, these well-performing teams transmitted important information and developed staff-specific care plans. Those plans included monitoring and contingency interventions for patients returning from the SEMS unit or other higher levels of care.

Case Review Conclusion

CHCF's performance in the *Health Information Management* indicator was variable compared to Cycle 4. The institution performed well with retrieving outside emergency department reports and hospital discharge summaries. However, diagnostic report processing was poor. Providers did not perform well with signing laboratory and diagnostic reports, and they rarely had access to any offsite radiology reports. Scanning performance was poor. Documents were frequently mislabeled in the electronic medical record. Huddle quality was inconsistent. Overall, CHCF performed poorly in several important areas in *Health Information Management*, and we rated this indicator *inadequate*.

Compliance Testing Results

The institution scored in the *inadequate* range with a score of 63.8 percent in the *Health Information Management* indicator. The following tests were *inadequate*:

- CHCF scored zero on labeling and filing of documents scanned into patients' electronic medical records. For this test, once the OIG identifies 24 mislabeled or misfiled documents, we deduct the maximum amount of points, which resulted in a score of zero for this test (MIT 4.006).
- We reviewed electronic medical records for 25 patients who were admitted to a community hospital and returned to the institution; providers timely reviewed 16 corresponding hospital discharge reports within three calendar days of the patient's discharge (64.0 percent). For seven patients, providers reviewed their hospital discharge reports one to 11 days late. For two remaining patients, providers reviewed reports 61 and 67 days late (MIT 4.007).

Two tests received *adequate* scores:

- Of 20 sampled specialty service consultant reports (75.0 percent), 15 were scanned into the patient's electronic medical records within five calendar days. Five documents were scanned one to two days late (MIT 4.003).
- CHCF medical records staff timely scanned patients' discharge reports into 16 of the 20 sampled patients' electronic medical records (80.0 percent). Four reports were scanned between one and seven days late (MIT 4.004).

One test received a *proficient* score:

- The institution timely scanned all ten sampled health care documents into patients' electronic medical records within three calendar days of the patient's encounter (MIT 4.001).

5 — HEALTH CARE ENVIRONMENT

This indicator addresses the general operational aspects of the institution’s clinics, including certain elements of infection control and sanitation, medical supplies and equipment management, the availability of both auditory and visual privacy for patient visits, and the sufficiency of facility infrastructure to conduct comprehensive medical examinations. The OIG rates this component entirely on the compliance testing results from the visual observations inspectors make at the institution during their onsite visit. There is no case review portion.

Case Review Rating:

Not Applicable

Compliance Score:

*Inadequate
(69.5%)*

Overall Rating:

Inadequate

Compliance Testing Results

The institution received scores in the *inadequate* range in the following five tests:

- CHCF appropriately disinfected, cleaned, and sanitized 18 of 35 clinic locations inspected (51.4 percent). In 17 clinic locations, the staff did not maintain the cleaning log. In addition, we found one clinic’s gurney stretcher exhibited extensive dirt and built-up dust (MIT 5.101) (*Figure 1*).



Figure 1: Unsanitary gurney

- The non-clinic bulk medical supply storage areas did not follow the supply management process and did not support the needs of the health care program, resulting in a score of zero for this test.

During our interview at the time of inspection, the warehouse managers expressed their concerns regarding the lack of training for nursing staff in following the approved supply management protocols. In addition, medical supplies were found stored beyond manufacturers’ guidelines and were found sitting directly on the floor (MIT 5.106).

- Only 23 of the 35 clinics inspected followed adequate medical supply storage and management protocols (65.7 percent). We found 10 clinics stored germicidal wipes in the same area with medical supplies. In addition, two clinics stored medical supplies beyond manufacturers' guidelines (*Figure 2*) (MIT 5.107).



Figure 2: Expired medical supplies

- Among 35 clinic locations, 25 (71.4 percent) met compliance requirements for essential core medical equipment and supplies. The remaining 10 clinics were missing one or more functional pieces of properly calibrated core equipment or other medical supplies necessary to conduct a comprehensive examination. The missing items included a peak flow meter, gloves, lubricating jelly, an automated external defibrillator, and examination table disposable paper. A blood pressure machine and nebulization units did not have current calibration stickers, an otoscope was not operational, and tongue depressors were stored in an unsanitary container (*Figure 3*) (MIT 5.108).



Figure 3: Tongue depressor stored in an unsanitary container

- We examined emergency medical response bags (EMRBs) to determine if staff inspected the bags daily and inventoried them monthly and whether they contained all essential items. EMRBs were compliant in only one of four applicable clinical locations (25.0 percent). We found one or more of the following deficiencies at three locations: staff failed to verify that the bag's compartments were sealed and intact; an EMRB was missing two different sizes of blood pressure cuffs: a regular (adult) and an extra-large; and the emergency crash cart had medical supplies stored beyond manufacturers' guidelines (MIT 5.111).

Two tests received scores in the *adequate* range:

- We observed clinician encounters with patients in 35 clinics. Clinicians followed good hygiene practices in 29 clinic locations (82.9 percent). At six clinic locations, clinicians failed to wash their hands before or after patient contact, or before applying gloves (MIT 5.104).
- Of the 35 clinics we observed, 29 had appropriate space, configuration, supplies, and equipment to allow clinicians to perform a proper clinical examination (82.9 percent). The remaining six clinics had one or more of the following deficiencies: examination tables had torn vinyl covers; an examination room did not provide visual privacy; and confidential medical records were easily accessible by unauthorized individuals (MIT 5.110).

Four tests received scores in the *proficient* range:

- Clinical health care staff at 31 of the 35 applicable clinics (88.6 percent) ensured that they properly sterilized or disinfected reusable invasive and non-invasive medical equipment. Clinical staff in four clinics failed to mention disinfecting examination tables before the start of the shift as part of their daily start-up protocol (MIT 5.102).
- Of the 35 clinics inspected, 34 of them had operating sinks and sufficient quantities of hand hygiene supplies in the examination areas (97.1 percent). One clinic's examination room did not have antiseptic soap (MIT 5.103).
- Health care staff at all 35 clinics followed proper protocols to mitigate exposure to bloodborne pathogens and contaminated waste (MIT 5.105).
- All 35 clinics had environments conducive to providing medical services; they provided reasonable auditory privacy, appropriate waiting areas, wheelchair accessibility, and sufficient non-exam room workspace (MIT 5.109).

Non-Scored Results

The OIG gathered information to determine whether CHCF staff maintained the institution's physical infrastructure in a manner that supported health care management's ability to provide timely or adequate healthcare. We did not score this question.

- When we interviewed health care managers, they did not express concerns about the facility's infrastructure or its effect on the staff's ability to provide adequate health care. At the time of inspection, CHCF did not have any infrastructure projects (MIT 5.999).
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6 — *INTER- AND INTRA-SYSTEM TRANSFERS*

This indicator focuses on the management of patients' medical needs and continuity of patient care during the inter- and intra-facility transfer process. The patients reviewed for this indicator include those received from, as well as those transferring out to, other CDCR institutions. The OIG review includes evaluation of the institution's ability to provide and document health screening assessments, initiation of relevant referrals based on patient needs, and the continuity of medication delivery to patients arriving from another institution. For those patients, the OIG clinicians also review the timely completion of pending health appointments, tests, and requests for specialty services. For patients who transfer out of the institution, 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 Rating:
Inadequate
Compliance Score:
Inadequate
(46.3%)
Overall Rating:
Inadequate

Case Review Results

We reviewed 63 inter and intra-system transfer events, including information from both the sending and receiving institutions. These included 53 hospitalization and offsite emergency department events, each of which resulted in a transfer back to the institution. There were 36 deficiencies, 13 of which were significant. We identified significant deficiencies in cases 1, 23, 29, 30, 37, and 39. The case review rating for this indicator was *inadequate*.

Transfers In

We reviewed three transfer-in cases, which yielded five relevant events. CHCF nurses initiated appropriate provider referrals, but did not consistently make appropriate nursing assessments. In cases 36 and 38, both patients had risk factors for valley fever, but the receiving and release (R&R) nurses did not recognize or identify them. We also found mislabeled records in two cases and one significant deficiency as noted in the following:

- In case 37, the nurse did not administer the newly transferred patient's bedtime medications, which included his insulin and seizure medications. This error placed the patient at risk for diabetic and seizure complications. When the provider performed a history and physical examination, the provider did not recognize or process the patient's pending cardiology appointment. The provider's error resulted in a lapse in specialty care.

Transfers Out

We found the transfer-out process acceptable. We reviewed four cases in which patients transferred out to other CDCR institutions. In all of them, CHCF nurses performed face-to-face evaluations before the patients transferred out of the institution. However, we found improvement opportunities in this area. CHCF nurses did not always record pertinent information such as where the patient was transferred to, or if CHCF sent medications and medical equipment with the patient. We also considered one deficiency significant:

- In case 39, the patient had a history of seizures, hypertension, and abdominal infection. CHCF transferred the patient to another CDCR institution without his seizure, hypertension, antibiotics, or other medications. This error placed the patient at elevated risk for a lapse in medication continuity and other medical complications.

Hospitalizations

Patients returning from hospitalizations are some of the highest-risk encounters because of two factors. First, these patients are generally hospitalized for severe illness or injury. Second, they are at risk because of potential lapses in care that can occur during any transfer.

CHCF performed poorly for patients returning from an offsite hospital or emergency department. We reviewed 53 hospital events that occurred in 22 cases and identified 26 deficiencies. Nurses frequently failed to complete essential portions of the nursing assessment, such as basic vital sign measurements, pain levels, or assessment of the affected body part. Also, nurses frequently did not give patients their medications in a timely manner or gave incorrect doses. Providers also sometimes failed to address new hospital diagnoses and recommendations (cases 1, 30, and 31). The following examples illustrate these problems with CHCF's hospital return process:

- In case 1, the patient had an intestinal bleed and low platelet (a component of the blood that helps control bleeding) levels. During two hospitalizations, the hospital physician repeatedly recommended stopping a blood thinning medication. Despite those recommendations, the CHCF provider continued prescribing the blood thinner. These errors placed the patient at an increased risk of bleeding. The hospital physician also recommended that providers avoid prescribing aspirin (a drug that disables platelets) unless the platelet level increased to a safe, specified level; however, the provider prescribed the aspirin without checking the platelet level, which also placed the patient at risk of further bleeding.
- In case 4, the patient had severe lung disease and depended on supplemental oxygen. He returned after a 10-day hospitalization and complained of shortness of breath. The nurse gave the patient a breathing treatment, but did not evaluate his response to the treatment and failed to determine whether the treatment was effective.
- In case 23, the patient returned from the hospital where physicians had diagnosed him with severe blood and leg infections. The nurse failed to examine the patient's leg. Also,

upon return from the hospital, the provider prescribed important antibiotics to continue to treat the leg infection. The patient received the medications several days later, creating a lapse in medication continuity and increasing the patient's risk for infection complications.

- In case 30, the hospital physician recommended getting an MRI scan of the heart to test for specific heart disease and a computed tomography (CT) scan of the chest to evaluate a lung nodule. The provider failed to address those recommendations.
- In case 31, the hospital physician recommended specific dosages of the patient's heart medications. When the patient returned from the hospital, a CHCF provider failed to prescribe the medications at the recommended dosages. Fortunately, a nurse recognized the errors and sent a message to a different provider the following day to correct the error.

Clinician Onsite Inspection

The R&R nurses were knowledgeable about their job duties and the transfer process. We met with medical, nursing, and pharmacy management to discuss some of the case review findings. CHCF managers explained that some of their institution's deficiencies occurred due to implementing the EHRs and their staff's unfamiliarity with the attendant new documentation and medication ordering processes. The managers reported that they provided their staff with additional training regarding the transfer process.

Case Review Conclusion

CHCF did not perform well for patients returning from an offsite hospital. Providers made critical errors when addressing new diagnoses and recommendations. We also found important lapses in medication continuity. At times, nurses' evaluations and supporting documentation were missing pertinent information. Nurses also did not consistently ensure medication continuity for patients who transferred into or out of the institution. The transfer process is one area the institution should target for quality improvement. We rated the *Inter- and Intra-System Transfers* indicator *inadequate*.

Compliance Testing Results

The institution scored in the *inadequate* range for this indicator, with a score of 46.3 percent, with *inadequate* scores in the following tests:

- Only 7 of 25 sampled patients (28.0 percent) who transferred into CHCF from other CDCR institutions had an initial health screening (CDCR Form 7277) completed on the same day the patient arrived. For 18 patients, nursing staff neglected to record an answer to one or more of the screening form questions (MIT 6.001).

- Of 25 sampled patients who transferred into CHCF, 14 had an existing medication order that required nursing staff to issue or administer medications upon arrival. Ten patients (71.4 percent) received their medications without interruption. Four patients incurred medication interruptions of one or more dosing periods upon arrival (MIT 6.003).
- Among 20 sampled patients who transferred out of CHCF to another CDCR institution, only 8 (40.0 percent) had their scheduled specialty service appointments properly documented on the health care transfer form. For 12 patients, CHCF failed to document specialty service appointments on the transfer forms (MIT 6.004).
- CHCF received a score of zero when we tested four patients transferring out of the institution to determine whether their transfer packages included required medications and related documentation. All four transfer packages were missing the medication administration record and the required transfer checklist forms (MIT 6.101).

One test received a *proficient* score:

- For 23 of 25 sampled patients (92.0 percent) who transferred into CHCF, nursing staff timely completed the assessment and disposition sections of the initial health screening form (CDCR Form 7277) on the same day that they performed the patient's initial health care screening. For two patients, nursing staff failed to complete the assessment and disposition section of the screening form (MIT 6.002).

7 — *PHARMACY AND MEDICATION MANAGEMENT*

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 numerous entities across various departments affect medication management, 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 Rating:
Inadequate
Compliance Score:
Inadequate
(51.9%)
Overall Rating:
Inadequate

Case Review Results

We reviewed 31 cases related to medications and found 24 medication deficiencies, 19 of which were significant. We identified significant deficiencies in cases 1, 2, 3, 4, 5, 10, 12, 17, 21, 22, 23, 24, 28, 29, 30, 32, 37, 39, and 82. We found lapses in medication continuity and medications that were not administered or prescribed correctly. The case review rating for this indicator was *inadequate*.

Medication Continuity

During this review period, CHCF performed poorly with chronic medication continuity due to delayed medication refills, unavailable medications, and interruptions related to the transfer process. These lapses in medication continuity increased the patients’ risk for medical complications. We also discussed several of these cases in the *Inter- and Intra-System Transfers* indicator. These deficiencies occurred in 14 cases: 1, 3, 4, 11, 24, 25, 29, 30, 37, 39, 82, and the following:

- In case 2, the patient submitted a refill request for his diabetic medication, but did not receive this medication. A week later, he submitted a second request. After not receiving the medication, he submitted a third request. The patient received the medication two weeks after his initial request. This lapse placed him at risk for diabetic complications.
- In case 21, the provider renewed the patient’s blood pressure medication improperly. The provider entered an incorrect start date, resulting in a five-day delay. This lapse in medication continuity placed the patient at an increased risk for complications such as stroke or heart attack.
- In case 23, the patient did not receive aspirin for one month because the nurses recorded the medication was “not available.” The OIG doubts the validity of the nurses’ documentation, as this medication is commonly available over-the-counter.

Medication Administration

We also found several problems with medication administration. Nurses frequently failed to administer medications timely or at all, gave incorrect doses, or recorded inaccurate administration, or failed to record administration at all. The nurses did not properly administer medications in cases 4, 5, 10, 11, 12, 21, 22, 23, 26, 28, 29, 30, 32, and 37. Nurses delayed administering newly prescribed medications, including critical antibiotics for infections, in cases 11, 16, 21, 22, 23, 24, 28, 29, 30, 32, and 114. The nurses also gave incorrect medication doses in cases 5, 23, 28, and 29. We also found inaccurate or missing documentation of medication orders and administration in cases 5, 10, 11, 21, 23, 26, 28, 30, 32, and 94. The following cases are only a few examples of these problems:

- In case 10, the provider ordered nurses to not administer the patient's blood pressure medication if the patient's blood pressure or heart rate was below a specific value. On numerous occasions, the nurses administered the patient's blood pressure medications even when the patient's heart rate was too low. Furthermore, the nurses failed to consistently check the patient's blood pressure and heart rate before giving the blood pressure medication, despite instructions to do so.
- In cases 5, 23, and 28, the nurses administered the wrong dosage of insulin. This error placed the patients at risk for diabetic complications.
- In case 29, the patient had a history of blood clots in his legs and lungs. The provider ordered a blood thinning medication to prevent clot formation. The nurse gave the patient double the prescribed dose for two days. This error placed the patient at an increased risk of bleeding and other complications.
- In case 30, the patient had a history of high blood pressure. The provider ordered a blood pressure medication to be given when the patient's blood pressure was elevated. On numerous occasions, nurses failed to administer the medication when the patient's blood pressure was elevated.

Clinician Onsite Inspection

We met with pharmacy and nursing managers to discuss our case review findings. CHCF managers attributed some deficiencies to the implementation of the new EHRS and their staff being unfamiliar with the new system. For example, if a provider prescribed keep-on-person (KOP) medications after the pharmacy had closed (e.g., on Friday evenings, weekends, or holidays), the pharmacy could not verify or fill the prescription. Without pharmacy verification, the EHRS could not alert the nurse to issue the medication, and the nurse would remain unaware of the new prescription until the pharmacy re-opened. CHCF does not have enough pharmacy staff to keep the pharmacy open on the weekends. Because of these issues, many patients did not receive medications prescribed on the weekends in a timely manner. At the time of our onsite inspection, CHCF was still developing a solution to resolve this concern. Managers also

attributed some errors to insufficient training of nursing staff, but explained that they had since provided additional training and education to their staff.

Case Review Conclusion

We found evidence of significant problems with medication continuity and administration. The institution also struggled with ensuring medication continuity for patients who received chronic medications, those transferring into or out of the institution, and those returning from an offsite hospital. Nurses also struggled with proper medication administration and documentation. Medication management remains an area CHCF should continue to target for quality improvement. We rated the *Pharmacy and Medication Management* indicator *inadequate*.

Compliance Testing Results

The institution received a score of 51.9 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

For this sub-indicator, the institution received an *inadequate* score of 51.0 percent. The following tests were *inadequate*:

- CHCF administered chronic care medications in a timely manner to 11 of the 23 applicable sampled patients (47.8 percent). For five patients, we found no evidence that they received or refused nurse-administered medications. Four patients did not receive their KOP medications per CCHCS policy requirements. Two patients' medications were not made available timely as ordered by the provider. For one patient, nursing staff administered a medication outside the provider's blood-pressure parameter order and also withheld another medication without a physician's order to do so (MIT 7.001).
- CHCF timely administered or delivered newly prescribed medications to 16 of the 25 sampled patients (64.0 percent). Six patients' medications were not made available timely to the patients. Two patients received their medication two days late. For one patient, nursing staff administered the wrong insulin dosage (MIT 7.002).
- Clinical staff timely provided new and previously prescribed medications to only 3 of 25 sampled patients (12.0 percent) who transferred from a community hospital and returned to the institution. Specifically, 17 patients' medications were not made available or administered timely as prescribed. For two patients, we found no evidence whether they received or refused their medications. Three patients did not receive required counseling for missed doses (MIT 7.003).

One test earned an *adequate* score:

- CHCF ensured that 20 of 25 sampled patients (80.0 percent) received their medications without interruption when they transferred from one housing unit to another. Five patients did not receive their medications at the proper dosing interval (MIT 7.005).

Observed Medication Practices and Storage Controls

The institution scored 61.8 percent in this sub-indicator, with the following tests scoring in the *inadequate* range:

- The institution employed adequate security controls over narcotic medications in 6 of the 34 applicable clinic and medication line locations where narcotics were stored (17.7 percent). At 28 locations, one or more of the following deficiencies occurred: the Omnicell inventory receipt and narcotics logbook showed that on multiple occasions, controlled substance inventory counts were not performed by two licensed nursing staff; nursing staff were unable to give a verbal account of the medication error reporting process; nurses waited until the end of the medication administration line to update the narcotics logbook; and nurses did not counter-sign the narcotics logbook to verify the proper destruction of controlled substances (MIT 7.101).
- We observed the medication preparation and administration processes at eight applicable medication line locations. Nursing staff were compliant regarding proper hand hygiene and contamination control protocols at five locations (62.5 percent). At three locations, not all nursing staff washed or sanitized their hands when required, such as before putting on gloves, after intentionally touching a patient's skin, before subsequent re-gloving, and before preparing and administering medications (MIT 7.104).
- Only two of eight inspected medication preparation and administration areas demonstrated appropriate administrative controls and protocols (25.0 percent). At six different locations, we observed one or more of the following deficiencies: medication nurses did not always ensure that patients swallowed direct observation therapy medications, and medication nurses did not follow manufacturers' guidelines related to the proper administration of insulin to diabetic patients. Those guidelines require medication nurses to verify the patient's blood glucose level from his KOP glucometer before administering medication, to disinfect previously opened multi-use insulin vials before withdrawing and administering medication, and to refrigerate insulin medication vials when not in active use (MIT 7.106).

One test received an *adequate* score:

- CHCF properly stored non-narcotic medications that did not require refrigeration in 27 of 36 applicable clinic and medication line storage locations (75.0 percent). In nine locations, we observed one or more of the following deficiencies: there was no established system to return expired medication prescriptions to the pharmacy; staff did not label multi-use medication with the date it was opened; staff did not properly separate external and internal medications when stored; the medication area lacked a designated area for return-to-pharmacy medications; the clinic's medication drawer was not sanitary; and a medication was stored beyond its expiration date (MIT 7.102).

Two tests received scores in the *proficient* range:

- The institution properly stored non-narcotic medications that required refrigeration in 30 of the 33 applicable clinics and medication line locations (90.9 percent). At one clinic, there was no established system to return paroled patient medication to the pharmacy. At one clinic, the medication refrigerator was found unsanitary. Another clinic stored expired medications (MIT 7.103).
- Nursing staff at all eight of the inspected medication line locations employed appropriate administrative controls and followed appropriate protocols during medication preparation (MIT 7.105).

Pharmacy Protocols

CHCF scored 40.8 percent in this sub-indicator. The following four tests were *inadequate*:

- In its main pharmacy, CHCF properly stored non-refrigerated medication. However, in its satellite pharmacy we found stored medications not clearly labeled for easy identification. As a result, the institution scored 50.0 percent for this test (MIT 7.108).
- The institution properly stored refrigerated or frozen medications in one of two pharmacies (50.0 percent). In the satellite pharmacy, the staff did not complete the temperature logbook (MIT 7.109).
- The institution's pharmacist-in-charge (PIC) did not properly account for narcotic medications stored in CHCF's pharmacy or review monthly inventories of controlled substances in the institution's clinical and medication line storage locations, resulting in a score of zero in this test. Specifically, the PIC did not properly complete multiple medication area inspection checklists (CDCR Form 7477) and had missed names, signatures, or dates on each inventory record (MIT 7.110).
- We examined 25 medication errors follow-up reports and five monthly medication error statistical reports generated by the institution's PIC. Only one of the PIC's 25 reports was timely or correctly processed (4.0 percent). The PIC at CHCF did not complete

24 medication error follow-up reports within the required period. The institution's PIC completed the reports between one and 20 days late (MIT 7.111).

One test received a *proficient* score:

- CHCF followed general security, organization, and cleanliness management protocols in its main and satellite pharmacies (7.107).

Non-Scored Tests

- In addition to the testing of reported medication errors, we follow up on any significant medication errors that were found during the case reviews or compliance testing to determine whether the errors were properly identified and reported. We provide those results for information purposes only. At CHCF, we found two reported severity level 4 medication errors: one was in March 2017 and the other was in August 2017. Both medication errors for the patients had already been identified in MIT 7.111 (MIT 7.998).
 - We interviewed patients in isolation units to determine whether they had immediate access to their prescribed KOP rescue inhalers and nitroglycerin medications. One applicable sampled patient had access to his asthmatic inhaler (MIT 7.999).
-

8 — ***PRENATAL AND POST-DELIVERY SERVICES***

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

As CHCF does not have female patients, this indicator does not apply.

Case Review Rating:

Not Applicable

Compliance Score:

Not Applicable

Overall Rating:

Not Applicable

9 — *PREVENTIVE SERVICES*

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

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(69.7%)
Overall Rating:
Inadequate

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

Compliance Testing Results

The institution scored in the *inadequate* range for this indicator at 69.7 percent. The following two tests were in the *inadequate* range:

- CHCF timely administered TB medications to four of the nine (44.4 percent) sampled patients. Nursing staff neglected to refer three patients to a provider for required counseling after they had missed a dose of medication. A provider did not see two other patients after they refused TB treatment (MIT 9.001).
- We reviewed CHCF’s monitoring of nine sampled patients who received TB medications and noted that the institution was compliant for only one of them (11.1 percent). For eight patients, the institution either failed to complete monitoring at all required intervals or failed to document weight changes (MIT 9.002).

One test received an *adequate* score:

- Of 30 sampled patients, 23 of them (76.7 percent) received their annual tuberculosis (TB) screenings within the last year and during their birth month, as required by policy. Four patients’ TB screenings did not occur during their birth months. Nursing staff did not properly complete the annual TB screening form for two patients. Nursing staff did not refer one patient who refused the TB screening for provider counseling (MIT 9.003).

Three tests were *proficient*:

- All 25 sampled patients timely received or were offered influenza vaccinations during the most recent influenza season (MIT 9.004).
- CHCF offered colorectal cancer screenings to all 25 sampled patients subject to the annual screening requirement (MIT 9.005).

- We tested whether patients who suffered from chronic care conditions were offered vaccinations for influenza, pneumonia, and hepatitis. At CHCF, 12 of the 14 sampled patients (85.7 percent) received all recommended vaccinations at required intervals. For two patients, the institution failed to document whether the patients had received or refused one or more of the required vaccinations (MIT 9.008).
-

10 — *QUALITY OF NURSING PERFORMANCE*

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

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

Case Review Results

Most CHCF patients lived in specialized medical housing units. We reviewed 604 nursing encounters within 73 cases. Among the nursing encounters reviewed, 188 were in the outpatient setting, or in the institution's E yard. We identified 227 deficiencies related to nursing care performance, 41 of which were significant. The case review rating for the *Quality of Nursing Performance* indicator was *adequate*.

Nursing Assessment

A major part of providing appropriate nursing care involves the quality of nursing assessment, which includes both the subjective (patient interview) and objective (observation and examination) portions of the evaluation. CHCF nurses generally performed satisfactory nursing assessments. We discovered some incomplete nursing assessments, which included missing elements from the subjective or objective portions of the documentation. We found four cases (5, 23, 24, and 97) in which the nurses did not obtain the necessary vital signs or examine the affected area of the patient's body.

Nursing Intervention

In most cases, CHCF nurses made timely and appropriate interventions for their patients. They usually provided care based on a nursing care plan or nursing protocol. When the patient's condition changed, the nurses usually notified a provider or transferred the patient to the SEMS

unit for further evaluation. We identified this pattern of good care in cases 3, 24, 29, 108, 109, 112, and the examples below:

- In case 2, custody staff reported the patient was unable to function independently. The SEMS nurse evaluated the patient and found the patient with an acute change in mental status. The nurse contacted the provider promptly, who then ordered the patient transferred immediately to the CTC for appropriate monitoring and treatment.
- In case 6, the CTC nurse immediately contacted the provider after recognizing the patient's difficulty with breathing and abnormal vital signs. The same nurse also appropriately provided oxygen supplementation to the patient and transferred the patient to the SEMS unit.
- In case 13, custody staff brought a patient to the clinic after the patient reported feeling weak and had trouble with breathing. The clinic nurse promptly assessed the patient, started him on oxygen, and notified the provider who directed the patient to the SEMS unit.
- In case 27, the patient complained of abdominal pain, nausea, and vomiting. The nurse noted there was no output in the patient's ileostomy (an opening in the abdomen made during surgery) and promptly notified the provider who sent the patient to an outside hospital. Hospital physicians successfully diagnosed and treated the patient's bowel obstruction.

Although nurses usually intervened for their patients satisfactorily, they did not always do so. We found occasions in which the nurses delayed or did not contact a provider, did not follow providers' orders correctly, or did not provide appropriate care. These instances occurred in cases 4, 19, 28, 37, and the following cases:

- In case 10, the hypertensive patient complained of chest pain, which could have been an emergency. The nurse did not perform an EKG, recheck the patient's elevated blood pressure, or notify the provider. Instead, the nurse inappropriately referred the patient for a routine (within 14 days) provider appointment.
- In case 18, the patient had a history of poorly controlled diabetes. He complained of severe bilateral foot and back pain. The nurse did not refer the patient to the provider to consider evaluation for nerve pain (a common symptom associated with diabetes).
- In case 22, the patient had severe scrotal pain and swelling. The nurse should have urgently referred the patient for a provider appointment. Instead, the nurse made a 14-day referral. This error placed the patient at risk of harm. The patient then submitted a second sick call request because the symptoms were getting worse. This time, the nurse failed to examine the patient. When the patient submitted a third sick call request, the nurse again made a routine, 14-day referral. Eventually, a provider ordered a one-day follow-up, but

because of the lack of provider availability, the institution still failed to schedule an appointment until seven days after the provider's order.

Nursing Documentation

Complete and accurate nursing documentation is another essential component of patient care. This documentation communicates the patient's medical history and identifies any change in the patient's medical condition. While outpatient nurses satisfactorily recorded their care, nurses in the specialized medical housing and the emergency services areas did not perform well with documentation. We discuss documentation in those areas in their respective indicators.

Nursing Sick Call

We reviewed 122 sick call requests. The nurses processed most sick call requests promptly. Sometimes the outpatient nurses failed to examine their symptomatic patients and required the patients to wait for a future provider appointment for an evaluation. We found these nursing errors in cases 22, 24, 25, and the case below:

- In case 23, the patient complained of right ear pain, swelling, and bleeding. Instead of examining the patient, the nurse recorded "outside the scope of nursing practice" and scheduled a provider appointment without first examining the patient and determining the severity of the patient's condition. On another occasion, the patient complained of eye pain with associated redness and vision changes. Once again, the nurse failed to examine the patient.

Urgent/Emergent Care

The SEMS nurses and the first medical responders (FMRs) provided good care during emergency medical responses. However, the nurses' documentation of emergency timelines was problematic. We also discussed these findings in the *Emergency Services* indicator.

Care Management

The role of a nursing care manager includes monitoring high-risk patients or those with chronic conditions, assessing them, starting appropriate interventions, and following treatment plans.

At CHCF, the primary care nurse also served as the nursing care manager. During our onsite visit, the care managers stated that by accessing the CCHCS Quality Management Master Registry, they could identify new care management patients. Care managers also found new patients by using the automatically generated morning huddle agenda. Health care teams then scheduled these patients for their initial care manager and provider visits. The care manager then performed assessments, discussed laboratory test results, reviewed medications, and provided education and teaching based on the patients' chronic care diagnoses and conditions.

Sometimes, CHCF nursing care managers performed well. The following cases showed effective care management:

- In case 13, the nursing care manager appropriately reviewed the patient's recent laboratory results, noted the patient had no abnormally high or low blood sugar levels, checked for medication compliance, and assessed the patient for diabetic complications. The nurse also discussed these results with the provider.
- In case 22, the nursing care manager evaluated the patient's asthma. The nurse assessed the patient's respiratory status and provided proper patient education.

In other cases, the performance of nursing care managers showed room for improvement:

- In cases 10 and 11, the nurse scheduled a care management visit for the patients' asthma condition, but failed to perform a complete assessment.
- In cases 12 and 28, the nurse failed to review recent laboratory results.
- In cases 21 and 24, the patients could have benefited from nursing care management to monitor their chronic issues, but they did not receive these services.

Wound Care

CHCF used two RNs, certified in wound care, to evaluate and treat patient wounds. Each nurse managed approximately 48 patients. Since Cycle 4, the institution formalized its wound care program by implementing new policies and procedures. A wound care nurse checked patients weekly to ensure consistent management of wounds. CHCF providers referred their patients to telemedicine wound care specialists, who gave additional support to the institution's wound care program. The specialists also conferred with the wound care nurses weekly and offered additional training to improve the wound care program.

Although the CHCF wound care program had improved since Cycle 4, we found problems. We reviewed 17 cases related to wound care and found nursing deficiencies in nine cases. In cases 24, 26, 28, 57, and 99, the nurses did not perform wound care as frequently as the provider ordered. We also identified failures to document the appearance of wounds in cases 4, 8, 21, and 28. Nurses also failed to educate their patients regarding wound care in cases 23 and 28.

Post-Hospital Returns

SEMS nurses performed poorly for patients returning from hospitalizations. We discussed these findings in the *Inter- and Intra-System Transfers* indicator.

Specialized Medical Housing

Nurses in the CTC and the OHU assessed and intervened for their patients acceptably. Although nursing performance in these areas was generally sufficient, we found nursing assessments that were unfocused, as well as failures to re-evaluate patients after providing treatments and incomplete nursing documentation. We discuss these findings further in the *Specialized Medical Housing* indicator.

Intra-System Transfers

The R&R nurses appropriately referred newly transferred patients to providers, but still made assessment errors. For patients leaving the institution, the nurses did not always record pertinent information. We described our findings in additional detail in the *Inter-and Intra-System Transfer* indicator.

Offsite Specialty Services Returns

SEMS nurses regularly performed sufficient assessments when evaluating patients returning from offsite specialty evaluations. We found one significant deficiency whereby the nurse failed to obtain a specialist recommendation in case 28. We discuss this case further in the *Specialty Services* indicator.

Clinician Onsite Inspection

We visited several clinical areas and spoke with nursing administration and staff in the PMU (Patient Management Unit), SEMS, OHU, CTC, outpatient clinics, specialty service area, and medication administration areas. We attended morning huddles in the primary clinics, OHUs, and CTCs. We discussed huddle performance in the *Health Information Management* indicator. The nurses we interviewed were knowledgeable about their patient population, duties, and responsibilities. Most nurses stated that morale was good, and they felt supported by their supervisors.

Both the CNE and nursing managers were receptive to us and were prepared to discuss our questions. They had also identified some nursing deficiencies we found before our onsite inspection and had already implemented quality improvement measures. They shared education and training records, which showed evidence of their efforts to improve the quality of care they provided. The various training programs included proper nursing assessments, documentation, and sick-call triage. The nursing managers started additional audits to monitor the quality of nursing care throughout the institution.

Case Review Conclusion

We found that compared to Cycle 4, the quality of nursing care at CHCF declined due to incomplete nursing assessments in both outpatient and inpatient areas. Also, we found errors in nursing performance, especially for those patients returning from an offsite hospitalization. Although we found nursing errors that impacted care, CHCF nursing performance was still barely sufficient to offset the deficiencies noted during this inspection. We, therefore, rated the *Quality of Nursing Performance* indicator *adequate*.

11 — *QUALITY OF PROVIDER PERFORMANCE*

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

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

Case Review Results

We reviewed 521 medical provider encounters and found one or more provider errors in 115 of those encounters. We identified an additional 57 provider deficiencies in other aspects of our inspection, for a total of 172 deficiencies. Of those 172 deficiencies, 75 were significant. Our physicians also rated the adequacy of care for 30 individual patients. Of these 30 cases, we rated 13 adequate and 17 inadequate. The case review rating for the *Quality of Provider Performance* indicator was *inadequate*.

Assessment and Decision-Making

CHCF providers repeatedly failed to make sound assessments or accurate diagnoses. Poor assessments and misdiagnoses frequently occurred throughout the cases reviewed. We found these errors in cases 1, 3, 5, 9, 11, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 34, and 82. The following are a few examples found during our case review:

- In case 1, the patient had several hospitalizations for altered mental status because of his end-stage liver disease. During one of these hospitalizations, the hospital physician recommended stopping the patient's clopidogrel (a blood thinner) as the patient had a high risk of bleeding due to his severe liver disease. The provider ignored the hospital's recommendation and restarted the medication, which placed the patient at an unnecessary risk for bleeding.
- In case 4, the patient had a history of end-stage lung disease that required oxygen. However, the provider failed to assess the patient's oxygen levels during a routine provider visit in the CTC.
- In case 14, the OHU nurse notified the provider of the patient's abdominal pain. The provider failed to consider the possible diagnoses and prescribed medication with the potential to worsen the patient's condition.
- In case 27, the OHU provider was scheduled to examine the patient after he sustained a fall. However, the provider instead focused the evaluation on the patient's complaint of a sore toe and failed to examine the patient for his fall.

- In case 28, the patient had several blood tests that showed critically low blood levels (severe anemia), but the provider failed to address these results. These errors placed the patient at risk for developing complications of anemia, such as palpitations, shortness of breath, weakness, and falls due to dizziness.

Review of Records

CHCF providers did not sufficiently review their patients' medical records. Insufficient record review occurred in cases 3, 16, 17, and the following:

- In case 1, the patient had recurring anemia. By July 2017, the patient's blood levels had decreased to a critically low level. None of the providers reviewed this abnormal laboratory result. As a result, providers did not address the patient's critically low blood level until he had dialysis several days later. The following week, the patient's blood level decreased even further. Again, none of the providers acted immediately to address the patient's dangerously severe anemia.
- In case 5, the provider failed to do a thorough review of the medical record and did not realize the patient's thyroid ultrasound scan revealed two large nodules. The provider did not address this abnormal finding, resulting in a delayed evaluation of the thyroid nodules.
- In case 15, the provider failed to perform a thorough chart review of the medical record and also did not recognize the patient did not have immunity to the hepatitis B virus. As a result, the provider did not offer the hepatitis B vaccine to the patient. Because of this oversight, the provider placed the patient at risk of contracting this serious viral infection.
- In case 19, the SEMS physician ordered an antibiotic for a presumed urinary tract infection. A nurse's note recorded the provider's order for the antibiotic. At a subsequent follow-up visit, a different provider failed to review the medical record carefully and was unaware the patient was taking an antibiotic for an infection.
- In case 22, multiple providers failed to review the medical record thoroughly. As a result, the providers prescribed the patient two separate medicated eye drops that contained the same drug. Because of this lapse in medical care, the providers placed the patient at risk of developing side effects such as an abnormally slow heart rate and hypotension (abnormally low blood pressure) because the patient was taking duplicate medications.

Emergency Care

Both the SEMS and on-call providers usually made accurate assessments and triage decisions. Patients requiring a higher level of care were appropriately sent to outside hospitals. CHCF emergency care provider performance was sufficient, as we also observed in Cycle 4. We provided further details in the *Emergency Services* indicator.

Chronic Care

As we found in Cycle 4, chronic care performance was poor. Providers continued to struggle with chronic care, especially with diabetic care. Providers failed to follow CCHCS guidelines and also ordered inappropriate follow-up intervals when treating uncontrolled blood sugar levels in diabetic patients. Furthermore, CHCF providers managed high blood pressure poorly. Overall, we found problems with chronic care in cases 10, 11, 12, 18, 19, 20, 25, and the following:

- In case 14, the provider failed to address the patient's elevated blood pressure even though the patient had a history of stroke. The patient required careful monitoring and treatment of his blood pressure, but did not receive these interventions.
- In case 15, the OHU provider stopped the patient's insulin and started an oral medication for diabetes. CCHCS guidelines recommend a short interval follow-up to monitor the patient's blood sugar closely, but the provider failed to order a close follow-up. As a result, the provider failed to review the patient's fasting blood sugar levels timely, and the patient's diabetes became uncontrolled.
- In case 23, the provider increased the patient's insulin because his diabetes was uncontrolled. The provider ordered a 30-day follow-up instead of the 3-to-7-day follow-up recommended by CCHCS guidelines. Also, the provider failed to review the patient's fasting blood sugar levels; the provider needed to review those levels to adjust the patient's insulin dose appropriately.
- Also in case 23, a different provider saw the patient for follow-up and did not review the patient's fasting blood sugar levels. As a result, the provider was unaware of the patient's uncontrolled diabetes and failed to adjust his insulin dose.
- In case 26, the provider increased the patient's insulin and added an oral medication because of the patient's poorly controlled diabetes. The provider ordered a 30-day follow-up instead of a short interval follow-up as recommended by CCHCS guidelines. After changing the patient's diabetic medications, the provider also failed to review the patient's fasting blood sugar levels and did not make proper adjustments to his medications.
- Also in case 26, the same provider repeatedly failed to review the patient's elevated blood pressure level. The patient had multiple cardiac risk factors that required close monitoring and treatment of his blood pressure.

Specialty Services

CHCF providers often failed to review or implement specialists' recommendations properly. They also failed to submit specialty referrals with the proper priority level. The *Specialty Services* indicator offers further details.

Documentation Quality

Provider documentation was extremely poor as there were numerous instances of insufficient documentation identified during this review period. Providers commonly wrote incomplete progress notes containing references to either a partial physical exam or none at all having been conducted, or that lacked a thorough and subjective narrative account. Providers often failed to record sufficient justification to support their medical decisions and sometimes failed to record anything at all. Insufficient documentation occurred in cases 1, 3, 5, 11, 14, 15, 16, 19, 21, 22, 24, 26, and the following case:

- In case 9, outside hospital physicians discharged the patient after they treated him for a critically low sodium level. The hospital physician observed that the patient had swelling of both legs upon discharge. However, the CHCF provider incorrectly recorded that the patient had normal lower extremities when the patient returned to the institution that same day.

We also found evidence of “cloned” progress notes, in which providers inappropriately copied outdated medical information and moved it forward into a current progress note. We identified these “cloned” progress notes in cases 1, 16, 21, and 26.

Provider Continuity

We observed problems with provider continuity mostly in the institution’s outpatient yard clinic (E yard). We identified these problems in cases 1, 11, 14, 18, 20, 21, 22, 23, 24, 25, and 27. Provider continuity was sufficient in the CTC and the OHU.

Clinician Onsite Inspection

During our case review period, CHCF was extremely short-staffed with 19 provider vacancies. The chief medical executive (CME) acknowledged that this significant provider shortage had negatively impacted patient care. By the time of the onsite inspection, the CME stated that CHCF’s provider shortage had improved, but the institution still had seven provider vacancies. Medical managers at CHCF felt that physician recruitment had improved when the managers re-implemented a flexible working schedule (10 hours per day, four days per week). The managers also attributed the improved staffing, in part, to the 15 percent recruitment and retention differential pay increase that this institution has offered over the past several years.

The medical managers could not explain many of the OIG’s concerns about the providers’ assessment and decision-making capabilities, however, because approximately half the providers we reviewed during this inspection were no longer working at CHCF.

The physician management team remained stable and unchanged from Cycle 4. This executive team comprised three chief physician and surgeons and one CME. CHCF providers described their physician executive team as fair, approachable, and willing to listen to their concerns. Provider morale had recently improved; providers directly attributed the improvement to stable

medical leadership and increased physician staffing. However, a few of the more experienced CHCF providers expressed frustration with having to learn and adapt to the new EHRs.

Case Review Conclusion

As a whole, CHCF provider performance was poor. Our case reviews showed strong patterns of deficiencies with provider assessment and decision-making, insufficient documentation, the cursory review of records, and mismanagement of chronic medical conditions. CHCF managers attributed these provider deficiencies to the high number of provider vacancies present during this review period. We do not reasonably expect a severely understaffed institution to provide adequate care. While CHCF has increased the number of providers on staff, thus mitigating this severe personnel concern, the improvement occurred after our review period concluded. Therefore, any benefit from the improved provider staffing is not reflected in this inspection. We rated CHCF's *Quality of Provider Performance* indicator *inadequate*.

12 — *RECEPTION CENTER ARRIVALS*

This indicator focuses on the management of medical needs and continuity of care for patients arriving from outside the CDCR system. The OIG review includes evaluation of the ability of the institution to provide and document initial health screenings, initial health assessments, continuity of medications, and completion of required screening tests; address and provide significant accommodations for disabilities and health care appliance needs; and identify health care conditions needing treatment and monitoring.

The patients reviewed for reception center cases are those received from non-CDCR facilities, such as county jails.

CHCF does not have a reception center; therefore, this indicator does not apply.

Case Review Rating:

Not Applicable

Compliance Score:

Not Applicable

Overall Rating:

Not Applicable

13 — *SPECIALIZED MEDICAL HOUSING*

This indicator addresses whether the institution follows appropriate policies and procedures when admitting patients to onsite inpatient facilities, including completion of timely nursing and provider assessments. The case review assesses all aspects of medical care related to these housing units, including quality of provider and nursing care. CHCF medical housing units comprise correctional treatment centers (CTCs) and outpatient housing units (OHUs).

Case Review Rating:
Inadequate
Compliance Score:
Adequate
(85.0%)
Overall Rating:
Inadequate

For this indicator, the case review and compliance review processes yielded different results, with the case reviewers assigning an *inadequate* rating and the compliance testing resulting in an *adequate* score. The main reason for the *inadequate* case review rating was that OHU and CTC providers demonstrated poor quality care that increased their patients' risk of harm. We determined that the overall rating for this indicator was *inadequate*.

Case Review Results

CHCF's medical facilities include 12 OHU and 14 CTC housing units where staff manage medically complex patients. CHCF designates the OHU units as medical housing areas that provide supportive services to patients who need help with daily living activities or short-term observations. The CTC units provide extensive nursing care and other inpatient health services to patients who need close medical supervision. We reviewed 20 CTC and nine OHU cases, and found 259 deficiencies, 85 of which were significant. The case review rating for this indicator was *inadequate*.

Provider Performance

Provider care was poor in specialized medical housing as we found 96 deficiencies related to provider performance. We found 45 significant deficiencies in cases 1, 3, 4, 9, 14, 15, 16, 17, 19, 27, 28, 29, and 30. The following are examples showing poor provider assessment:

- In case 3, a nurse notified the provider that the patient's left leg was showing skin breakdown and fluid leakage. The provider not only delayed ordering dressing changes and an antibiotic, but also never documented conducting an examination of the patient's lower extremity. This error increased the patient's risk of infection.
- In case 9, the patient had abdominal distention, lethargy, and confusion. The offsite provider ordered an abdominal X-ray immediately, which revealed the patient had a bowel obstruction, a medical emergency. However, the offsite provider did not inform the on-call physician that this X-ray was pending. As a result, a provider never checked the abdominal X-ray, and the patient died five hours later. This patient's death may have been prevented if a provider had checked the X-ray, had known of the patient's

bowel obstruction, and had promptly sent the patient to an outside hospital for further management of his condition.

- In case 30, a provider evaluated the patient for persistent swelling of his scrotum. However, there was no evidence that the provider examined the patient's scrotum.

Provider care was superficial and incomplete. In addition, the providers were at times unaware of diagnostic and laboratory results. The following are examples of this type of insufficient record review:

- In case 1, several providers failed to review the medical record thoroughly and did not recognize the patient's irregular heart rhythm on two separate EKGs. Because the patient's irregular heart rhythm went undiagnosed, the providers increased the patient's risk of having a stroke or developing a blood clot in his lung.
- In case 16, the provider did not thoroughly review the prior progress note and therefore, was unaware the radiology department never performed a chest X-ray in response to the patient's shortness of breath.

Providers did not adequately address hospital recommendations after patients were discharged. In addition, providers performed poorly when addressing specialists' recommendations. The following cases are such examples:

- In case 1, the patient had an intestinal bleed and low platelet levels. The hospital physician recommended stopping the patient's clopidogrel (a blood thinning medication that decreases platelet function) and prescribing aspirin instead. While the providers prescribed aspirin for the patient, they did not stop the patient's clopidogrel. This failure to stop prescribing the patient's blood-thinning medications significantly increased the his risk of bleeding again.
- In case 30, the specialist made recommendations that the patient receive a CT scan of the chest to assess a lung nodule. However, the providers did not address these recommendations.

Nursing Performance

CTC and OHU nursing performance was barely sufficient. Although nurses admitted their patients timely and started care plans based on their patients' needs, we found a pattern of incomplete nursing assessment and documentation. We were most concerned when nurses failed to implement providers' orders and their failure to recognize whenever patients' symptoms warranted nursing interventions. We also observed most of these significant nursing deficiencies in Cycle 4 as well. We identified 103 nursing deficiencies in 15 cases. Eight cases showed an elevated risk of patient harm (cases 4, 5, 7, 11, 19, 27, 30, and 37). The following examples in the areas of nursing assessment, intervention, implementation, and documentation show room for significant improvement.

Assessment

In eight cases, we identified absent or incomplete nursing assessments that could have significantly impacted the patient's medical care. These assessment deficiencies included partial vital signs, a lack of focused assessment of the affected body part or wound, and a missed evaluation before and after administering treatment or medications, as noted in the following examples:

- In case 4, the patient often had difficulty breathing. The CTC nurses administered breathing treatments, but failed to listen to the patient's lung sounds before and after each treatment. Therefore, the nurses did not assess if the patient's lung sounds had improved following each treatment. On another occasion, the patient again complained of shortness of breath. The nurse failed to administer a breathing treatment and also did not re-evaluate the patient.
- In case 5, the patient had a chronic breathing condition and required hospitalization for low oxygen levels. When the patient returned to the institution, the CTC nurses failed to assess the patient's respiratory status. The patient continued to have difficulty breathing and required another hospitalization for his continued low oxygen levels.
- Also, in case 5, CHCF staff transferred the patient to a different CTC unit. None of the CTC nurses monitored the patient's respiratory status sufficiently to determine if his symptoms had worsened. Six weeks later, the patient required hospitalization for respiratory distress.

Despite the above examples, nurses usually made adequate nursing assessments as demonstrated in the example below:

- In case 27, the patient was noncompliant and usually refused his medications and nursing assessments. Despite these refusals, the nurse appropriately assessed the patient when he developed symptoms and notified the provider. Also, the OHU nurse counseled the patient extensively regarding his noncompliance with his diabetic care. When he returned to CHCF after being hospitalized for a small bowel obstruction, the CTC nurse reliably assessed the patient and immediately informed the provider of any changes in the patient's condition.

Intervention and Implementation

CHCF nurses had problems reliably following the providers' orders and intervening when appropriate. These deficiencies included the following failures: check vital signs, monitor the patient as frequently as the provider ordered, inform the CTC RN or provider of abnormal findings, or administer the prescribed treatment or medication. We found these problems in 12 cases, some of which are depicted in the following:

- In case 11, the OHU nurse failed to correctly obtain orthostatic blood pressures (positional blood pressure measurements) by placing the patient in both a reclining and an upright position. Instead, the nurse only checked the patient’s blood pressure in a sitting or upright position.
- In case 19, the diabetic patient had an extremely high blood sugar level. The provider ordered the nurse to recheck the patient’s blood sugar and administer additional insulin if the patient’s result remained elevated. The nurse did not follow the provider’s order. Frequently, the CTC nurses identified critically elevated blood sugars, but did not inform the provider of the abnormal findings. Elevated blood sugars placed the patient at risk for diabetic complications.
- In case 30, the patient had a history of high blood pressure. A provider prescribed a blood pressure medication for nurses to administer when the patient’s blood pressure rose above a specific level. On numerous occasions, nurses failed to administer the medication, and the patient’s blood pressure remained elevated. These errors placed the patient at risk for a heart attack or stroke. Also, the nurses did not consistently record the patient’s intake and output levels despite a provider’s order to do so.
- In case 37, the provider ordered orthostatic vital signs for three days in addition to a urinalysis. The OHU nurses did not follow the provider’s order. Also, on a different occasion, the nurses did not inform a provider of abnormal orthostatic vital signs. These errors placed the patient at risk for a possible missed diagnosis or wrong treatment.

CTC and OHU nurses also acted as first medical responders during an emergency in these areas. The nurses responded quickly and intervened appropriately. We found one instance in which the nurses made errors with their emergency interventions:

- In case 7, the nurse failed to check the unresponsive patient for the presence of a pulse or breathing. Because of this error, the emergency staff did not start CPR promptly. The OHU nurse also requested 9-1-1 activation, but failed to direct a specific person to perform the task, resulting in a delay in contacting EMS. When the nurses noted a pulse, they stopped CPR, but did not check the patient for breathing. The nurses also failed to restart CPR immediately when the patient’s heart stopped beating again. We also discussed this case in the *Emergency Service* indicator.

Documentation

We identified a pattern of incomplete nursing documentation. As a result, this pertinent information was not available to subsequent nurses or medical providers and could have led to additional medical errors. The following are examples:

- In case 3, the patient had two seizures, and the OHU nurse documented, “See notes for full details.” However, no additional notes detailed the seizure events.

- In case 4, the CTC nurse withheld the patient's blood pressure medication due to low blood pressure. However, the nurse did not document the actual blood pressure reading.
- In case 8, the CTC nurse neither completed the CPR record nor documented interventions such as the use of an automated external defibrillator (AED), intravenous fluid and medication administration, airway interventions if provided, or the patient's blood sugar results.

Clinician Onsite Inspection

During the onsite inspection, patients occupied most of the available 420 CTC medical and the 592 OHU beds. Most patients were long-term residents, with each unit having assigned primary care providers. The staff performed daily huddles. In addition, nursing supervisors were present at all times in the CTC and the OHU. The nursing supervisors said they had recently conducted a quality improvement audit and had been increasing the number of reviews performed. Since their most recent audit, they had provided training and education to the nurses regarding the specialized medical housing admission processes, and were focusing on nurse assessments and proper documentation.

Case Review Conclusion

Patients living in specialized medical housing areas need close monitoring and in-depth medical care. Patients returning from hospitalization or specialty visits also require a thorough review of their medical records to address all new diagnoses and recommendations. The specialized medical housing providers showed poor medical judgments, demonstrated superficial patient care, and provided an inadequate review of hospital and specialty records. Provider errors increased their patients' risk of harm. Nursing assessments only bordered on the acceptable. Nurses struggled to follow providers' orders and recorded incomplete nursing documentation. Due to the poor performance of CHCF's medical providers as well as the problems we observed with nursing care, we rated the *Specialized Medical Housing* indicator *inadequate*.

Compliance Testing Results

The institution received a score of 85.0 percent in this indicator, with the following three tests scoring in the *adequate* range:

- Nursing staff completed an initial assessment on the date patients were admitted to the CTC and the OHU for all 41 patients whose records we sampled (MIT 13.001).
- Providers evaluated 21 of the 24 sampled patients (87.5 percent) within 24 hours of admission to the CTC, and also completed the required history and physical examinations. For two patients, providers did not conduct this examination. For one patient, the provider evaluated the patient one day late (MIT 13.002).

- When we observed the working order of sampled call buttons in CTC and OHU patient rooms, we found all working properly. In addition, according to staff members interviewed, custody officers and clinicians could expeditiously access patients' locked rooms when emergent events occurred (MIT 13.101).

One test scored in the *inadequate* range:

- When we tested whether providers completed their SOAPE notes at required 3-day intervals for the CTC and 14-day intervals for the OHU, we discovered SOAPE notes were timely and accurately completed for 21 of the 40 sampled patients (52.5 percent). For 17 patients, provider notes were one to 18 days late. For the remaining two patients, providers did not complete their required notes (MIT 13.003).
-

14 — *SPECIALTY SERVICES*

This indicator focuses on specialist care from the time a physician completes a request for services or a physician's order for specialist care 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 the 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 provider updates the patient on the plan of care.

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(65.7%)
Overall Rating:
Inadequate

Case Review Results

We reviewed 272 events related to *Specialty Services*, mostly specialty consultations and procedures. We found 65 deficiencies in this category, 33 of which were significant. The case review rating for this indicator was *inadequate*.

Access to Specialty Services

We found that most of the initial referrals at CHCF were completed within acceptable time frames except in cases 3, 14, 23, 30, and 34. However, we also found recurrent delays in specialty follow-ups in cases 9, 18, 30, 31, 32, and 34. The following are a few examples of these types of deficiencies:

- In case 18, the provider requested an urgent 14-day appointment with an endocrinologist (a doctor who treats hormonal imbalances) because the patient had uncontrolled diabetes. This appointment did not occur for more than one month, which placed the patient at risk for developing diabetic ketoacidosis (a life-threatening diabetic complication).
- In case 23, the provider requested an urgent evaluation with an ophthalmologist (an eye surgeon) due to concern for an acute eye infection that may have required expedited treatment. However, the patient did not see the ophthalmologist until after a 20-day delay, and he was diagnosed with a serious viral infection of his eye. This delay was significant because this eye infection could have led to permanent vision loss.
- In case 30, the provider requested a follow-up appointment with a cancer specialist to address the patient's lung nodule. This follow-up never occurred, and the patient was not evaluated for possible lung cancer.
- In case 31, the patient had abdominal surgery for a bowel obstruction. The surgeon was concerned that the patient's chronic kidney and liver diseases would prevent proper wound healing. The surgeon requested a short-interval follow-up to monitor the patient's wound, but the follow-up occurred two weeks late.

- In case 34, the patient had a history of multiple myeloma (a type of bone marrow cancer), which required close monitoring. The provider requested a follow-up with the cancer specialist within 28 days, but the appointment occurred three weeks outside the requested time interval. This error was significant as the cancer specialist recommended additional chemotherapy that was delayed by this lapse in medical care.

Nursing Performance

CHCF nurses performed acceptably for patients returning from offsite specialty appointments. Generally, nurses provided patient assessments, reviewed specialists' findings and recommendations, and communicated those results to providers. We found 14 nursing deficiencies in several cases. These were mostly minor deficiencies that included partial assessments, incomplete documentation, and failures to provide patient education. The following examples demonstrate opportunities for improvement:

- In case 23, the patient returned from the eye specialist who recommended discontinuing the eye drops. The nurse failed to notify the provider, and the patient continued to self-administer the eyedrops. The provider stopped the eye drops two days later.
- In case 28, the patient returned from the specialist without proper paperwork, and the nurse did not attempt to retrieve the specialist's urgent recommendation. As a result, the patient's pre-operative cardiology appointment did not occur timely.

Provider Performance

CHCF providers did not properly review or implement specialists' recommendations, or request referrals to occur within appropriate time frames in cases 18, 22, 23, 25, and 30. We identified six significant deficiencies. The following are examples of poor provider performance as it related to specialty services:

- In case 18, the patient had uncontrolled diabetes before his evaluation with the endocrinologist. Although the endocrinologist saw the patient and recommended a three-month follow-up, the provider instead ordered a four-month specialist follow-up.
- In case 22, the patient saw a urologist (a genito-urinary tract specialist) because his urinary incontinence medical device had malfunctioned. The urologist recommended the patient have a different medical device placed at a "special care clinic," but the provider failed to specify that location in the referral. As a result, the urologist was unable to perform the procedure, which further delayed the patient's medical care.
- In case 23, the provider evaluated a suspicious lesion on the patient's ear, which could have been cancerous. The provider inappropriately submitted a 92-day, routine-priority referral for a dermatologist. This lengthy referral time was not appropriate given the patient could have had undiagnosed cancer.

- In case 25, the patient saw the kidney specialist for his chronic kidney disease. The provider failed to order the iron supplementation that the specialist recommended for the patient's anemia.

Health Information Management

As we also saw in Cycle 4, CHCF performed satisfactorily with processing specialty reports. Staff usually retrieved and scanned offsite specialty reports into the EHRS promptly, except in cases 4 and 35. The following is an example of these rare deficiencies and should be used for the purpose of quality improvement:

- In case 35, CHCF staff failed to retrieve and scan the patient's offsite specialty visits into the EHRS for more than one year. This oversight resulted in a significant lapse in medical care because the patient had an inoperable brain tumor, and an important report was not available to guide the provider's care at the follow-up visit.

We identified a pattern wherein CHCF staff scanned specialty reports into the EHRS without appropriate provider review. We found specialty reports that were not signed or initialed by providers in cases 3, 23, 32, and 35.

Clinician Onsite Inspection

The Utilization Management nurses scheduled specialty appointments and used the EHRS message center to communicate pertinent information to providers. The telemedicine nurse kept an organized tracking and scheduling system for all telemedicine appointments. CHCF staff reported it was challenging at times to ensure specialist appointments were scheduled within the ordered time frames, but they reported only a minimal backlog of appointments. The specialty nurses were responsible for handling the offsite specialty reports and ensuring specialists' recommendations were obtained. The specialty nurses were also responsible for retrieving these offsite specialty reports if the reports did not return with the patient. CHCF also provided onsite specialty services with three nurses assigned to assist specialists during visits. These nurses also informed the provider once an appointment was completed and when to expect the specialty report.

Case Review Conclusion

CHCF did not perform well with specialty services. While providers did an adequate job identifying and initially referring patients when needed, we still found issues with delays in specialist follow-ups that affected patient care. The providers also did not thoroughly review or implement specialists' recommendations. Furthermore, a pattern was found in which specialty reports were scanned into the EHRS without evidence of provider review. We rated the *Specialty Services* indicator *inadequate*.

Compliance Testing Results

The institution received a score of 65.7 percent in this indicator, with the following four tests scoring in the *inadequate* range:

- Providers timely received and reviewed high-priority specialists' reports for 10 of the 15 sampled patients (66.7 percent). One patient's report was received four days late. For four other patients, we found no evidence that the institution had ever received the specialists' reports (MIT 14.002).
- Providers timely received and reviewed the specialists' reports following routine specialty service appointments for 9 of 13 sampled patients (69.2 percent). For two patients, providers reviewed the specialist reports one and 17 days late. For the remaining two patients, we found no evidence that CHCF ever received the report (MIT 14.004).
- Among 20 sampled patients who transferred into CHCF with an approved specialty service, five patients (25.0 percent) received it within the required time frame. Eight patients received their specialty services between 4 and 43 days late. Six other patients had two or more approved services; for these, CHCF provided specialty services between 4 and 87 days late, while other specialty services were not provided. One other patient also never received his specialty service (MIT 14.005).
- For 18 sampled patients who had a specialty service denied by CHCF's health care management, only four patients (22.2 percent) received timely notification of this denial, including the provider meeting with the patient within 30 days to discuss alternate treatment strategies. For five patients, providers communicated the denials between 3 and 27 days late. For the other nine patients, providers did not communicate the denial status at all (MIT 14.007).

Three tests received scores in the *proficient* range:

- For 13 of 15 sampled patients (86.7 percent), high-priority specialty services appointments occurred within 14 calendar days of the provider's order. Two patients received their high-priority specialty services three and seven days late (MIT 14.001).
- CHCF provided routine specialty service appointments for all 15 sampled patients within the required time frame (MIT 14.003).
- CHCF health care management denied providers' specialty service requests in a timely manner for 18 of 20 sampled patients (90.0 percent). Management denied two specialty service requests one and 21 days late (MIT 14.006).

15 — ADMINISTRATIVE OPERATIONS (SECONDARY)

This indicator focuses on the institution’s administrative health care oversight functions. The OIG evaluates whether the institution promptly processes patient medical appeals and addresses all appealed issues. Inspectors also verify that the institution follows reporting requirements for adverse/sentinel events and patient deaths.

The OIG verifies that the Emergency Medical Response Review Committee (EMRRC) performs required reviews and that staff perform required emergency response drills. Inspectors also assess whether the Quality Management Committee (QMC) meets regularly and adequately addresses program performance. For those institutions with licensed facilities, inspectors also verify that required committee meetings are held. In addition, the OIG examines whether the institution adequately manages its health care staffing resources by evaluating whether job performance reviews are completed as required; specified staff possess current, valid credentials and professional licenses or certifications; nursing staff receive new employee orientation training and annual competency testing; and clinical and custody staff have current emergency medical response certifications. The *Administrative Operations* indicator is a secondary indicator; therefore, it was not considered at all when we determined the institution’s overall rating.

Case Review Rating:

Not Applicable

Compliance Score:

Inadequate

(71.1%)

Overall Rating:

Inadequate

Compliance Testing Results

The institution received a score of 71.1 percent in this indicator with six tests scoring in the *inadequate* range:

- We reviewed, but did not validate, medical appeals data provided by the institution. CHCF processed only 5 of the 12 months’ appeals timely (41.7 percent). Seven months of appeals were not processed timely (MIT 15.001).
- We reviewed the one reported adverse/sentinel event (ASE) that occurred at CHCF during the prior 12-month period that required a root cause analysis and four monthly status reports per policy. The institution’s ASE was reported to the CCHCS ASE committee 29 days late. In addition, the institution submitted only two status reports during the four-month period. As a result, CHCF received a score of zero for this test (MIT 15.002).
- Of the 12 sampled incident packages for emergency medical responses reviewed by the institution’s EMRRC during the prior six-month period, only 2 of 12 packages (16.7 percent) complied with CCHCS policy. Ten incident packages did not include the required EMRRC checklist (MIT 15.005).
- We reviewed 12 months of CHCF’s local governing body (LGB) meeting minutes and determined that the LGB met at least quarterly; however, CHCF’s CEO did not timely

approve two of the four quarterly meeting minutes (50.0 percent), which were 28 and 68 days late (MIT 15.006).

- Inspectors reviewed the summary reports and related documentation for three medical emergency response drills conducted during the prior quarter. CHCF did not conduct a comprehensive response drill for these three watches. We found one or more of the following deficiencies: there was no indication of custody participation; multiple required forms were missing; and necessary drill elements were also missing. As a result, the institution received a score of zero for this test (MIT 15.101).
- Supervisors completed a proper clinical performance appraisal for only 8 of 20 CHCF providers (40.0 percent). Twelve other providers did not have either timely or properly completed appraisals, including the following (MIT 15.106):
 - Twelve providers had a unit health record clinical appraisal (UCA) completed, but the reviewers' results were not discussed with the providers.
 - Two providers' performance reviews were missing the required PCP 360-degree evaluation.
 - One provider's PCP 360-degree evaluation was 32 days late.
 - One provider's Individual Development Plan (IDP) was missing the reviewer's date.
 - Two providers' IDPs were 18 and 56 days late.

Ten tests earned *proficient* scores:

- CHCF's Quality Management Committee (QMC) met monthly, evaluated program performance, and acted when management identified areas for improvement (MIT 15.003).
- CHCF took adequate steps to ensure the accuracy of its Dashboard data reporting (MIT 15.004).
- Based on a sample of ten second-level medical appeals, the institution's responses addressed all of the patients' appealed issues (MIT 15.102).
- Medical staff reviewed and timely submitted the Initial Inmate Death Report to CCHCS' Death Review Unit for nine of ten cases tested, resulting in a score of 90.0 percent. For one death report packet, the institution submitted the death report nine minutes late (MIT 15.103).
- All ten sampled nurses were current with their clinical competency validations (MIT 15.105).

- All providers at the institution were current with their professional licenses. Similarly, all nursing staff and the PIC were current with their professional licenses and certification requirements (MIT 15.107, 15.109).
- All active-duty providers and nurses were current with their emergency response certifications (MIT 15.108).
- All pharmacy staff and providers who prescribed controlled substances had current Drug Enforcement Agency registrations (MIT 15.110).
- All nursing staff hired within the last year timely received new employee orientation training (MIT 15.111).

Non-Scored Results

- We gathered non-scored data regarding the completion of death review reports by CCHCS' Death Review Committee (DRC). Ten deaths occurred during our review period: three unexpected (Level 1) deaths and seven expected (Level 2) deaths. The DRC is required to complete death review summary reports within 60 days from the date of death for the Level 1 deaths and within 30 days from the date of death for the Level 2 deaths; these reports must be submitted to the institution's CEO within 7 calendar days thereafter. None of the death reviews at CHCF met CCHCS' reporting guidelines. For three of the Level 1 deaths, the DRC completed one report 11 days late and submitted it to CHCF's CEO 18 days late; for two other Level 1 deaths, we found no evidence that the final Death Review summary reports had been completed at the time of our inspection. For seven of the Level 2 deaths that occurred at CHCF, the DRC completed its reports from 9 to 43 days late and submitted them to the CEO between 17 and 51 days late (MIT 15.998).
- The OIG discusses the institution's health care staffing resources in the *About the Institution* section of this report (MIT 15.999).

RECOMMENDATIONS

The OIG recommends the following:

- The chief executive officer (CEO) and the chief support executive (CSE) should ensure that all CHCF providers have access to and show proficiency using the radiology information system (RIS) to retrieve and review offsite radiology reports. Alternatively, CHCF can scan offsite radiology reports directly into the EHRS medical record, which would be a more efficient method of enabling providers to review offsite reports. During this inspection, we found that a majority of CHCF providers did not review offsite radiology reports because they were inaccessible.
- The CEO and the CSE should identify and fix the processes that resulted in X-rays and laboratory tests being delayed or that were not completed, which we identified during this inspection.
- The CSE and the chief nurse executive (CNE) should rectify the problems we found whereby standby emergency medical services (SEMS) nurses did not consistently collect and process laboratory specimens when those tests were performed during weekends.
- All CHCF executives should analyze why the processing of diagnostic and specialty reports was delayed and attempt to correct the situation to alleviate future occurrences. We found delays with both the initial retrieval, and the providers' review, of those reports.
- The CNE should train and improve the clinical performance of nurses in multiple areas. The training should focus on making thorough assessments, recording complete documentation, and administering all medications correctly. We found errors in these areas throughout the institution.
- The CEO, the CNE, and the pharmacist-in-charge (PIC) should analyze why problems occurred with pharmacy and nursing processes, and adjust these processes to correct problems we found with medication administration and medication continuity.
- The chief medical executive (CME) should improve the hiring, training, and monitoring processes the institution used to ensure sufficient provider quality. We found serious problems with providers' assessments, misdiagnoses, review of records, and chronic care performance. Most CHCF staff attributed these problems to severe provider understaffing during this review period.
- The CEO and the CNE should adjust specialty scheduling processes to ensure that patients who require urgent or short-interval specialty follow-ups receive them. During this inspection, we found that delayed specialty follow-ups occurred more frequently with urgent or expedited follow-up orders.

POPULATION-BASED METRICS

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

The Healthcare Effectiveness Data and Information Set is a set of standardized performance measures developed by the National Committee for Quality Assurance with input from over 300 organizations representing every sector of the nation's health care industry. It is used by over 90 percent of the nation's health plans as well as many leading employers and regulators. HEDIS 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, we 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. We collected data utilizing various information sources, including the electronic medical record, the Master Registry (maintained by CCHCS), as well as a random sample of patient records analyzed and abstracted by trained personnel. We did not independently validate the data obtained from the CCHCS Master Registry and Diabetic Registry, and we presume it to be accurate. For some measures, we used the entire population rather than statistically random samples. While the OIG is not a certified HEDIS compliance auditor, we use similar methods to ensure that measures are comparable to those published by other organizations.

Comparison of Population-Based Metrics

For the California Health Care Facility, nine HEDIS measures were selected and are listed 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

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

When compared statewide, CHCF outperformed Medi-Cal in all five diabetic measures, and outperformed or matched Kaiser in four of the five diabetic measures. The institution scored lower than Kaiser (North and South) in diabetic eye exams.

When compared nationally, CHCF outperformed Medicaid and commercial plans in all five diabetic measures, and outperformed Medicare in four of the five measures. CHCF outperformed the United States Department of Veterans Affairs (VA) in three of the four applicable measures. The institution scored lower than Medicare and the VA in diabetic eye exams.

Immunizations

Comparative data for immunizations was only fully available for the VA and partially available for Kaiser, commercial plans, Medicaid, and Medicare. With respect to administering influenza vaccinations to younger adults and older adults, CHCF scored higher than all reporting health plans. With regard to administering pneumococcal vaccines to older adults, CHCF scored higher than Medicare and lower than the VA.

Cancer Screening

With respect to colorectal cancer screening, CHCF outperformed all reporting health plans.

Summary

CHCF performed very well with regard to population-based metrics in comparison to the other health care plans reviewed. The institution may improve its score for diabetic eye exams by reducing the number of refusals through patient education regarding the benefits of this preventive service.

CHCF Results Compared to State and National HEDIS Scores

Clinical Measures	California					National		
	CHCF Cycle 5 Results ¹	HEDIS Medi-Cal 2017 ²	HEDIS Kaiser (No. CA) 2016 ³	HEDIS Kaiser (So. CA) 2016 ³	HEDIS Medicaid 2017 ⁴	HEDIS Com- mercial 2017 ⁴	HEDIS Medicare 2017 ⁴	VA Average 2016 ⁵
Comprehensive Diabetes Care								
HbA1c Testing (Monitoring)	100%	87%	94%	94%	87%	91%	94%	99%
Poor HbA1c Control (>9.0%) ^{6, 7}	10%	38%	20%	23%	43%	33%	26%	18%
HbA1c Control (<8.0%) ⁶	78%	52%	70%	63%	47%	56%	63%	-
Blood Pressure Control (<140/90)	83%	63%	83%	83%	60%	62%	64%	76%
Eye Exams	63%	57%	68%	81%	55%	54%	70%	89%
Immunizations								
Influenza Shots – Adults (18–64)	76%	-	56%	57%	39%	48%	-	52%
Influenza Shots – Adults (65+)	80%	-	-	-	-	-	71%	72%
Immunizations: Pneumococcal	88%	-	-	-	-	-	74%	93%
Cancer Screening								
Colorectal Cancer Screening	95%	-	79%	82%	-	62%	67%	82%

1. Unless otherwise stated, data was collected in November 2017 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 *Medi-Cal Managed Care External Quality Review Technical Report (July 1, 2016 – June 30, 2017)*.

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

4. National HEDIS data for Medicaid, commercial plans, and Medicare was obtained from the 2017 *State of Health Care Quality Report*, available on the NCQA website: www.ncqa.org. The results for commercial plans were based on data received from various health maintenance organizations.

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

6. For this indicator, the entire applicable 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: 46.3% – 85.0%	
Indicator	Compliance Score (Yes %)
1 – Access to Care	68.2%
2 – Diagnostic Services	62.8%
3 – Emergency Services	Not Applicable
4 – Health Information Management (Medical Records)	63.8%
5 – Health Care Environment	69.5%
6 – Inter- and Intra-System Transfers	46.3%
7 – Pharmacy and Medication Management	51.9%
8 – Prenatal and Post-Delivery Services	Not Applicable
9 – Preventive Services	69.7%
10 – Quality of Nursing Performance	Not Applicable
11 – Quality of Provider Performance	Not Applicable
12 – Reception Center Arrivals	Not Applicable
13 – Specialized Medical Housing (OHU, CTC, SNF, Hospice)	85.0%
14 – Specialty Services	65.7%
15 – Administrative Operations	71.1%

Reference Number	1 – Access to Care	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
1.001	Chronic care follow-up appointments: Was the patient’s most recent chronic care visit within the health care guideline’s maximum allowable interval or within the ordered time frame, whichever is shorter?	14	11	25	56.0%	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?	9	16	25	36.0%	0
1.003	Clinical appointments: Did a registered nurse review the patient’s request for service the same day it was received?	28	2	30	93.3%	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?	28	2	30	93.3%	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?	13	8	21	61.9%	9
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?	5	2	7	71.4%	23
1.007	Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame?	13	12	25	52.0%	0
1.008	Specialty service follow-up appointments: Do specialty service primary care physician follow-up visits occur within required time frames?	12	12	24	50.0%	6
1.101	Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms?	6	0	6	100.0%	0
Overall percentage:					68.2%	

Reference Number	2 – Diagnostic Services	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
2.001	Radiology: Was the radiology service provided within the time frame specified in the provider's order?	9	1	10	90.0%	0
2.002	Radiology: Did the primary care provider review and initial the diagnostic report within specified time frames?	2	8	10	20.0%	0
2.003	Radiology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	3	7	10	30.0%	0
2.004	Laboratory: Was the laboratory service provided within the time frame specified in the provider's order?	10	0	10	100.0%	0
2.005	Laboratory: Did the primary care provider review and initial the diagnostic report within specified time frames?	10	0	10	100.0%	0
2.006	Laboratory: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	2	7	9	22.2%	1
2.007	Pathology: Did the institution receive the final diagnostic report within the required time frames?	7	3	10	70.0%	0
2.008	Pathology: Did the primary care provider review and initial the diagnostic report within specified time frames?	8	1	9	88.9%	1
2.009	Pathology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	4	5	9	44.4%	1
Overall percentage:					62.8%	

3 – Emergency Services

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

Reference Number	4 – Health Information Management	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated healthcare documents (provider progress notes) scanned within 3 calendar days of the patient encounter date?	10	0	10	100.0%	0
4.002	Are dictated/transcribed documents scanned into the patient’s electronic health record within five calendar days of the encounter date?	Not Applicable				
4.003	Are High-Priority specialty notes (either a Form 7243 or other scanned consulting report) scanned within the required time frame?	15	5	20	75.0%	0
4.004	Are community hospital discharge documents scanned into the patient’s electronic health record within three calendar days of hospital discharge?	16	4	20	80.0%	0
4.005	Are medication administration records (MARs) scanned into the patient’s electronic health record within the required time frames?	Not Applicable				
4.006	During the inspection, were medical records properly scanned, labeled, and included in the correct patients’ files?	0	24	24	0.0%	0
4.007	For patients discharged from a community hospital: Did the preliminary hospital discharge report include key elements and did a primary care provider review the report within three calendar days of discharge?	16	9	25	64.0%	0
Overall percentage:					63.8%	

Reference Number	5 – Health Care Environment	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
5.101	Are clinical health care areas appropriately disinfected, cleaned and sanitary?	18	17	35	51.4%	0
5.102	Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	31	4	35	88.6%	0
5.103	Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	34	1	35	97.1%	0
5.104	Does clinical health care staff adhere to universal hand hygiene precautions?	29	6	35	82.9%	0
5.105	Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	35	0	35	100.0%	0
5.106	Warehouse, Conex and other non-clinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program?	0	1	1	0.0%	0
5.107	Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	23	12	35	65.7%	0
5.108	Do clinic common areas and exam rooms have essential core medical equipment and supplies?	25	10	35	71.4%	0
5.109	Do clinic common areas have an adequate environment conducive to providing medical services?	35	0	35	100.0%	0
5.110	Do clinic exam rooms have an adequate environment conducive to providing medical services?	29	6	35	82.9%	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?	1	3	4	25.0%	31
Overall percentage:					69.5%	

Reference Number	6 – Inter- and Intra-System Transfers	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
6.001	For endorsed patients received from another CDCR institution or COCF: Did nursing staff complete the initial health screening and answer all screening questions on the same day the patient arrived at the institution?	7	18	25	28.0%	0
6.002	For endorsed patients received from another CDCR institution or COCF: When required, did the RN complete the assessment and disposition section of the health screening form; refer the patient to the TTA, if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening?	23	2	25	92.0%	0
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?	10	4	14	71.4%	11
6.004	For patients transferred out of the facility: Were scheduled specialty service appointments identified on the patient's health care transfer information form?	8	12	20	40.0%	0
6.101	For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents?	0	4	4	0.0%	0
Overall percentage:					46.3%	

Reference Number	7 – Pharmacy and Medication Management	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.001	Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows?	11	12	23	47.8%	2
7.002	Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames?	16	9	25	64.0%	0
7.003	Upon the patient’s discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames?	3	22	25	12.0%	0
7.004	For patients received from a county jail: Were all medications ordered by the institution’s reception center provider administered, made available, or delivered to the patient within the required time frames?	Not Applicable				
7.005	Upon the patient’s transfer from one housing unit to another: Were medications continued without interruption?	20	5	25	80.0%	0
7.006	For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption?	Not Applicable				
7.101	All clinical and medication line storage areas for narcotic medications: Does the Institution employ strong medication security over narcotic medications assigned to its clinical areas?	6	28	34	17.7%	3
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?	27	9	36	75.0%	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?	30	3	33	90.9%	4
7.104	Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes?	5	3	8	62.5%	29
7.105	Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients?	8	0	8	100.0%	29
7.106	Medication preparation and administration areas: Does the Institution employ appropriate administrative controls and protocols when distributing medications to patients?	2	6	8	25.0%	29
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	100.0%	0

Reference Number	7 – Pharmacy and Medication Management	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.108	Pharmacy: Does the institution’s pharmacy properly store non-refrigerated medications?	1	1	2	50.0%	0
7.109	Pharmacy: Does the institution’s pharmacy properly store refrigerated or frozen medications?	1	1	2	50.0%	0
7.110	Pharmacy: Does the institution’s pharmacy properly account for narcotic medications?	0	2	2	0.0%	0
7.111	Does the institution follow key medication error reporting protocols?	1	24	25	4.0%	0
Overall percentage:					51.9%	

8 – Prenatal and Post-Delivery Services

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

Reference Number	9 – Preventive Services	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
9.001	Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed?	4	5	9	44.4%	0
9.002	Patients prescribed TB medication: Did the institution monitor the patient monthly for the most recent three months he or she was on the medication?	1	8	9	11.1%	0
9.003	Annual TB Screening: Was the patient screened for TB within the last year?	23	7	30	76.7%	0
9.004	Were all patients offered an influenza vaccination for the most recent influenza season?	25	0	25	100.0%	0
9.005	All patients from the age of 50 - 75: Was the patient offered colorectal cancer screening?	25	0	25	100.0%	0
9.006	Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy?	Not Applicable				
9.007	Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy?	Not Applicable				
9.008	Are required immunizations being offered for chronic care patients?	12	2	14	85.7%	11
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:					69.7%	

10 – Quality of Nursing Performance

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

11 – Quality of Provider Performance

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

12 – Reception Center Arrivals

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

Reference Number	13 – Specialized Medical Housing	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient on the day of admission, or within eight hours of admission to CMF’s Hospice?	41	0	41	100.0%	0
13.002	For CTC and SNF only: Was a written history and physical examination completed within the required time frame?	21	3	24	87.5%	17
13.003	For OHU, CTC, SNF, and Hospice: Did the primary care provider complete the Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes on the patient at the minimum intervals required for the type of facility where the patient was treated?	21	19	40	52.5%	1
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?	25	0	25	100.0%	0
Overall percentage:					85.0%	

Reference Number	14 – Specialty Services	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	Did the patient receive the high priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service?	13	2	15	86.7%	0
14.002	Did the primary care provider review the high priority specialty service consultant report within the required time frame?	10	5	15	66.7%	0
14.003	Did the patient receive the routine specialty service within 90 calendar days of the primary care provider order or Physician Request for Service?	15	0	15	100.0%	0
14.004	Did the primary care provider review the routine specialty service consultant report within the required time frame?	9	4	13	69.2%	2
14.005	For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames?	5	15	20	25.0%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	18	2	20	90.0%	0
14.007	Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame?	4	14	18	22.2%	2
Overall percentage:					65.7%	

Reference Number	15 – Administrative Operations	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.001	Did the institution promptly process inmate medical appeals during the most recent 12 months?	5	7	12	41.7%	0
15.002	Does the institution follow adverse / sentinel event reporting requirements?	0	1	1	0.0%	0
15.003	Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified?	6	0	6	100.0%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	1	0	1	100.0%	0
15.005	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	2	10	12	16.7%	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?	2	2	4	50.0%	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	0.0%	0
15.102	Did the institution's second level medical appeal response address all of the patient's appealed issues?	10	0	10	100.0%	0
15.103	Did the institution's medical staff review and submit the initial inmate death report to the Death Review Unit in a timely manner?	9	1	10	90.0%	0
15.104	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	Not Applicable				
15.105	Are nursing staff who administer medications current on their clinical competency validation?	10	0	10	100.0%	0
15.106	Are structured clinical performance appraisals completed timely?	8	12	20	40.0%	0
15.107	Do all providers maintain a current medical license?	25	0	25	100.0%	0
15.108	Are staff current with required medical emergency response certifications?	2	0	2	100.0%	1
15.109	Are nursing staff and the Pharmacist-in-Charge current with their professional licenses and certifications, and is the pharmacy licensed as a correctional pharmacy by the California State Board of Pharmacy?	6	0	6	100.0%	1

Reference Number	15 – <i>Administrative Operations</i>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.110	Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	1	0	1	100.0%	0
15.111	Are nursing staff current with required new employee orientation?	1	0	1	100.0%	0
Overall percentage:					71.1%	

APPENDIX B — CLINICAL DATA

Table B-1: CHCF Sample Sets

Sample Set	Total
Anticoagulation	3
Death Review/Sentinel Events	5
Diabetes	3
Emergency Services – CPR	4
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
	75

Table B-2: CHCF Chronic Care Diagnoses

Diagnosis	Total
Anemia	12
Anticoagulation	14
Arthritis/Degenerative Joint Disease	13
Asthma	12
COPD	22
Cancer	11
Cardiovascular Disease	26
Chronic Kidney Disease	21
Chronic Pain	31
Cirrhosis/End Stage Liver Disease	11
Coccidioidomycosis	1
DVT/PE	1
Deep Venous Thrombosis/Pulmonary Embolism	6
Diabetes	46
Gastroesophageal Reflux Disease	25
Hepatitis C	23
Hyperlipidemia	38
Hypertension	63
Mental Health	19
Seizure Disorder	10
Sleep Apnea	8
Thyroid Disease	13
	426

Table B-3: CHCF Event – Program

Diagnosis	Total
Diagnostic Services	375
Emergency Care	81
Hospitalization	84
Intra-system Transfers-In	5
Intra-system Transfers-Out	5
Not Specified	1
Outpatient Care	362
Specialized Medical Housing	786
Specialty Services	278
	1,977

Table B-4: CHCF Review Sample Summary

	Total
MD Reviews Detailed	30
MD Reviews Focused	2
RN Reviews Detailed	21
RN Reviews Focused	45
Total Reviews	98
Total Unique Cases	75
Overlapping Reviews (MD & RN)	23

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

California Health Care Facility (CHCF)

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
<i>Access to Care</i>			
MIT 1.001	Chronic Care Patients (25)	Master Registry	<ul style="list-style-type: none"> Chronic care conditions (at least one condition per patient—any risk level) Randomize
MIT 1.002	Nursing Referrals (25)	OIG Q: 6.001	<ul style="list-style-type: none"> See <i>Intra-system Transfers</i>
MITs 1.003–006	Nursing Sick Call (3 per clinic) (30)	MedSATS	<ul style="list-style-type: none"> Clinic (each clinic tested) Appointment date (2–9 months) Randomize
MIT 1.007	Returns from Community Hospital (25)	OIG Q: 4.007	<ul style="list-style-type: none"> See <i>Health Information Management (Medical Records)</i> (returns from community hospital)
MIT 1.008	Specialty Services Follow-up (30)	OIG Q: 14.001 & 14.003	<ul style="list-style-type: none"> See <i>Specialty Services</i>
MIT 1.101	Availability of Health Care Services Request Forms (6)	OIG onsite review	<ul style="list-style-type: none"> Randomly select one housing unit from each yard
<i>Diagnostic Services</i>			
MITs 2.001–003	Radiology (10)	Radiology Logs	<ul style="list-style-type: none"> Appointment date (90 days–9 months) Randomize Abnormal
MITs 2.004–006	Laboratory (10)	Quest	<ul style="list-style-type: none"> Appt. date (90 days–9 months) Order name (CBC or CMPs only) Randomize Abnormal
MITs 2.007–009	Pathology (10)	InterQual	<ul style="list-style-type: none"> 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 (10)	OIG Qs: 1.001, 1.002, & 1.004	<ul style="list-style-type: none"> Non-dictated documents 1st 10 IPs MIT 1.001, 1st 5 IPs MITs 1.002, 1.004
MIT 4.002	(0)	OIG Q: 1.001	<ul style="list-style-type: none"> Dictated documents First 20 IPs selected
MIT 4.003	(20)	OIG Qs: 14.002 & 14.004	<ul style="list-style-type: none"> Specialty documents First 10 IPs for each question
MIT 4.004	(20)	OIG Q: 4.007	<ul style="list-style-type: none"> Community hospital discharge documents First 20 IPs selected
MIT 4.005	(0)	OIG Q: 7.001	<ul style="list-style-type: none"> MARs First 20 IPs selected
MIT 4.006	(24)	Documents for any tested inmate	<ul style="list-style-type: none"> Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.007	Returns From Community Hospital (25)	Inpatient claims data	<ul style="list-style-type: none"> 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 (35)	OIG inspector onsite review	<ul style="list-style-type: none"> Identify and inspect all onsite clinical areas.
Inter- and Intra-System Transfers			
MIT 6.001–003	Intra-System Transfers (25)	SOMS	<ul style="list-style-type: none"> Arrival date (3–9 months) Arrived from (another CDCR facility) Rx count Randomize
MIT 6.004	Specialty Services Send-Outs (20)	MedSATS	<ul style="list-style-type: none"> Date of transfer (3–9 months) Randomize
MIT 6.101	Transfers Out (4)	OIG inspector onsite review	<ul style="list-style-type: none"> R&R IP transfers with medication

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Pharmacy and Medication Management			
MIT 7.001	Chronic Care Medication (25)	OIG Q: 1.001	<ul style="list-style-type: none"> See <i>Access to Care</i> At least one condition per patient—any risk level Randomize
MIT 7.002	New Medication Orders (25)	Master Registry	<ul style="list-style-type: none"> Rx count Randomize Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns from Community Hospital (25)	OIG Q: 4.007	<ul style="list-style-type: none"> See <i>Health Information Management (Medical Records)</i> (returns from community hospital)
MIT 7.004	RC Arrivals – Medication Orders (N/A at this institution)	OIG Q: 12.001	<ul style="list-style-type: none"> See <i>Reception Center Arrivals</i>
MIT 7.005	Intra-Facility Moves (25)	MAPIP transfer data	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Identify and inspect clinical & med line areas that store medications
MITs 7.104–106	Medication Preparation and Administration Areas (varies by test)	OIG inspector onsite review	<ul style="list-style-type: none"> Identify and inspect onsite clinical areas that prepare and administer medications
MITs 7.107–110	Pharmacy (2)	OIG inspector onsite review	<ul style="list-style-type: none"> Identify & inspect all onsite pharmacies
MIT 7.111	Medication Error Reporting (25)	Monthly medication error reports	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Delivery date (2–12 months) Most recent deliveries (within date range)
	Pregnant Arrivals (N/A at this institution)	OB Roster	<ul style="list-style-type: none"> Arrival date (2–12 months) Earliest arrivals (within date range)

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
<i>Preventive Services</i>			
MITs 9.001–002	TB Medications (9)	Maxor	<ul style="list-style-type: none"> • Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • Randomize
MIT 9.003	TB Evaluation, Annual Screening (30)	SOMS	<ul style="list-style-type: none"> • Arrival date (at least 1 year prior to inspection) • Birth Month • Randomize
MIT 9.004	Influenza Vaccinations (25)	SOMS	<ul style="list-style-type: none"> • Arrival date (at least 1 year prior to inspection) • Randomize • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening (25)	SOMS	<ul style="list-style-type: none"> • Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • Randomize
MIT 9.006	Mammogram (<i>N/A at this institution</i>)	SOMS	<ul style="list-style-type: none"> • Arrival date (at least 2 yrs prior to inspection) • Date of birth (age 52–74) • Randomize
MIT 9.007	Pap Smear (<i>N/A at this institution</i>)	SOMS	<ul style="list-style-type: none"> • Arrival date (at least three yrs prior to inspection) • Date of birth (age 24–53) • Randomize
MIT 9.008	Chronic Care Vaccinations (25)	OIG Q: 1.001	<ul style="list-style-type: none"> • 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) (<i>N/A at this institution</i>)	Cocci transfer status report	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • Randomize
Specialized Medical Housing			
MITs 13.001–003	OHU & CTC (41)	CADDIS	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Review by location
Specialty Services			
MITs 14.001–002	High-Priority (15)	MedSATS	<ul style="list-style-type: none"> • Approval date (3–9 months) • Randomize
MITs 14.003–004	Routine (15)	MedSATS	<ul style="list-style-type: none"> • Approval date (3–9 months) • Remove optometry, physical therapy or podiatry • Randomize
MIT 14.005	Specialty Services Arrivals (20)	MedSATS	<ul style="list-style-type: none"> • Arrived from (other CDCR institution) • Date of transfer (3–9 months) • Randomize
MIT 14.006–007	Denials (15)	InterQual	<ul style="list-style-type: none"> • Review date (3–9 months) • Randomize
	(5)	IUMC/MAR Meeting Minutes	<ul style="list-style-type: none"> • Meeting date (9 months) • Denial upheld • Randomize

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
<i>Administrative Operations</i>			
MIT 15.001	Medical Appeals (all)	Monthly medical appeals reports	<ul style="list-style-type: none"> Medical appeals (12 months)
MIT 15.002	Adverse/Sentinel Events (1)	Adverse/sentinel events report	<ul style="list-style-type: none"> Adverse/sentinel events (2–8 months)
MITs 15.003–004	QMC Meetings (6)	Quality Management Committee meeting minutes	<ul style="list-style-type: none"> Meeting minutes (12 months)
MIT 15.005	EMRRC (12)	EMRRC meeting minutes	<ul style="list-style-type: none"> Monthly meeting minutes (6 months)
MIT 15.006	LGB (4)	LGB meeting minutes	<ul style="list-style-type: none"> Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills (3)	Onsite summary reports & documentation for ER drills	<ul style="list-style-type: none"> Most recent full quarter Each watch
MIT 15.102	2nd Level Medical Appeals (10)	Onsite list of appeals/closed appeals files	<ul style="list-style-type: none"> Medical appeals denied (6 months)
MIT 15.103	Death Reports (10)	Institution-list of deaths in prior 12 months	<ul style="list-style-type: none"> Most recent 10 deaths Initial death reports
MIT 15.104	RN Review Evaluations (N/A)	Onsite supervisor periodic RN reviews	<ul style="list-style-type: none"> RNs who worked in clinic or emergency setting six or more days in sampled month Randomize
MIT 15.105	Nursing Staff Validations (10)	Onsite nursing education files	<ul style="list-style-type: none"> On duty one or more years Nurse administers medications Randomize
MIT 15.106	Provider Annual Evaluation Packets (20)	Onsite provider evaluation files	<ul style="list-style-type: none"> All required performance evaluation documents
MIT 15.107	Provider licenses (25)	Current provider listing (at start of inspection)	<ul style="list-style-type: none"> Review all
MIT 15.108	Medical Emergency Response Certifications (all)	Onsite certification tracking logs	<ul style="list-style-type: none"> All staff <ul style="list-style-type: none"> Providers (ACLS) Nursing (BLS/CPR) Custody (CPR/BLS)
MIT 15.109	Nursing staff and Pharmacist in Charge Professional Licenses and Certifications (all)	Onsite tracking system, logs, or employee files	<ul style="list-style-type: none"> All required licenses and certifications

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
<i>Administrative Operations</i>			
MIT 15.110	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations (all)	Onsite listing of provider DEA registration #s & pharmacy registration document	<ul style="list-style-type: none"> All DEA registrations
MIT 15.111	Nursing Staff New Employee Orientations (all)	Nursing staff training logs	<ul style="list-style-type: none"> New employees (hired within last 12 months)
MIT 15.998	Death Review Committee (10)	OIG summary log - deaths	<ul style="list-style-type: none"> Between 35 business days & 12 months prior CCHCS death reviews

**CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES'
RESPONSE**

April 19, 2019

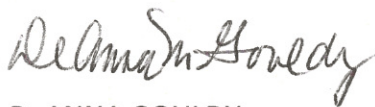
Roy Wesley, Inspector General
Office of the Inspector General
10111 Old Placerville Road, Suite 110
Sacramento, CA 95827

Dear Mr. Wesley:

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 November 2017 to October 2018. California Correctional Health Care Services (CCHCS) acknowledges the OIG findings.

Thank you for preparing the report. Your efforts have advanced our mutual objective of ensuring transparency and accountability in CCHCS operations. If you have any questions or concerns, please contact me at (916) 691-3747.

Sincerely,



DeANNA GOULDY
Associate Director
Risk Management Branch
California Correctional Health Care Services



cc: Clark Kelso, Receiver
Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Richard Kirkland, Chief Deputy Receiver
Stephen Tseng, M.D., Chief of Medical Inspections, OIG
Doreen Pagaran, R.N., Nurse Consultant Program Review, OIG
Yulanda Mynhier, Director, Health Care Policy and Administration, CCHCS
R. Steven Tharratt, M.D., M.P.V.M., FACP, Director, Health Care Operations, CCHCS
Roscoe Barrow, Chief Counsel, CCHCS Office of Legal Affairs
Lara Saich, Deputy Director, Policy and Risk Management Services, CCHCS
Renee Kanan, M.D., Deputy Director, Medical Services, CCHCS
Jane Robinson, R.N., Deputy Director, Nursing Services, CCHCS
Annette Lambert, Deputy Director, Quality Management, Clinical Information and Improvement Services, CCHCS
Eureka Daye, Ph.D., MPH, MA, CCHP, Regional Health Care Executive, Region I, CCHCS
Jasdeep Bal, M.D., Regional Deputy Medical Executive, Region I, CCHCS
Deborah Bradford, R.N., Regional Nursing Executive, Region I, CCHCS
Raul Recarey, Chief Executive Officer, CHCF
Kristine Lopez, Staff Services Manager II (A), Program Compliance Section, CCHCS
Sara Meier, Staff Services Manager I (A), Program Compliance Section, CCHCS
Misty Polasik, Staff Services Manager I, OIG