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Office of the Inspector General

California Institution for Men
Medical Inspection Results
Cycle 5

January 2019

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

Office of the Inspector General
CALIFORNIA INSTITUTION FOR MEN
Medical Inspection Results
Cycle 5

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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. We leave that determination 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 Penal Code mandates the OIG's inspections, and they are 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, the OIG inspects institutions delegated back to CDCR from the Receivership. There is no difference in the standards used for assessment of a delegated institution versus those for an institution not yet delegated. At the time of the Cycle 5 inspection of California Institution for Men, the Receiver had delegated this institution back to CDCR (on October 7, 2016).

This fifth cycle of inspections continues 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, we took larger samples than we 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, we have combined these into one secondary indicator, *Administrative Operations*.

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EXECUTIVE SUMMARY

The OIG completed the Cycle 5 medical inspection of California Institution for Men (CIM) in August 2018. The vast majority of our inspection findings were based on CIM's health care delivery between February 2017 and February 2018. 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 June 2018 to follow up on their 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 58 cases, which contained 1,028 patient-related events. Our compliance team tested 95 policy questions by observing CIM's processes and examining 443 patient records and 1,366 data points. We distilled the results from both the case review and compliance testing into 14 health care indicators and have listed the individual indicators and ratings applicable for this institution in the *CIM Executive Summary Table* on the following page. Our experts made a considered and measured opinion that the overall quality of health care at CIM was ***inadequate***.

CIM Executive Summary Table

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

* 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 1,028 patient care events.[1] The vast majority of our case review covered the period between August 2017 and February 2018. As depicted on the executive summary table on page *iv*, we rated 11 of the 14 indicators applicable to CIM. Of those 11 applicable indicators, we rated 1 *proficient*, 6 *adequate*, and 4 *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 (i.e., 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

- CIM performed well with most aspects of access to care, as most provider and nursing appointments occurred timely.

- CIM performed well with diagnostic services, as the institution timely completed diagnostic tests, retrieved the results, and scanned them into the medical record.

Program Weaknesses — Clinical

- CIM providers performed poorly in multiple aspects of patient care, including chronic care, hospital returns, and specialty services. Providers repeatedly made errors managing diabetes and hypertension. They often failed to review and address hospital discharge and specialist recommendations.

- CIM performed poorly in the outpatient housing unit (OHU). The providers demonstrated poor medical judgment and cursory reviews of specialty and hospital records.

- CIM's hospital return processes were deficient. We found many medication errors and ineffective nursing assessments for patients returning from hospitalizations.

- CIM's specialty services were unsatisfactory. CIM providers often failed to carefully review or implement specialists' recommendations, and the institution missed several important specialty appointments.

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

Compliance Testing Results

Of the 14 health care indicators applicable to CIM, compliance inspectors evaluated 11; 6 were *proficient*, 2 were *adequate*, and 3 were *inadequate.*[2] The vast majority of our compliance testing was of medical care that occurred between February 2017 and November 2017. There were 95 individual compliance questions within those 11 indicators, generating 1,366 data points, that tested CIM's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[3] *Appendix A — Compliance Test Results* provides details regarding the 95 questions.

Program Strengths — Compliance

- CIM nursing staff and providers did an excellent job completing nursing and provider assessments of patients admitted to the OHU within the required time frame.

- CIM providers timely completed history and physical examinations for patients who arrived through the institution's reception center. In addition, nursing staff timely administered, read, and documented the results of tuberculosis (TB) skin tests for newly arrived patients.

- Patients at CIM received their diagnostic services timely. Providers also did a good job reviewing diagnostic services results within the required time frame.

- CIM nursing staff received and reviewed their patients' Health Care Service Request forms (CDCR Form 7362) within CCHCS policy guidelines.

- CIM scheduled timely provider follow-up appointments for chronic care patients and for those who returned from a community hospitalization.

Program Weaknesses — Compliance

- CIM medical clinics lacked properly calibrated medical equipment and medical supplies needed to provide standard medical care.

- Nursing staff did not always timely administer medications to patients who had a temporary layover at CIM or who recently arrived at CIM from a county jail with ordered medications.

- Medication lines at CIM did not follow proper security controls over narcotic medications and did not properly store non-narcotic refrigerated and non-refrigerated medications.

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

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

- CIM performed poorly in listing approved specialty service appointments on health care transfer information forms.

Recommendations

The OIG recommends the following:

- The chief medical executive (CME) should audit the records of patients returning from the hospital, an emergency department, or specialty consultations to ensure the providers are addressing all their patients' diagnoses, medications, and recommendations. The CME should also consider designating the chief physician and surgeon (CP&S) or another provider to review each of these records to ensure that the institution implements any urgent recommendations. We found serious lapses in care due to poor provider performance in this area.

- The CME should revamp the methods the institution uses to appraise provider performance. Although we found serious provider quality problems during this inspection, the CME was unaware of any provider performance issues.

- The chief nursing executive (CNE) should also inspect the records of patients returning from a hospital or emergency department to ensure the nurses thoroughly review the discharge summaries, perform complete assessments, and implement essential recommendations.

- The CNE and the pharmacist in charge should launch a quality improvement program to increase medication continuity for patients who return from an outside emergency room or hospital. We found serious problems with medication continuity for these patients during our inspection.

- The CME should instruct the providers to specify the appropriate clinical time frames for specialty services within EHRS orders. The CNE should instruct the specialty department to schedule services according to those time frames. These changes should help ensure that the institution schedules specialty appointments within clinically appropriate time frames.

- CCHCS should modify the specialty access policy and eliminate both "routine" and "urgent" priority time frames. Instead, CCHCS should monitor specialty access by measuring the ability of each institution to provide specialty services within the time frame specified in each EHRS order.

Population-Based Metrics

In general, CIM performed comparably to other health plans as measured by population-based metrics. In comprehensive diabetes care, CIM outperformed Medi-Cal in all five diabetic measures, and the institution outperformed Kaiser in four of the five diabetic measures. CIM scored slightly lower in diabetic blood pressure control than Kaiser, North and South regions.

When compared nationally, the institution outperformed Medicaid, commercial plans, and Medicare in all five diabetic measures. The institution also outperformed the United States Department of Veterans Affairs (VA) in two of the four applicable measures, scoring slightly lower in diabetic blood pressure control and diabetic eye exams.

CIM also outperformed all reporting health care plans for administering influenza vaccinations to younger and older adults, but the results were mixed regarding administering pneumococcal vaccines to older adults. With respect to colorectal cancer screening, CIM scored higher than commercial plans and Medicare, but lower than Kaiser (North and South) and the VA.

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 Institution for Men (CIM) was the 33rd 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

Opened in 1941, the California Institution for Men (CIM) is located in San Bernardino County. The institution's primary mission is to provide housing and programming for the general population and sensitive needs (Level II) patients. The California Institution for Men is a large complex consisting of four separate facilities: Facilities A and C primarily house Level II sensitive needs yard custody patients; Facility D houses general population patients and is designated as a Secure Level I; Facility B houses medium- and maximum-custody-level patients and also serves as a reception center, receiving and processing male patients who have been newly committed to CDCR, primarily from Riverside and San Diego Counties.

The institution operates ten medical clinics where health care staff members handle routine requests for medical services. In addition, CIM operates a triage and treatment area (TTA) for urgent and emergent patient care, a receiving and release (R&R) clinic for assessment of arriving and departing patients, and its licensed correctional treatment center (CTC) for patients requiring inpatient care. In its outpatient housing unit (OHU), CIM also treats patients requiring assistance with the activities of daily living but who do not require a higher level of inpatient care. CCHCS has designated CIM as an "intermediate" health care institution. These institutions are predominantly located in or near urban areas, close to tertiary care centers and specialty care providers for the most cost-effective care.

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

Based on staffing data the OIG obtained from CCHCS as identified in the following *CIM Health Care Staffing Resources as of November 2017* table, CIM's vacancy rate among nursing staff was 14.73 positions in November 2017. At the time of the OIG's inspection, CIM had three nursing staff on extended leave.

CIM Health Care Staffing Resources as of November 2017

	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff**	Total
Authorized Positions	6.00	18.00	16.88	185.53	226.41
Filled by Civil Service	6.00	18.00	17.00	170.80	211.80
Vacant	0.00	0.00	(0.12)	14.73	14.61
Percent Filled by Civil Service	100.00%	100.00%	100.71%	92.06%	93.55%
Filled by Telemed	N/A	0.00	N/A	N/A	0.00
Percent Filled by Telemed	N/A	0.00%	N/A	N/A	0.00%
Filled by Registry	0.00	0.00	0.00	28.28	28.28
Percent Filled by Registry	0.00%	0.00%	0.00%	15.24%	12.49%
Total Filled Positions	6.00	18.00	17.00	199.08	240.08
Total Percentage Filled	100.00%	100.00%	100.71%	107.30%	106.04%
Appointments in last 12 Months	1.00	1.00	6.00	25.00	33.00
Redirected Staff	0.00	0.00	0.00	1.00	1.00
Staff on Extended Leave^	0.00	0.00	0.00	3.00	3.00
Adjusted Total: Filled Positions	6.00	18.00	17.00	195.08	236.08
Adjusted Total: Percentage Filled	100.00%	100.00%	100.71%	105.15%	104.27%

*Executive Leadership includes Chief Physician & Surgeon
**Nursing Staff includes Sr Psych Tech/Psych Tech
^In Authorized Positions
Note: The OIG did not validate the CIM Health Care Staffing Resources and Filled Positions data.

As of November 13, 2017, the Master Registry for CIM showed that the institution had a total population of 3,610. Within that total population, CDCR designated 16.4 percent as high medical risk, Priority 1 (High 1), and 30.4 percent 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 following table illustrates the breakdown of the institution's medical risk levels at the start of the OIG medical inspection.

CIM Master Registry Data as of November 13, 2017

Medical Risk Level	Number of Patients	Percentage
High 1	592	16.4%
High 2	1,099	30.4%
Medium	974	27.0%
Low	945	26.2%
Total	**3.610**	**100%**

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 *CIM 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 determine or 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 we derive the ratings for the primary quality indicators *Health Care Environment* and *Preventive Services* 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 continue 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's 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 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] California Correctional Health Care Services (CCHCS) Quality Management Section, *High-Risk Patient Performance Report – Appropriate Placement in the CCHCS Primary Care Environment,* August 2012; **https://cchcs.ca.gov/wp-content/uploads/sites/60/2017/08/T21_20120915_Appendix6.pdf** (accessed 9-10-18).

[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.

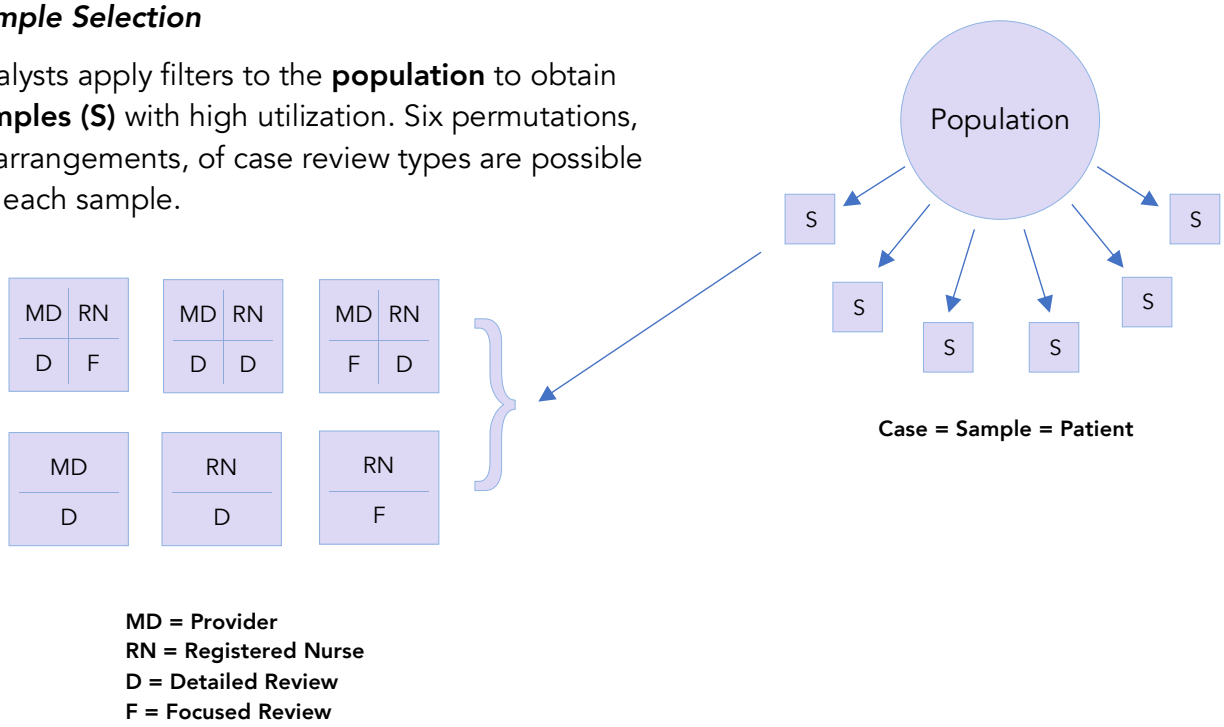
Case Review Sampling Methodology

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, next page). 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.



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: CIM Sample Sets*, the OIG clinicians evaluated medical records for 58 unique cases. *Appendix B, Table B-4: CIM Case Review Sample Summary* clarifies that both nurses and physicians reviewed 16 of those cases, for 74 case reviews in total. Physicians performed detailed reviews of 27 cases, and nurses performed detailed reviews of 14 cases, totaling 41 detailed case reviews. Nurses also performed a focused review of an additional 33 cases. These reviews generated 1,028 case review events (*Appendix B, Table B-3: CIM Event – Program*).

While the sample method specifically pulled only 6 chronic care cases, i.e., 3 diabetes cases and 3 anticoagulation cases (Appendix B, Table B-1: CIM Sample Sets), the 58 unique cases sampled included 231 chronic care diagnoses, including 16 additional cases with diabetes (for a total of 19) and 1 additional anticoagulation case (for a total of 4) (Appendix B, Table B-2: CIM 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.

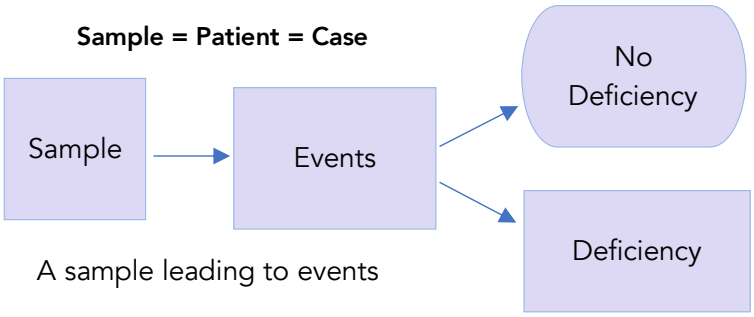
Case Review Testing Methodology

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 5, and Chart 1, previous page). As the OIG clinician inspector reviews the medical record for each case, 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

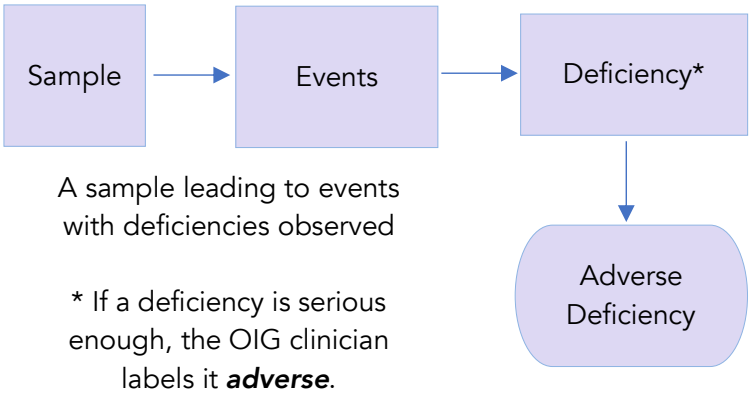
Case Review Testing

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 exists. 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 occurring 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 *CIM 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 attained answers to 95 objective medical inspection test (MIT) questions designed to assess the institution's compliance with critical policies and procedures applicable to the delivery of medical care. To conduct most tests, inspectors randomly selected samples of patients for whom the testing objectives were applicable and reviewed their electronic health records. In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed health records for 447 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, field registered nurse inspectors conducted a detailed onsite inspection of CIM's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,366 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 CIM's infrastructure, protocols for tracking medical appeals and local operating procedures, and staffing resources.

[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.

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

Scoring of Compliance Testing Results

After compiling the answers to the 95 questions for the 11 applicable indicators, the OIG derived a score for each quality indicator by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Based on those results, the OIG assigned a rating to each quality indicator of *proficient* (greater than 85.0 percent), *adequate* (between 75.0 percent and 85.0 percent), or *inadequate* (less than 75.0 percent).

OVERALL QUALITY INDICATOR RATING FOR CASE REVIEWS AND COMPLIANCE TESTING

The OIG derived the final rating for each quality indicator by considering the ratings from the case reviews and from the compliance testing, as applicable. The case review evaluations and the compliance testing results usually agreed, but there were instances for this inspection when the rating differed for particular quality indicators. 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 deficiencies 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 ratings assigned to each of the quality indicators applicable to the institution, giving more weight to those indicators that 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.

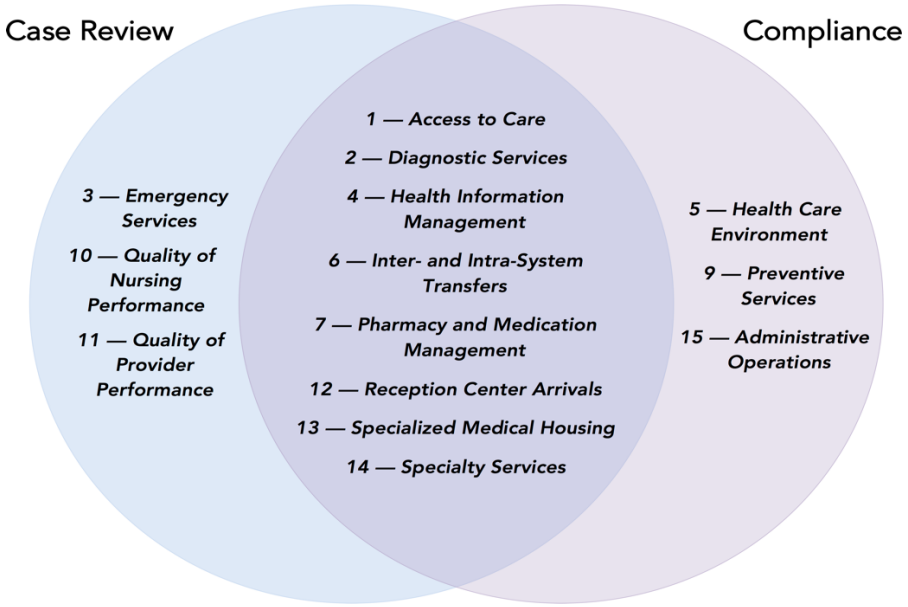
POPULATION-BASED METRICS

The OIG identified a subset of Healthcare Effectiveness Data Information Set (HEDIS) measures applicable to the CDCR patient population. To identify outcomes for CIM, the OIG reviewed some of the compliance testing results, randomly sampled additional patients' records, and obtained CIM 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 *CIM Executive Summary Table* on page *iv* of this report identifies the 14 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 CIM was ***inadequate***.

Summary of Case Review Results: The clinical case review component assessed 11 of the 14 indicators applicable to CIM. Of these 11 indicators, OIG clinicians rated 1 *proficient*, 6 *adequate*, and 4 *inadequate*.

The OIG physicians rated the overall adequacy of care for each of the 27 detailed case reviews they conducted. Of these 27 cases, 1 was *proficient*, 14 were *adequate*, and 12 were *inadequate*. In the 1,028 events reviewed, there were 220 deficiencies, 60 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. Major health care organizations typically identify and track adverse deficiencies for the purpose of quality improvement. Adverse deficiencies are not typically representative of

medical care delivered by the organization. We normally identify 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, we caution against drawing inappropriate conclusions regarding the institution based solely on adverse deficiencies. We identified six adverse deficiencies in the case reviews at CIM:

- In case 6, the patient had aortic stenosis (narrowing of the aorta), which had progressed from mild to moderate severity and required monitoring. The provider did not address the aortic stenosis during any of the patient's chronic care or follow-up visits. The provider also did not realize that the patient's cardiology follow-up appointment did not occur. After more than a year of lapsed care, the patient developed chest pain and shortness of breath with exertion, as well as dizziness. The provider failed to consider that the patient's symptoms may have been due to his worsening aortic stenosis. Subsequently, the patient lost consciousness and required CPR. Unfortunately, the resuscitation was unsuccessful, and the patient died. The inappropriate management of the patient's aortic stenosis placed the patient at risk of harm and may have contributed to his death. We also discuss this case in the *Quality of Provider Performance* indicator.

- In case 18, the patient had no previous tuberculosis (TB) infection and no prior abnormal TB tests. A provider reviewed a newly positive TB blood test that suggested the patient had developed latent or active TB infection. Active pulmonary TB would require staff to place the patient in respiratory isolation to prevent the spread of the disease to other inmates and prison staff. Nonetheless, on subsequent visits, the provider did not address the positive test and did not obtain a chest X-ray to assess for possible active TB infection. The institution did not address the abnormal TB test until the OIG notified CCHCS about this lapse in care. Fortunately, subsequent tests showed no evidence of active TB. We also discuss this case in the *Quality of Provider Performance* indicator.

- In case 24, the elderly patient with previous gastrointestinal bleeding had two consecutive laboratory tests that showed significantly worsening anemia. Also, the patient had signs and symptoms of anemia, including fatigue, dizziness, and an abnormally rapid heart rate. Furthermore, the patient had dark stool, which was even more suggestive of gastrointestinal bleeding. The provider should have transferred the patient to a community hospital for further evaluation but did not. This error placed the patient at risk of life-threatening complications of anemia and bleeding. We also discuss this case in the *Quality of Provider Performance* indicator.

- Also in case 24, the patient returned from hospitalization with the diagnosis of a left kidney mass suspicious for cancer. The hospital physician recommended the patient see a urologist to follow up on the mass. The provider did not properly review the hospital records and failed to address the left kidney mass. The provider's error placed the patient at risk for delayed or untreated kidney cancer. We also discuss this case in the *Quality of Provider*

Performance and *Specialized Medical Housing* indicators.

- In case 27, the patient had an abnormal test showing blood in the stool. Some conditions that can cause blood in the stool include intestinal bleeding and intestinal cancer. Although the provider signed the test result, the provider did not address the abnormal test. This oversight placed the patient at risk of serious complications from possible intestinal bleeding or cancer. We also discuss this case in the *Quality of Provider Performance* indicator.

- In case 29, the patient was diagnosed at his previous CDCR institution with lung cancer. The cancer was invading the patient's right main bronchus. The patient was symptomatic and was coughing up blood. The sending institution transferred the patient to CIM promptly for urgent treatment because there were no oncology services available near the sending institution. When the patient arrived at CIM, the provider failed to request an urgent oncology consultation. Instead, the provider ordered a routine (90-day) referral, which contributed to a three- and half-month delay in the patient's cancer treatment. We also discuss this case in the *Quality of Provider Performance* indicator.

Summary of Compliance Results: The compliance component assessed 11 of the 14 indicators applicable to CIM. Of these 11 indicators, OIG inspectors rated 6 *proficient*, 2 *adequate*, and 3 *inadequate*. Each section of this report summarizes the results of those assessments, and *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 patients have Health Care Services Request forms (CDCR Form 7362) available in their housing units.

Case Review Rating:
Adequate
Compliance Score:
Proficient
(86.2%)
Overall Rating:
Adequate

For this indicator, the case review and compliance review processes yielded different results, with the case reviewers assigning an *adequate* rating and the compliance testing resulting in a *proficient* score. Case review testing found issues with wound care appointments, nurse follow-ups, and provider follow-ups after specialty services. Because the institution had room to improve in those areas, we determined that the overall rating for this indicator was *adequate*.

Case Review Results

We reviewed 653 provider, nurse, specialty, and hospital events that required follow-up appointments. We identified seven deficiencies relating to access to care, five of which were significant. Although the total number of deficiencies was low, the pattern and severity of those deficiencies suggested that the institution had room for improvement with registered nurse (RN) follow-ups, specialty access, and primary care provider follow-ups after specialty services. The case review rating for the *Access to Care* indicator was *adequate*.

Provider-to-Provider Follow-up Appointments

Provider-ordered follow-up appointments are essential elements of access to care. CIM performed well with these appointments. We reviewed 48 provider-initiated follow-ups, and all the appointments occurred timely.

Provider-to-Nurse Appointments

The OIG clinicians reviewed five providers' requests for nursing follow-ups and identified two deficiencies.

RN Sick Call Access

CIM performed well with sick call access. We reviewed 47 sick call face-to-face events, and CIM scheduled sick call appointments timely.

Nurse-to-Provider Referrals

Sick call nurses assess patients and make referrals to a provider if indicated. The OIG clinicians reviewed 15 nurse-initiated provider referrals, and CIM performed well as there were no deficiencies.

Nurse Follow-up Appointments

CIM had difficulty ensuring nurse follow-up appointments. The OIG clinicians reviewed nine cases requiring a nurse follow-up and identified missed appointments in the following cases:

- In cases 17 and 58, the nurses did not perform wound care as requested.
- In case 31, the appointment with the RN care management did not occur.

Intra-System Transfers

CIM performed well ensuring timely provider and RN appointments for patients who transferred in from other CDCR facilities, and all pending specialty appointments occurred timely.

Follow-up After Hospitalization

CDCR providers should see patients returning from a hospitalization within a time frame that ensures patient safety and optimal clinical outcomes, but in no case later than five days after the discharge date. CIM performed very well with these appointments. We reviewed 33 hospital return events, and all provider follow-ups occurred timely.

Specialized Medical Housing

CIM providers timely completed history and physical examinations for all newly admitted outpatient housing unit (OHU) patients and saw the patients regularly. We found no deficiencies in this category.

Access to Specialty Services

CIM did not consistently provide access to specialty appointments. We identified three significant deficiencies with follow-up specialty appointments, which we discuss in the *Specialty Services* indicator.

Provider Follow-up After Specialty Service Visits

CIM did not consistently provide follow-ups for patients returning from specialty appointments. In 25 cases in which the patient received a specialty service, two contained significant deficiencies:

- In case 19, the patient saw a specialist who recommended a computed tomography (CT) scan to follow up on the patient's lung cancer. When the patient returned from the specialist, the provider follow-up appointment after the specialty consult did not occur. Without a scheduled follow-up, the patient was at risk for a lapse in care.

- In case 21, the patient saw a specialist who recommended a needle biopsy of the patient's lymph nodes. The required 14-day provider follow-up appointment did not occur. Without a scheduled follow-up, the patient was at risk for a lapse in care.

Follow-up After Urgent/Emergent Care

CIM performed well scheduling provider follow-up after staff discharged patients from the triage and treatment area (TTA). All provider appointments occurred within the appropriate time frame.

Clinician Onsite Inspection

During the onsite visit, clinic nurses reported seeing an average of 10 patients each day in the RN clinics. Providers reported seeing an average of 8 to 12 patients each day. Each of the five clinics had a designated office technician (OT) who attended daily clinic huddles and coordinated with the providers to ensure that they scheduled all important follow-up appointments. The OTs reported that there were no provider or nursing appointment backlogs.

Case Review Conclusion

CIM performed well in most aspects of the *Access to Care* indicator, as the OTs usually ensured that most provider, nursing, and specialty appointments occurred timely. However, the institution should provide improved nurse access to wound care and nurse follow-ups. The institution should ensure timely follow-up specialty appointments, as well as more reliable access to providers after the patients return from a specialty appointment. The OIG clinicians rated this indicator *adequate*.

Compliance Testing Results

The institution performed in the *proficient* range with a compliance score of 86.2 percent in the *Access to Care* indicator. The following tests earned scores in the *proficient* range:

- We sampled 25 patients who suffered from one or more chronic care conditions; 22 patients (88.0 percent) timely received their provider-ordered follow-up appointments. Two patients received chronic care appointments from 1 to 35 days late; and for the remaining patient,

chronic care follow-up did not occur at all (MIT 1.001).

- We sampled 30 Health Care Services Request forms (CDCR Forms 7362) submitted by patients across all facility clinics. Nursing staff reviewed all service request forms the same day they collected them (MIT 1.003).

- Nursing staff completed timely face-to-face triage encounters for 29 of 30 sampled patients (96.7 percent). For one patient, the nurse conducted the visit one day late (MIT 1.004).

- Providers conducted timely follow-up appointments for all 25 sampled patients who were discharged from a community hospital (MIT 1.007).

Three tests received scores in the *adequate* range:

- Among 25 patients sampled who transferred into CIM from other institutions and whom nursing staff referred to a provider based on the initial health care screening, providers timely saw 20 (80.0 percent). Five patients received provider appointments between 1 and 26 days late (MIT 1.002).

- We sampled 28 patients who received high-priority or routine specialty services; 21 of them (75.0 percent) received a timely follow-up appointment. Three patients' high-priority specialty service follow-up appointments were 1 to 25 days late. Two patients' routine specialty service follow-up appointments were 7 and 13 days late. For one patient, the provider failed to discuss the routine specialty service result during a follow-up visit, and for the remaining one patient, the routine specialty service follow-up appointment did not occur at all (MIT 1.008).

- Patients had access to health care services request forms at five of six housing units (83.3 percent). One inspected housing unit did not have a system in place for reordering health care request forms (CDCR Form 7362) and did not have a secured lockable box for patients to submit their requests confidentially (MIT 1.101).

The OIG inspectors found room for improvement in the following area:

- We sampled three health care services request forms on which the nurse referred the patient for a provider appointment. Two patients (66.7 percent) received a timely appointment. One patient did not receive a provider visit at all (MIT 1.005).

2 — *DIAGNOSTIC SERVICES*

Case Review Rating:
Proficient
Compliance Score:
Proficient
(87.8%)
Overall Rating:
Proficient

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 Results

We reviewed 154 diagnostic services and found only four deficiencies, two of which were significant. CIM performed very well in this indicator. The case review rating for this indicator was *proficient.*

Test Completion

CIM demonstrated an effective laboratory process, as the institution completed nearly all laboratory tests, X-rays, onsite ultrasounds, computerized tomography (CT) scans, and magnetic resonance imaging (MRI) scans promptly. We found only two tests that were not completed:

- In case 20, the patient agreed to undergo colon cancer screening. The nurse dispensed the fecal occult blood test (FOBT) cards; however, staff never collected and processed the cards and never performed the test.

- In case 24, a provider ordered a blood test, but the staff did not perform the test.

Health Information Management

CIM retrieved and scanned laboratory reports, diagnostic procedure reports, and pathology reports into the medical records timely, and the providers reviewed the diagnostic reports promptly.

Clinician Onsite Inspection

CIM had an effective tracking process to ensure that staff completed diagnostic procedures timely. The phlebotomists went to each yard to draw blood tests, except in D yard where the patients went directly to the laboratory for blood tests. When patients needed urgent laboratory tests, an RN obtained the sample and arranged the expedited handling and processing of the tests. When

the TTA RN received a laboratory test result with critically abnormal values, the RN promptly notified a provider to ensure proper care.

Case Review Conclusion

CIM performed well in this indicator. Deficiencies were rare, and the OIG clinicians identified no patterns of problems. We rated the *Diagnostic Services* indicator at CIM *proficient*.

Compliance Testing Results

The institution received a *proficient* compliance score of 87.8 percent in the *Diagnostic Services* indicator, which encompasses radiology, laboratory, and pathology services. For clarity, we discuss each type of diagnostic service separately below:

Radiology Services

- All of the radiology services sampled were timely performed, and the test results were timely communicated to the patients (MIT 2.001, 2.002). While the provider reviewed the reports timely for nine of the ten samples (90.0 percent), one sample was reviewed four days late (MIT 2.003).

Laboratory Services

- Eight of ten sampled patients (80.0 percent) received their provider-ordered laboratory services timely. For two patients, the institution provided laboratory services one and two days late (MIT 2.004). CIM providers then reviewed eight of ten resulting laboratory services reports within the required time frame (80.0 percent). Two reports were reviewed three days late (MIT 2.005). Lastly, providers timely communicated corresponding laboratory reports to six of ten patients (60.0 percent). Three patients received their results three days late. For the remaining patient, the written communication received from the provider did not identify the specific laboratory test referenced (MIT 2.006).

Pathology Services

- CIM received final pathology reports timely for all ten patients sampled (MIT 2.007). In addition, providers properly evidenced their review of pathology results for nine of ten sampled patients (90.0 percent). Staff reviewed one report one day late (MIT 2.008). Finally, providers timely communicated the pathology results to nine of the ten patients (90.0 percent). Staff communicated one report seven days late (MIT 2.009).

3 — *EMERGENCY SERVICES*

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

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

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

Case Review Results

We reviewed 27 urgent/emergent events and found 23 deficiencies within various aspects of emergency care. The OIG clinicians considered 2 of the 23 deficiencies significant, both of which occurred in case 8. The case review rating for this indicator was *adequate*.

CPR Response

CIM demonstrated good CPR response. In the reviewed cases, either custody or health care staff appropriately initiated CPR. First medical responders arrived promptly and provided necessary care. We found no delays in CPR response. However, we could not reliably determine if there were delays in other, non-CPR emergency responses because CIM nurses often failed to record accurate timelines.

Provider Performance

The providers made appropriate triage decisions when patients presented emergently to the TTA and medical clinics. The providers were frequently available for immediate consultation. We identified no provider deficiencies.

Nursing Performance

CIM nurses usually provided appropriate assessments and interventions. However, we found two worrisome nursing deficiencies, both of which occurred in the same case:

- In case 8, the patient had a severely low blood count suggestive of critical anemia. The provider asked the TTA RN to evaluate the patient for anemia symptoms. If the patient was symptomatic, the nurse was to contact the provider for further instructions. The nurse found that the patient indeed had symptoms of severe anemia, but the RN inappropriately released the patient back to his housing without notifying the provider. The nurse's error placed the patient at significant risk of harm due to the possibility of complications from the untreated anemia.

- Also in case 8, on a separate occasion, the patient developed a high fever of 102.3 degrees Fahrenheit. The TTA RN gave the patient a medication to relieve the fever, but the medication did not work. Even though the patient had a persistent fever, the TTA RN did not notify a provider. Instead, the nurse inappropriately released the patient back to general housing.

Nursing Documentation

The TTA nurses recorded incomplete chronological information during medical emergencies. The first medical responders and the TTA nurses neglected to record the times of requested emergent medical response or the times of medical response staff arrival. These documentation deficiencies resulted in our inability to assess emergent response timelines in some of these cases accurately. If not corrected, the poor nursing documentation can result in the failure of the Emergency Medical Response Review Committee (EMRRC) to identify and correct delays in emergent care.

Emergency Medical Response Review Committee

CIM nursing and physician leadership conducted a clinical and timeline review of all patients transferred to a higher level of care. The EMRRC generally reviewed these emergency cases satisfactorily. However, on four occasions, their reviews did not capture the nursing deficiencies identified by the OIG clinicians.

Clinician Onsite Inspection

The TTA was located in the D yard and had four beds. Two nurses staffed the TTA for each of three daily shifts. On weekday evening shifts, a third nurse assisted with patients returning from offsite specialty consultations. The TTA RN was also responsible for assessing any patient who returned from a community hospital. Providers were readily available for consultation, even after hours. There was an onsite provider scheduled weekdays until 11:00pm.

During day and evening weekday shifts, an RN first medical responder (FMR) provided emergent responses. When the RN FMR was not available, the licensed vocational nurse (LVN) FMR would respond instead and would request assistance from the TTA RN when needed. Because of the distance between the yards and the TTA, the emergency medical services (EMS) ambulance frequently responded directly to the medical clinics in the prison yards instead of to the TTA to minimize their response times.

Each of CIM's four yards contained an after-hours medication cabinet (Omnicell) where nurses could obtain medications during urgent events. However, cardiac monitoring equipment and intravenous supplies, including intravenous fluids, were only available in the TTA located in D yard.

Case Review Conclusion

Despite CIM's unique challenge of extreme distance between the various yards and the TTA, the institution generally provided timely emergency responses. The providers made appropriate clinical decisions, and the nurses usually provided acceptable care. The OIG clinicians rated the *Emergency Services* indicator *adequate*.

4 — *HEALTH INFORMATION MANAGEMENT*

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

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

CIM converted to the new electronic health record system (EHRS) in August 2017; therefore, most testing occurred in the EHRS, with a minor portion of the testing done in the electronic unit health record (eUHR).

Case Review Results

We reviewed 1,028 medical events and identified 18 health information management deficiencies, 5 of which were significant. Despite the low frequency of errors, we found a significant problem with CIM's handling of specialty reports. We rated the *Health Information Management* indicator *adequate.*

Interdepartmental Transmission

We found no problems in this area, as we did not identify any deficiencies in communication between the departments within the institution.

Hospital Records

CIM timely retrieved, reviewed, and scanned most hospital records into the medical record. We reviewed 36 community hospital events, including emergency department visits. We found only one significant deficiency:

- In case 19, during hospitalization, the patient had a CT scan that identified a new pulmonary nodule and a left kidney mass. The institution did not scan the CT scan report into the patient's medical record.

Missing Documents (Progress Notes and Forms)

CIM performed well ensuring that staff scanned most records, other than specialty reports, into the electronic medical record. Additionally, with the implementation of the EHRS, most nurses and providers directly recorded their encounters into the electronic system, eliminating one step during which records could have been lost or misfiled.

Laboratory, Diagnostic, and Pathology Reports

Staff at CIM properly retrieved and scanned into the medical records laboratory, diagnostic procedure, and pathology reports. We found no significant deficiencies in this area.

Specialty Services Reports

CIM staff usually timely retrieved and scanned specialty service reports into the medical record. However, we found a pattern in which the institution did not always process specialty reports correctly. We identified two missing specialty reports:

- In case 19, a positron emission tomography/computed tomography (PET/CT) scan report was missing from the medical record.

- In case 23, an angiogram report was missing from the medical record.

CIM usually retrieved specialty reports timely; however, one report was received late:

- In case 19, a telemedicine oncology consultation was not received until 14 days after the consultation.

Legibility

Providers and nurses typed or dictated their progress notes, and there were no legibility problems.

Scanning Performance

CIM staff scanned most documents accurately and timely. There were only four minor deficiencies related to scanning performance, including the following:

- In case 21, a gastroenterology (GI) specialty report was incorrectly labeled as an ear, nose, and throat (ENT) consult.

Clinician Onsite Inspection

When we interviewed specialty service staff, we confirmed that CIM experienced delays in obtaining telemedicine specialty reports. The institution claimed that certain specialty reports were at times difficult to obtain. The OIG maintains that CIM has room for improvement in its specialty report handling.

Case Review Conclusion

Compared to the Cycle 4 inspection, CIM showed improvement. We no longer found inappropriately cloned documents, and legibility was no longer an issue. CIM's management of health information was good in most areas. However, the institution could improve with its handling of specialty reports. We rated CIM's *Health Information Management* indicator *adequate.*

Compliance Testing Results

The institution scored in the *adequate* range with a score of 75.5 percent in the *Health Information Management* indicator. The following tests earned scores of *proficient*:

- CIM staff scanned 19 of 20 specialty service consultant reports sampled into the patients' electronic medical records within five calendar days (95.0 percent). However, staff scanned one high-priority specialty service report two days late (MIT 4.003).

- Staff scanned 24 of 25 sampled community hospital discharge reports into patients' electronic medical records within five calendar days (96.0 percent); staff scanned one report one day late (MIT 4.004).

- CIM medical records staff timely scanned 19 of 20 medication administration records (MARs) into patients' electronic medical records (95.0 percent). Staff scanned one MAR one day late (MIT 4.005).

- We reviewed electronic medical record files for 25 patients who returned to the institution after a community hospitalization; providers timely reviewed all hospital discharge reports within three calendar days of discharge (MIT 4.007).

Three tests received *inadequate* scores:

- CIM timely scanned 8 of 11 sampled non-dictated health care documents into patients' electronic medical records (72.7 percent). Staff scanned three non-dictated health care documents one to two days late (MIT 4.001).

- The institution scored 70.0 percent for timely scanning of dictated health care documents into patients' electronic medical records. Staff timely scanned seven of ten dictated health care documents within five calendar days of the patient encounter, but staff scanned three other sampled patients' documents from three to four days late (MIT 4.002).

- The institution scored zero for the labeling and filing of electronic medical record documents. For this test, the OIG bases its score on an allowable maximum of 24 mislabeled or misfiled documents. For the CIM medical inspection, there were more than 24 mislabeled or misfiled documents (MIT 4.006).

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
(55.0%)

Overall Rating:
Inadequate

Compliance Testing Results

CIM earned an *inadequate* compliance score of 55.0 percent in the *Health Care Environment* indicator. The institution received scores in the *inadequate* range on the following seven tests:

- Health care staff at 10 of 14 clinics followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste (71.4 percent). Four other clinics did not have puncture-resistant containers in examination rooms for medical staff to discard expended needles and sharps. In addition, one of the four clinics did not have personal protective equipment readily accessible to clinical staff (MIT 5.105).

- The non-clinic bulk medical supply storage areas were not in compliance with the supply management protocols and did not support the needs of the health care program, resulting in a score of zero on this test. Staff stored medical supplies beyond manufacturers' guidelines, in a location subjected to excessive heat, and directly on the floor (MIT 5.106).

- Only 5 of the 14 clinics inspected followed adequate medical supply storage and management protocols (35.7 percent). Nine clinics had one or more of the following deficiencies: clinics stored medical supplies beyond manufacturers' guidelines (*Figure 1*); disinfectant agents were in the same area with medical supplies; medical storage areas were disorganized; staff stored personal food items in the bulk medical supply storage area; and medical supplies were not clearly identifiable (MIT 5.107).

Figure 1: Expired medical supplies

- Only 7 of 14 clinic locations (50.0 percent) met compliance requirements for essential core medical equipment and supplies. The remaining seven clinics were missing one or more functional pieces of properly calibrated core equipment or other medical supplies necessary to conduct a comprehensive exam. The missing items included a nebulization unit, an examination table, an oto-ophthalmoscope, tips for the otoscope, tongue depressors, a Snellen eye chart, a biohazard receptacle or plastic bags, an automated external defibrillator (AED), and an emergency medical response bag (EMRB). In addition, an ophthalmoscope was non-operational (MIT 5.108).

- Clinic common areas at 5 of the 11 applicable clinics had an environment conducive to providing medical services (45.5 percent). The location of triage and blood draw stations in five clinics compromised patients' auditory privacy. One other clinic lacked wheelchair mobility access (MIT 5.109).

- We inspected 13 clinic examination rooms, and 5 of them (38.5 percent) were conducive to appropriate clinical care. In eight clinics, one or more of the following deficiencies were identified: confidential records were clearly visible and easily accessible; there was insufficient space in the examination rooms to perform a patient examination (*Figure 2*); staff stored personal belongings in the same area as examination room supplies; multiple patients were examined in the same examination room, which compromised their auditory privacy (*Figure 3*); and the examination room configuration did not provide visual privacy during patient encounters (MIT 5.110).

Figure 2: Examination room with insufficient space and compromised privacy

Figure 3: Multi-patient examination room with compromised privacy

- We examined EMRBs in seven applicable clinics to determine whether clinical staff inspected the bags daily and inventoried them monthly and whether the bags contained all essential items. Only two of the seven EMRBs were compliant (28.6 percent). One or more of the following deficiencies emerged at five locations: staff failed to verify that the bag's compartments were sealed and intact; staff had failed to inventory the EMRB within the last 30 days; and clinics stored EMRB medical supplies beyond the manufacturers' guidelines (MIT 5.111).

Two tests received scores in the *adequate* range:

- Of the 14 clinic locations inspected, 11 (78.6 percent) had operable sinks and sufficient quantities of hand hygiene supplies in the examination areas. In two clinics, patient restrooms did not have sufficient quantities of hygiene supplies such as antiseptic soap and disposable hand towels. In addition, one of the two clinics did not have an operational sink (*Figure 4*). In another clinic, the clinicians had no access to an operational sink within reasonable proximity (MIT 5.103).

Figure 4: Patient restroom with no operational sink

- We observed that health care staff in 11 of 14 clinics adhered to universal hand hygiene precautions (78.6 percent). At three clinic locations, staff failed to wash or sanitize their hands before or after patient contact or before applying gloves (MIT 5.104).

Two tests received scores in the *proficient* range:

- Of the 14 clinics examined, 12 (85.7 percent) were appropriately disinfected, cleaned, and sanitized. At one clinic, floors were visibly dirty. Another clinic had dust build-up in the corners and under the sink (MIT 5.101).

- Clinical health care staff at 13 of the 14 applicable clinics (92.9 percent) ensured that reusable invasive and non-invasive medical equipment was properly sterilized or disinfected. One clinic did not properly process previously sterilized instruments (MIT 5.102).

Non-Scored Results

The OIG gathered information to determine if the institution maintained its physical infrastructure in a manner that supported health care management's ability to provide timely or adequate health care. The OIG does not score this question.

- When OIG inspectors interviewed health care managers, they did not identify any significant concerns. At the time of the OIG's medical inspection, CIM had several significant infrastructure projects underway, which included increasing clinic space at four yards. There were new clinic construction plans for A yard, Facility B-Reception Center Health Care Processing, two clinics on D yard, and a new health care administration building. Additional construction would reconfigure and renovate clinic spaces on B and C yards, central health services, and the infirmary. Most of these projects started in summer 2015 with the exception of the infirmary, which started in fall 2017. There was one clinic estimated to break ground in spring 2018, and some clinic projects that were pending due to construction changes or dependence on the completion of other in-progress construction work. The managers estimated that these projects would be completed from early 2018 to late 2020 (MIT 5.999).

6 — *INTER- AND INTRA-SYSTEM TRANSFERS*

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(74.3%)
Overall Rating:
Inadequate

This indicator focuses on the management of patients' medical needs and continuity of patient care during the inter- and intra-system 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 Results

We reviewed 33 events in which patients returned from a community hospital or emergency department, 5 cases in which patients transferred into CIM from other CDCR institutions, and 4 cases in which patients transferred out to other CDCR institutions. In total, we reviewed 94 inter- and intra-system transfer events. There were 29 deficiencies, 8 of which were significant. We found significant deficiencies in cases 19, 23, 24, 34, 55, and 60. The case review rating for the *Inter- and Intra-System Transfers* indicator was *inadequate.*

Transfers In

The OIG clinicians reviewed five transfer-in cases, which yielded 14 related events. CIM nurses timely evaluated these patients, performed adequate assessments and interventions, and appropriately initiated provider appointments. The following is one example:

- In case 34, the patient arrived without his prescribed medications, including nitroglycerin for chest pain and a rescue inhaler for asthma. The provider re-prescribed these medications and ordered them filled immediately. However, the nurse did not administer these essential medications until the following day.

Transfers Out

CIM nurses did not consistently list essential care items on the transfer form before patients transferred to other facilities. We reviewed four cases in which patients transferred out of CIM. Although the nurses ensured that medications were with the patients, the CIM nurses did not thoroughly complete the Health Care Transfer Information forms (CDCR Form 7371) in two of the four cases:

- In case 59, the RN failed to identify a pending ophthalmology follow-up.

- In case 60, the RN failed to identify the patient's peripherally inserted central catheter (catheter inserted into a blood vessel next to the heart), a pending telemedicine appointment, and a prescribed nutritional supplement.

Hospitalizations

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

CIM had difficulty ensuring continuity of care for patients who returned from an outside hospital. We reviewed 33 events in which a patient returned to CIM from a hospitalization or emergency department and identified 21 deficiencies. Six were significant, occurring in cases 19, 23, 24, and 55.

CIM TTA nurses made incomplete assessments in cases 1, 7, 22, 23, 24, and 39. We also found problems with post-hospital medication continuity in cases 8, 23, 24, and 55. The following examples illustrate these problems:

- In case 8, the patient returned from the hospital but did not receive his blood pressure medication until three days later.

- In case 23, the patient returned from the hospital with an abdominal surgical incision and complained of post-operative pain. The nurse did not assess the patient's pain so did not provide appropriate pain control. Additionally, the nurse did not assess when that patient last had a bowel movement, an essential part of the nurse assessment because post-operative patients are at risk for constipation and potentially serious complications.

- In case 55, the patient returned from the hospital, and a provider prescribed an increased dose of a blood pressure medication; however, the patient received both the increased dose and the dose from before his hospitalization. This error increased the risk of hypotension (low blood pressure) and unnecessary medication adverse side effects.

CIM generally obtained pertinent hospital records and ensured the providers reviewed these records; however, in case 39, staff failed to retrieve the patient's X-ray and procedure reports from the hospital. We found one significant deficiency related to a missing hospital summary:

- In case 19, during the hospitalization, the patient had a CT scan showing new findings of a lung nodule. CIM did not retrieve or scan the CT report into the medical record.

CIM providers performed poorly addressing new diagnoses and recommendations when patients returned from hospitalization. The following examples demonstrated poor provider assessment after hospitalization:

- In case 21, the patient had a stricture of his upper digestive tract and required a gastric tube to bypass the stricture for feeding. The patient returned from an emergency department with the diagnosis of gastric-tube malfunction. The emergency room physician recommended to follow up with a general surgeon in one week to replace the tube; however, the CIM provider ordered a routine priority general surgery appointment. The gastric-tube was not replaced until more than one month later.

- In case 23, the patient returned from the hospital after an aortic aneurysm repair and was discharged with a potentially toxic anti-arrhythmic medication. The hospital physician recommended the patient follow up with cardiology within two weeks. Instead, the CIM provider ordered a routine cardiology appointment within 90 days, and that appointment did not occur.

- In case 24, the hospital physician diagnosed the patient with a kidney mass that may have been cancer and recommended the patient follow up with the kidney specialist; however, the CIM provider did not review the hospital record. CIM did not address the kidney mass until nine months later when the OIG alerted CCHCS of this oversight during our review of this case.

Case Review Conclusion

CIM nurses generally performed well with patients transferring into CIM from other CDCR institutions. However, they often did not identify essential care items for patients transferring to different institutions. CIM did poorly maintaining sufficient care for patients returning from an outside hospital or emergency room. CIM had difficulty maintaining medication continuity for these patients. CIM nurses made poor assessments for these patients while providers often failed to review hospital discharge summaries and did not implement hospital-recommended interventions. Because of the problems we identified, we rated CIM's *Inter- and Intra-System Transfers* indicator *inadequate.*

Compliance Testing Results

The institution performed in the *inadequate* range in this indicator, with a compliance score of 74.3 percent. CIM earned *inadequate* scores on the following tests:

- For 16 of 25 sampled patients who transferred into CIM from other CDCR institutions, nursing staff completed an Initial Health Screening (CDCR Form 7277) on the same day the patient arrived (64.0 percent). For nine patients, nursing staff neglected to record an answer to one of the screening form questions (MIT 6.001).

- Among 20 sampled patients who transferred out of CIM to other CDCR institutions, only 9 (45.0 percent) had their scheduled specialty service appointments properly included on the health care transfer form. For 11 patients, CIM failed to document specialty service appointments on the transfer forms (MIT 6.004).

- CIM scored 62.5 percent when we inspected the transfer packages of eight sampled patients who transferred out of CIM during the onsite inspection to determine whether the patients' transfer packages included required medications and related documentation. Two transfer packages were missing medications. One patient's transfer package contained a medication that was not listed on his active medication order list (MIT 6.101).

Two tests received scores in the *proficient* range:

- Nursing staff timely completed the assessment and disposition sections of the screening form for all 25 sampled patients (MIT 6.002).

- Of the 25 sampled patients who transferred into CIM, 16 had an existing medication order that required nursing staff to issue or administer medications upon arrival. All 16 patients received their medications timely (MIT 6.003).

7 — *PHARMACY AND MEDICATION MANAGEMENT*

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(63.2%)
Overall Rating:
Inadequate

This indicator is an evaluation of the institution's ability to provide appropriate pharmaceutical administration and security management, encompassing the process from the written prescription to the administration of the medication. By combining both a quantitative compliance test with case review analysis, this assessment identifies issues in various stages of the medication management process, including ordering and prescribing, transcribing and verifying, dispensing and delivering, administering, and documenting and reporting. Because 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.

For this indicator, the case review and compliance review processes yielded different results, with the case reviewers assigning an *adequate* rating and the compliance testing resulting in an *inadequate* score. Compliance testing showed poor medication continuity for patients who returned from an outside hospital and for newly arrived patients from a county jail. In addition, CIM demonstrated extremely poor medication practices and storage controls, which included improper nurse administration of medications and unsafe storage of narcotic and non-narcotic medications. We determined that the overall rating for this indicator was *inadequate*.

Case Review Results

We evaluated 70 events related to medications and found 14 deficiencies, 2 of which were significant. The case review rating of the *Pharmacy and Medication Management* indicator was *adequate*.

Medication Continuity and Administration

CIM performed well with chronic care medication continuity, as the patients received their medications timely and as prescribed.

Intra-System and Intra-Facility Medication Continuity

CIM usually did well maintaining medication continuity for newly arrived patients from other CDCR facilities. However, the institution had difficulty maintaining medication continuity for patients returning from an outside hospital. We discuss these findings in the *Inter- and Intra-System Transfers* indicator.

Specialized Medical Housing Medication Continuity

The OHU patients generally received medications timely and as prescribed; however, there were three deficiencies related to medication management. We discuss the following example also in the *Specialized Medical Housing* indicator:

- In case 22, the patient with hypertension did not receive his blood pressure medications on two occasions.

Clinician Onsite Inspection

CIM's main pharmacy was in D yard and supplied medications to the other four yards. The distance between the main pharmacy and the yards is significant. For instance, C yard is about one and a half miles from the main pharmacy. There were 14 medication administration areas, including one in the OHU. The pharmacist in charge assigned a pharmacy technician to each yard to ensure that they delivered medications to all the yards. Each of the five yards had an Omnicell (automated medication storage cabinet) stocked with medications.

During the onsite visit, the patient care teams discussed medication issues in the morning huddles. The providers were informed of expiring medications and renewed those prescriptions promptly.

Case Review Conclusion

CIM's patients often had multiple medical problems and often required numerous medications. The medication administration areas were far away from the main pharmacy. Despite these challenges, CIM staff usually performed sufficiently administering most needed medications, except for those patients returning from an outside emergency room or hospital. The case review clinicians rated the *Pharmacy and Medication Management* indicator *adequate*.

Compliance Testing Results

The institution scored 63.2 percent in the *Pharmacy and Medication Management* indicator, an *inadequate* rating. For discussion purposes below, we divide this indicator into three sub-indicators: medication administration, observed medication practices and storage controls, and pharmacy protocols.

Medication Administration

In this sub-indicator, the institution received an *inadequate* score of 73.0 percent. The following four tests scored in the *inadequate* range:

- Among 23 applicable patients, 15 (65.2 percent) timely received their ordered chronic care medications. Eight patients did not receive their keep-on-person (KOP) medications per CCHCS policy requirements (MIT 7.001).

- Clinical staff timely provided new and previously prescribed medications to 14 of 25 patients sampled who transferred from a community hospital and returned to the institution (56.0 percent). For seven patients, providers did not order new medications by the required time after patients' arrival from community hospitals. The remaining four patients received their medications from one to three days late (MIT 7.003).

- We reviewed electronic medical records of 20 sampled patients who recently arrived at CIM from a county jail and identified 11 patients who needed to be reissued medications upon their arrival. Of the 11 applicable patients sampled, 6 received their medications timely (54.6 percent). Five patients received their medications from one to two days late (MIT 7.004).

- Nursing staff administered medications without interruption to seven of ten patients who were en route from one institution to another with a temporary layover at CIM (70.0 percent). For three patients, the institution did not document if staff administered or delivered the medications by the next dosing interval (MIT 7.006).

Two tests earned scores in the *proficient* range:

- Among 25 patients sampled, 24 (96.0 percent) timely received their newly ordered medication. One patient received his directly observed therapy (DOT) medication one day late (MIT 7.002).

- CIM ensured that 24 of 25 sampled patients who transferred from one housing unit to another (96.0 percent) received their prescribed medications without interruption. One patient did not receive one or more doses of his medication at the next dosing interval after the transfer occurred (MIT 7.005).

Observed Medication Practices and Storage Controls

The institution scored 39.0 percent in this sub-indicator, with the following five tests scoring in the *inadequate* range:

- We interviewed nursing staff and inspected narcotics storage areas at applicable clinics and pill line locations to assess narcotics security controls. Nursing staff implemented strong medication security controls over narcotic medications in one of ten locations (10.0 percent). In nine clinics, one or more of the following deficiencies occurred: narcotic medications did not remain under double lock control; staff did not describe the appropriate narcotics discrepancy reporting process; medication nurses removed stock from the narcotics locker in a manner that did not allow a spontaneous count; and the narcotics logbook showed that on multiple occasions a controlled substance inventory was not performed by two licensed nursing staff (MIT 7.101).

- CIM safely stored non-refrigerated, non-narcotic medications in 2 of the 14 applicable clinic and medication line storage locations (14.3 percent). In 12 locations, we identified one or more of the following deficiencies: the medication area lacked a designated area for return-to-pharmacy medications; personal food items were stored in the medication room; medication storage areas were unlocked; multi-use medication was not labeled with the date it was opened; oral and topical medications were not properly separated when stored; and medications were stored outside the required temperature range (MIT 7.102).

- CIM safely stored refrigerated, non-narcotic medications in three of eight applicable clinic and medication line storage locations (37.5 percent). In five locations, one or more of the following deficiencies were observed: a medication refrigerator was unlocked; staff stored food items in the medication refrigerator; clinics stored medications beyond the manufacturers' guidelines; staff did not maintain historical daily temperature logs for the month of October 2017; and the temperature logbook showed that on multiple occasions the refrigerator temperatures were not within the acceptable range (MIT 7.103).

- Inspectors 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 prior to putting on gloves or before re-gloving (MIT 7.104).

- Staff at only three of eight inspected medication preparation and administration areas demonstrated appropriate administrative controls and protocols (37.5 percent). At five locations, one or more of the following deficiencies were observed: medication nurses did not always ensure patients swallowed DOT medications; medication nurses did not always verify the patient's identity via picture identification prior to administering medications;

medication nurses did not distribute medications to the patients within the required time frame; and patients waiting to receive their medications did not have sufficient outdoor cover to protect them from heat or inclement weather. We also observed CIM medication nurses not following manufacturers' guidelines related to proper administration of insulin to diabetic patients. Those guidelines require medication nurses to use a new glucose test strip for re-testing the blood sugar levels and to disinfect previously opened multi-use insulin vials before withdrawing and administering medication (MIT 7.106).

One test received an *adequate* score:

- CIM nursing staff at six of eight sampled locations employed appropriate administrative controls and protocols when preparing patients' medications (75.0 percent). At two medication line locations, medications were not in their original packaging (MIT 7.105).

Pharmacy Protocols

CIM scored an *adequate* 80.0 percent in this sub-indicator, with the following tests earning *proficient* scores:

- In its main pharmacy, the institution followed general security, organization, and cleanliness management protocols; properly stored and monitored non-narcotic medications that required refrigeration and those that did not; and maintained adequate controls over and properly accounted for narcotic medications (MIT 7.107, 7.108, 7.109, 7.110).

The following test earned an *inadequate* score:

- We examined 25 medication error follow-up reports and 5 statistical medication error reports generated by the institution's pharmacist in charge (PIC). All 25 of the PIC's reports were either not timely or incorrectly processed. As a result, CIM scored zero on this test. We found the following errors: the PIC did not complete medication error follow-up reports for any of the 25 reports. The PIC also did not submit the statistical report of medication errors in March 2017. Furthermore, the PIC did not share 2 of the 25 follow-up reports with the local pharmacy and therapeutics or other improvement committees (MIT 7.111).

Non-Scored Tests

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

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

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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 CIM 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:
Adequate
(78.0%)
Overall Rating:
Adequate

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

Compliance Testing Results

The institution scored in the *adequate* range in this indicator with a compliance score of 78.0 percent. The following two tests earned scores in the *proficient* range:

- CIM timely administered or offered influenza vaccinations during the most recent influenza season to all 25 patients sampled (MIT 9.004).

- CIM offered colorectal cancer screenings to 24 of 25 sampled patients subject to the annual screening requirement (96.0 percent). For one patient, health care staff did not offer a colorectal cancer screening within the previous 12 months, and the patient did not have a normal colonoscopy within the last ten years (MIT 9.005).

One test received an *adequate* score:

- We sampled 30 patients to determine if the institution provided the annual TB screenings within the last year and during their birth month as CCHCS policy required. Out of the 30 patients sampled, 25 (83.3 percent) timely received their screening. For five patients, the TB screening did not occur in the patient's birth month as required (MIT 9.008).

Three tests scored in the *inadequate* range:

- CIM scored 71.4 percent for administering timely TB medications to patients with TB. Out of 21 patients, 15 received their medications timely. The institution failed to document if three patients received the required counseling for missed doses; and nursing staff failed to document if three patients either received or refused TB medications (MIT 9.001).

- The institution scored poorly for monitoring of patients on TB medications. For 9 of 21 patients, the institution failed to complete monitoring at all required intervals (57.1 percent) (MIT 9.002).

- We tested whether CIM offered vaccinations for influenza, pneumonia, and hepatitis to patients who suffered from chronic conditions. Six of ten applicable patients sampled (60.0 percent) received all recommended vaccinations at required intervals. For three patients, there was no evidence that CIM administered hepatitis A and B vaccinations or that there was a documented immunity. There was no evidence the remaining one patient received or refused a pneumococcal immunization within the last five years (MIT 9.008).

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10 — *QUALITY OF NURSING PERFORMANCE*

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

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

We reviewed 236 nursing encounters, 97 of which were in the outpatient setting. Most outpatient nursing encounters were for sick call requests, walk-in visits, and RN follow-up visits. In all, there were 123 deficiencies identified related to nursing care performance, 8 of which were significant. We rated this indicator *adequate* overall.

Nursing Sick Call

We reviewed 47 sick call nursing encounters. Nurses timely reviewed sick call requests and usually assessed patients on the next business day. When a patient requested to be seen for a potentially urgent condition, the nurses successfully arranged a same-day assessment. However, the sick call nurse assessments were frequently incomplete. Of the 47 sick call events reviewed, we found 27 minor deficiencies in which nurses made incomplete assessments. Although none of these deficiencies was significant, they did represent a target for quality improvement.

Nursing Assessment

A major component of high-quality nursing care is assessment, which consists of essential subjective and objective evaluations needed to establish and plan nursing interventions. CIM nurses did perform their assessments timely. However, in the outpatient nursing setting, many of the nurses made incomplete assessments, which increased the risk of medical errors.

- In case 1, the diabetic patient complained of sharp, severe foot pain. Diabetes can damage the nerves and impair the circulation in the extremities, often resulting in delayed wound healing. The clinic RN did not inspect the foot for wounds and did not assess the patient for adequate circulation and sensation.

- In case 24, the patient complained of abdominal and throat pains, hiccups, and a productive cough. Although the clinic nurse obtained vital signs and referred the patient to a provider, the nurse failed to perform basic subjective and objective assessments. The nurse did not ask when the patient's symptoms began, did not inspect the throat, and did not listen to the lungs.

- In case 54, the diabetic patient complained of right foot pain, numbness, and swelling. The RN noted the foot was swollen but did not assess the foot's range of motion and did not check for adequate blood flow.

Nursing Intervention

Planning and implementation are basic components of the nursing process. After the nurse assesses and establishes the nursing diagnoses, the nurse decides which actions or interventions the patient needs and performs those interventions based on the assessment findings. Although the nurses did not always make complete assessments, their plans were clinically appropriate and usually resolved their patients' complaints.

Nonetheless, on a few occasions, the patient's symptoms warranted prompt reassessment or immediate contact with a provider, but the nurse failed to arrange these. Additionally, at times the nurses' assessments and planned interventions did not correlate. The following are examples of these deficiencies:

- In case 3, the patient had dizziness and a low heart rate. The patient's dizziness improved. However, the clinic nurse did not reassess the patient's low heart rate. Furthermore, the clinic nurse advised the patient to increase oral hydration because the nurse thought the patient was dehydrated. However, a dehydrated person would normally have an elevated heart rate, not a low heart rate. The nurse did not assess for signs of dehydration, and the nurse's findings did not support the nurse's rationale for advising the patient to increase fluid consumption.

- In cases 26 and 44, the clinic nurses did not reassess their patients' elevated blood pressures and did not assess their patients' compliance with blood pressure medications.

Nursing Documentation

Complete and accurate nursing documentation is essential for good medical care. Health care staff use documentation to communicate a patient's past and current medical conditions and to identify changes in their patients' conditions. CIM nurses usually recorded their care satisfactorily, an improved performance since the implementation of the EHRS.

In outpatient nursing, we found only minor documentation deficiencies. Most of the deficiencies were related to wound care. In cases 16, 17, 21 and 58, the nurses did not always document the appearance of their patients' wounds. We also discuss nursing documentation deficiencies in the *Emergency Services* and *Specialized Medical Housing* indicators.

Urgent/Emergent Care

The emergency nursing care provided at CIM was usually sufficient. However, we found two serious nursing errors in emergency care. The *Emergency Services* indicator discusses these further.

Care Management

The role of a chronic care manager includes assessing patients, initiating appropriate interventions to support patients' treatment plans, and monitoring patients with chronic conditions to intervene for those at increased risk for developing serious health complications. In our case reviews, we found scant evidence of RN care management visits. Even in the rare case in which there was a care management appointment, the RN did not perform well.

- In case 26, the provider referred the patient with uncontrolled high blood pressure for an RN care management visit. During the visit, the RN found the patient had elevated blood pressure. The RN did not check whether the patient was taking his prescribed blood pressure medications and did not recheck the patient's high blood pressure. The RN did not educate the patient and did not ensure the patient followed up with the provider.

Intra-System Transfers and Reception Center Arrivals

CIM nurses provided sufficient care for patients arriving at the institution, whether the patients arrived from a county jail or another CDCR institution. However, CIM nurses often failed to list essential care items on the transfer form before their patients transferred to another facility. The *Inter-and Intra-System Transfers* and the *Reception Center* indicators discuss these in more detail.

Post-Hospital Returns

The TTA nurses evaluated patients returning from an outside hospital or emergency department. We identified nine nursing deficiencies in the areas of assessment, documentation, and record review. Although we rated the nurses' performance in this area acceptable, CIM nurses can improve their

performance in this area by ensuring medication continuity and making complete assessments. We further describe the nursing performance in the *Inter- and Intra-Systems Transfer* indicator.

Specialized Medical Housing

CIM nurses gave satisfactory care in the OHU. Most of the issues we identified were minor. We discuss nursing performance in this area further in the *Specialized Medical Housing* indicator.

Specialty Services

CIM TTA nurses provided appropriate care for patients who returned from their offsite specialist visits. We found one significant deficiency in which the telemedicine nurse ignored a severely elevated blood pressure. The *Specialty Services* indicator also discusses this issue.

Clinician Onsite Inspection

The institution's four separate facilities are spread out over an expansive campus. Each of the four facilities utilized medical providers, RNs, LVNs, mental health, and dental providers. Also, facility B contained a receiving and release area (R&R) as well as administrative segregation units. Facility D had two separate medical clinics, a TTA and an OHU. The pharmacy was also located on facility D. CIM had recently moved the health care leadership team to a new building located outside of facility D.

We attended morning huddles in facilities B and D. The interdisciplinary huddles were informative and organized. CIM followed the statewide template, which addressed new arrivals, patients returning from specialist appointments, and community hospital admissions. The institution was also implementing new nursing workflows within each of its primary care clinics. The medical team expected the LVN provider assistant to obtain specialist records for the providers' review. Although CIM nursing leadership had not fully implemented this process, they recognized the importance of ensuring specialist records were available during a patient's provider appointment.

Case Review Conclusion

In general, CIM nurses provided timely evaluation, sufficient assessment, and appropriate interventions. Nonetheless, CIM nursing care in the outpatient areas showed significant room for improvement. In this inspection, outpatient nurses demonstrated patterns of incomplete assessment, intervention errors, and the absence of meaningful chronic care management. Fortunately, most of the deficiencies we found were minor and did not place patients at significant risk of harm. We rated CIM's *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. The case review clinicians review the provider care regarding appropriate evaluation, diagnosis, and management plans for programs including, but not limited to, nursing sick call, chronic care programs, TTA, specialized medical housing, and specialty services.

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

OIG physicians alone assess provider care. There is no compliance testing component associated with this quality indicator.

Case Review Results

We reviewed 265 medical provider encounters and identified 55 deficiencies related to provider performance, of which 38 were significant. Of the 27 cases reviewed, we rated 1 *proficient*, 14 *adequate*, and 12 *inadequate*. We rated this indicator *inadequate* overall.

Assessment and Decision-Making

CIM providers made numerous errors and demonstrated unsatisfactory assessment and poor decision-making. These deficiencies frequently occurred, as they were present in 14 of the 27 detailed physician case reviews (cases 6, 12, 13, 15, 17, 18, 19, 21, 23, 24, 25, 26, 27, and 29). The following examples demonstrated poor provider assessment:

- In case 21, the patient had oral cancer, and the specialist recommended obtaining a needle biopsy of the lymph nodes to assess for cancer recurrence. The provider failed to order the biopsy. Subsequently, the specialist evaluated the patient without the needed diagnostic test, resulting in a delay in care. We also discuss this case in the *Specialty Services* indicator.

- In case 24, the patient returned from hospitalization with the diagnosis of a left kidney mass suspicious for cancer. The hospital physician recommended the patient see a urologist to follow up on the mass. The provider did not properly review the hospital records and failed to address the left kidney mass. The provider's error placed the patient at risk for delayed or untreated kidney cancer. We also discuss this case in the *Specialized Medical Housing* indicator.

- In case 29, the patient was diagnosed at his previous CDCR institution with lung cancer. The patient was symptomatic and was coughing up blood. The sending institution transferred the patient to CIM promptly for urgent treatment because there were no oncology services available near the sending institution. When the patient arrived at CIM, the provider failed to request an urgent oncology consultation. Instead, the provider ordered a routine (90-day)

referral, which delayed the patient's cancer treatment.

CIM providers often did not recognize potential adverse medication side-effects or drug interactions. The following examples demonstrated poor decision-making when providers prescribed medications:

- In case 15, the patient had chronic kidney disease, and a provider prescribed long-term use of a nonsteroidal anti-inflammatory drug (NSAID). NSAIDs are toxic to the kidneys and are not recommended for patients with kidney disease. This error placed the patient at risk of worsening kidney failure.

- In case 23, a provider prescribed a potentially dangerous anti-arrhythmic medication (used for treating abnormal heart rhythms). Because of the medication's toxicity, providers are required to order multiple baseline and follow-up monitoring tests. The provider failed to order baseline thyroid function, pulmonary function, and eye examination tests. Also, the provider failed to monitor the patient's thyroid function tests while the patient received the medication.

Abnormal Diagnostic Tests

CIM providers performed poorly addressing abnormal diagnostic tests such as X-ray and laboratory results. The following examples demonstrated poor provider performance when presented with abnormal diagnostic tests:

- In case 12, the patient had testicular cancer that had spread to his spine. His X-ray showed a new spinal body compression, which may have represented cancer recurrence. Providers need to act on these results immediately because cancer-related spinal compressions can lead to permanent paralysis if not treated promptly. However, after the provider reviewed the X-ray report, the provider did not see the patient until 14 days later. This delay placed the patient at increased risk of complications from cancer recurrence.

- In case 18, the patient had no previous TB infection and no prior abnormal TB tests. A provider reviewed a newly positive TB blood test that suggested the patient had developed latent or active TB infection. Active pulmonary TB would require staff to place the patient in respiratory isolation to prevent the spread of the disease to other inmates and prison staff. Nonetheless, on subsequent visits, the provider did not address the positive test and did not obtain a chest X-ray to assess for possible active TB infection. The institution did not address the abnormal TB test until the OIG notified CCHCS about this lapse in care. Fortunately, subsequent tests showed no evidence of active TB.

- In case 24, the elderly patient with previous gastrointestinal bleeding had two consecutive laboratory tests that showed significantly worsening anemia. Also, the patient had signs and

symptoms of anemia, including fatigue, dizziness, and an abnormally rapid heart rate. Furthermore, the patient had dark stool, which was even more suggestive of gastrointestinal bleeding. The provider should have transferred the patient to a community hospital for further evaluation but did not. This error placed the patient at risk of life-threatening complications of anemia and bleeding.

- In case 25, the patient with liver cancer had an elevated tumor marker level suggestive for cancer recurrence. The provider reviewed the abnormal laboratory result but did not schedule a timely follow-up appointment to address the abnormal test result. This delay placed the patient at risk of cancer complications.

- In case 27, the patient had an abnormal test showing blood in the stool. Some conditions that can cause blood in the stool include intestinal bleeding or intestinal cancer. Although the provider signed the test result, the provider did not address the abnormal test. This oversight placed the patient at risk of serious complications from possible diagnoses such as intestinal bleeding or cancer.

Hospital Return Care

CIM providers performed poorly and often failed to address new diagnoses and recommendations when their patients returned from hospitalization. We discuss this performance further in the *Inter- and Intra-System Transfers* indicator.

Emergency Care

CIM providers were readily available for consultation with the TTA nursing staff when patients presented emergently to the TTA. The providers did well and made appropriate triage decisions. We found no provider deficiencies related to emergency care.

Chronic Care

CIM providers performed poorly in managing chronic medical conditions. Chronic care errors occurred in cases 6, 13, 15, 17, 18, 19, 20, 23, 24, 26, and 27. The following examples demonstrated poor diabetic care:

- In case 13, the patient had out-of-control diabetes during the review period, and the provider made only two insulin adjustments over seven months. Current medical standards recommend that providers adjust insulin weekly. The delayed treatment of poorly controlled diabetes placed the patient at risk for diabetic complications.

- In case 15, the patient had three consecutive blood tests that showed worsening diabetic control during the review period. Although the provider evaluated the patient six times, the

provider only made four insulin adjustments. For one of the insulin adjustments, the provider inappropriately decreased the insulin dose, leading to further worsened diabetic control.

- In case 17, the patient had poorly controlled diabetes requiring insulin adjustment. The provider ordered an eight-week follow-up. The provider should have had the patient follow up weekly to reassess the patient's glycemic control and to adjust insulin as indicated. Glycemic control for insulin-dependent diabetic patients requires close monitoring and timely insulin titration.

CIM providers performed poorly managing hypertension. The following examples demonstrated poor hypertension management:

- In case 15, the patient had chronic kidney disease with excessive protein in the urine, and he required optimal blood pressure control. On multiple encounters, the provider did not address the elevated blood pressure levels that suggested poorly controlled hypertension. The provider's oversight placed the patient at risk of cardiovascular events and kidney failure.

- In case 26, the patient had elevated blood pressure readings during all eight provider encounters in the review period. The provider made only three medication adjustments. During one occasion, the patient had severely elevated blood pressure, which could have led to a stroke. The provider should have ordered intensive blood pressure monitoring, reviewed those results during the morning huddles, and scheduled a close follow-up to reassess the patient's blood pressure control and to adjust his medications further.

The following example also demonstrated poor chronic care management:

- In case 6, the patient had aortic stenosis (narrowing of the aorta) which had progressed from mild to moderate severity and required monitoring. The provider did not address the aortic stenosis during any of the patient's chronic care or follow-up visits. The provider also did not realize that the patient's cardiology follow-up appointment did not occur. After more than a year of lapsed care, the patient developed chest pain and shortness of breath with exertion, as well as dizziness. The provider failed to consider that the patient's symptoms may have been due to the patient's worsening aortic stenosis. Subsequently, the patient lost consciousness and required CPR. Unfortunately, the resuscitation was unsuccessful, and the patient died. The inappropriate management of the patient's aortic stenosis placed the patient at risk of harm and may have contributed to his death.

Specialty Services

CIM providers often did not properly address specialists' diagnoses and recommendations.

We discuss examples of these errors in the *Specialty Services* indicator.

Specialized Medical Housing

CIM providers often had problems with diagnosing and treating OHU patients correctly. We discuss this poor provider performance in the *Specialized Medical Housing* indicator.

Health Information Management

The providers documented their outpatient, TTA, and specialty housing encounters timely. The progress notes were either dictated or typed and were legible. CIM providers generally performed well in this area.

Clinician Onsite Inspection

At the time of the OIG clinician onsite visit, there were no provider vacancies. The chief medical executive (CME) affirmed that all annual provider evaluations were current. The CME was unaware of any poorly performing providers. CIM usually assigned each provider to one designated clinic to enhance continuity of care. Each provider usually saw 8 to 12 patients per day. The providers were generally satisfied with the institution's nursing, diagnostic, and specialty services. The providers attended a daily morning report meeting, during which they discussed patients in the hospital or returning from the hospital. In addition to the morning report, the providers led the clinic morning huddles, which were productive. The huddles were also attended by nurses, care coordinators, custody staff, mental health staff, and office technicians. The clinic team discussed any significant TTA encounters or hospital returns from the previous day.

Case Review Conclusion

CIM providers performed poorly in multiple aspects of patient care. CIM providers often made poor assessments and decisions. They prescribed medications inappropriately and failed to follow up on abnormal diagnostic test results. They often failed to review and implement hospital and specialist recommendations properly. Furthermore, they had significant difficulty delivering appropriate chronic care. We identified one significantly underperforming physician and referred that provider to CCHCS for further review.

Overall, the CIM providers' combined performance was poor and resulted in *inadequate* ratings for 12 of the 27 detailed cases our physicians reviewed. We rated CIM's *Quality of Provider Performance* indicator *inadequate.*

12 — *RECEPTION CENTER ARRIVALS*

Case Review Rating:
Adequate
Compliance Score:
Proficient
(88.1%)
Overall Rating:
Adequate

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.

For this indicator, the case review and compliance review processes yielded different results, with the case reviewers assigning an *adequate* rating and the compliance testing resulting in a *proficient* score. Our analysis determined that applicable compliance results in the *Pharmacy and Medication Management* indicator showed the institution had marked difficulty issuing reception center patients their regular medications within appropriate time frames. Because of the clinical importance of medication continuity for these patients, a *proficient* rating was not warranted, and we rated this indicator *adequate* overall.

Case Review Results

We reviewed 23 related events in five cases in which the patient arrived through the reception center, and we found five minor deficiencies. The case review rating of CIM's *Reception Center Arrivals* indicator was *adequate*.

Access to Care

CIM's receiving and release (R&R) nurses evaluated new patient arrivals and ordered provider appointments within appropriate time frames. Patients received the required screening tests, and CIM providers performed thorough intake assessments and addressed pending specialty appointments.

Medication Continuity

CIM R&R nurses and providers usually reconciled medications promptly in the cases we reviewed. We found one medication deficiency:

- In case 38, the R&R RN did not issue a rescue inhaler to an asthmatic patient to keep with him for urgent self-administration as needed.

Onsite Inspection

CIM's R&R is located in facility B and is used to manage both inter-system and reception center arrivals. CIM staffed the area with RNs on the day and evening shifts. In addition to processing patients who arrived from county jails, these nurses also evaluated patients arriving from and transferring out to other CDCR institutions.

Case Review Conclusion

CIM generally performed sufficiently for newly arrived patients who transferred from a county jail. CIM had difficulty with medication continuity for these patients. The case review rating of CIM's *Reception Center Arrivals* indicator was *adequate.*

Compliance Testing Results

The institution scored in the *proficient* range in this indicator with a compliance score of 88.1 percent. The following five tests scored in the *proficient* range:

- Reception center nursing staff timely completed, signed, and dated the assessment and disposition section of the initial health screening form for all 20 patients sampled (MIT 12.002).

- Nurses referred 20 patients who arrived at CIM from county jails to see a provider. Providers saw 19 of the 20 referred patients timely (95.0 percent). A provider saw one patient 63 days late (MIT 12.003).

- Providers timely completed reception center history and physical examinations within seven calendar days of the patient's arrival for 19 of 20 sampled patients (95.0 percent). For one patient, the provider completed the history and physical 53 days late (MIT 12.004).

- We sampled 20 reception center patients to test for required intake tests; all 20 timely received the applicable intake tests (MIT 12.005).

- We sampled 20 reception center arrivals to ensure that each patient had a timely completed and properly documented TB skin test. All 20 patients had their TB tests timely administered, read, and documented (MIT 12.007).

One test received an *adequate* score:

- We sampled 20 reception center patients to ensure that they received a timely health screening upon arrival at the institution. Nursing staff conducted timely and complete screenings for 16 of those patients sampled (80.0 percent). For four patients, nurses did not complete all of the required screening questions (MIT 12.001).

Two tests indicated room for improvement with *inadequate* scores:

- After ordering intake tests for reception center arrivals, providers timely reviewed and communicated the test results to 13 of 20 patients sampled (65.0 percent). For seven patients, providers either reviewed the test results late or communicated the patient's results from 1 to 50 days late (MIT 12.006).

- The institution timely administered the coccidioidomycosis (valley fever) skin test to 14 of the 20 sampled reception center patients (70.0 percent). Staff did not timely offer the test to four patients, and staff did not obtain the other two patients' refusals within the required time frame (MIT 12.008).

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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. CIM's specialized medical housing unit is the outpatient housing unit (OHU).

Case Review Rating:
Inadequate
Compliance Score:
Proficient (100.0%)
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 *proficient* score. Because the compliance tests in this indicator do not accurately reflect the quality of patient care, we rely on the case review rating for the overall rating of this indicator. Thus, we rated this indicator *inadequate* overall.

Case Review Results

We reviewed 12 patient admissions to the OHU, which included 32 provider and 28 nursing encounters. We found 28 deficiencies, 4 of which were significant (in cases 12, 21, 23, and 24). The case review rating for this indicator was *inadequate*.

Provider Performance

The OHU provider performed poorly in the OHU, as they made poor medical assessments and decisions. The following examples demonstrated poor provider assessment:

- In case 12, the patient had cancer that had spread to the spine and was residing in the OHU for enhanced nursing care. A spine X-ray demonstrated a new vertebral body compression fracture suggestive of cancer progression. The OHU provider reviewed the X-ray report but did not evaluate the patient until 14 days later, placing the patient at risk of delayed cancer diagnosis and treatment. We also discuss this case in the *Quality of Provider Performance* indicator.

- In case 35, the patient had heart disease, and the provider prescribed nitroglycerin medication to treat episodes of chest pain. However, the provider prescribed the nitroglycerin via nurse administration rather than allowing the patient to keep it with him to use immediately when needed. This error placed the patient at risk of delayed treatment of chest pain or heart disease.

The OHU provider performed poorly addressing recommendations made by the hospital physicians after the patient returned from the hospital. The following examples demonstrated poor provider

assessment after hospitalization:

- In case 23, the patient returned from hospitalization with a repaired aortic aneurysm and a prescription for a potentially dangerous anti-arrhythmic heart medication. The hospital physician recommended a follow-up appointment with a cardiologist two weeks after discharge. However, the OHU provider did not request the cardiology follow-up within the recommended time frame, which demonstrated the provider's poor assessment and understanding of the patient's condition. We also discuss this case in the *Quality of Provider Performance* indicator.

- In case 24, the patient returned from hospitalization with the diagnosis of a left kidney mass suspicious for cancer. The hospital physician recommended the patient see a urologist to follow up on the mass. The provider did not properly review the hospital records and failed to address the left kidney mass. The provider's error placed the patient at risk for delayed or untreated kidney cancer.

Nursing Performance

We identified nine nursing deficiencies in the OHU, one of which was significant. The RNs performed timely admission assessments and usually contacted the providers when warranted. However, at times nurses performed incomplete assessments, and their documentation lacked pertinent information, such as wound appearance. Also, there were instances in which the nurses did not document their communications with the providers for clinical issues. Among the 12 OHU cases reviewed, we identified nursing assessment deficiencies in cases 23, 24, 35, and 38.

Most nursing deficiencies were minor and related to incomplete assessments or documentation. While OHU nursing performance was generally sufficient, we provide the following examples for quality improvement purposes:

- In case 21, the patient with oral cancer requiring a feeding tube for nutritional intake had refused the liquid nutritional supplement and complained of difficulty swallowing. The patient's heart rate increased, which should have suggested possible dehydration since the patient had not been taking fluids. However, the RN did not consider this possibility and did not contact a provider to report these findings before releasing the patient to the general population.

- In case 24, the patient had a history of diabetes, and CIM staff admitted him to the OHU for weakness after he returned from a hospitalization. The OHU admitting nurse did not assess the patient's blood glucose levels.

- In case 38, the asthmatic patient arrived from a county jail and was admitted to the OHU for assistance with daily living activities. The OHU nurse did not assess the frequency of the

patient's rescue inhaler use and did not ensure that the patient had a rescue inhaler to keep on his person for emergency use. Additionally, the patient informed the nurse that he had a seizure earlier that day, but the nurse did not recognize the patient's history of previous seizures or inform the provider.

Medication Management

The OHU patients generally received medications timely and as prescribed; however, there were three deficiencies related to medication management. The following example identified a lapse in OHU medication management:

- In case 22, the patient did not receive two blood pressure medications on two separate occasions.

Clinician Onsite Inspection

CIM had 44 medical OHU beds and 34 mental health beds. There were two negative-pressure rooms, which are designed to prevent the spread of airborne infections. There were two providers assigned to the OHU. An RN was present during the day shift, while LVNs staffed the evening and night shifts. The TTA RN and nursing supervisor were available to assist the LVNs during those shifts.

Case Review Conclusion

Patients residing in the OHU are medically complex and need close monitoring. OHU patients returning from a hospitalization also require a thorough review of hospital records to address all new diagnoses and recommendations. CIM's OHU provider showed poor medical judgment and inadequate review of hospital records, thereby placing OHU patients at risk of harm. We rated the CIM *Specialized Medical Housing* indicator *inadequate.*

Compliance Testing Results

The institution received a *proficient* compliance score of 100.0 percent in this indicator. All three applicable tests earned scores of 100.0 percent:

- For all ten patients sampled, nursing staff timely completed an initial health assessment on the day medical staff admitted the patient to the OHU (MIT 13.001).

- CIM providers timely completed subjective, objective, assessment, plan, and education (SOAPE) notes at required three-day intervals for all seven applicable OHU patients sampled (MIT 13.003).

- We observed the working order of sampled call buttons in OHU patient rooms and found all

working properly. In addition, according to staff members interviewed, custody officers and clinicians were able to expeditiously access patients' locked rooms when emergent events occurred (MIT 13.101).

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14 — *SPECIALTY SERVICES*

Case Review Rating:
Inadequate
Compliance Score:
Proficient
(86.2%)
Overall Rating:
Inadequate

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.

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 a *proficient* score. We determined that while the institution performed well with scheduling initial specialty appointments, it did not always schedule specialty follow-ups reliably. Moreover, CIM providers often failed to review specialty recommendations appropriately, resulting in lapses in care. Because of the clinical importance of providers reviewing and implementing specialists' recommendations, we rated this indicator *inadequate* overall.

Case Review Results

We reviewed 186 events related to the S*pecialty Services* indicator, which included 143 specialty consultations and procedures and 43 nursing encounters. There were 23 deficiencies, 11 of which were significant. The case review rating for this indicator was *inadequate.*

Access to Specialty Services

CIM usually scheduled specialty services within clinically appropriate time frames. However, we identified two significant deficiencies that suggested that CIM did not reliably schedule specialty follow-up appointments:

- In case 23, the patient had a recently repaired aortic aneurysm and was taking an anti-arrhythmic medication. The provider requested a cardiology follow-up, but the appointment did not occur.

- In case 25, the patient had prior liver cancer, and a provider requested an oncology follow-up in 55 days; however, a scheduling error occurred when the patient went to the oncologist's office six weeks early. The specialist noted the appointment was too soon and asked CIM to reschedule the patient. Unfortunately, CIM's specialty scheduler did not reschedule the appointment correctly, and the appointment occurred eight weeks late.

Nursing Performance

The TTA nurses evaluated patients after they returned from offsite specialty appointments. A different nurse facilitated the telemedicine specialty appointments. We reviewed 43 specialty nursing events and identified eight deficiencies. Most of the deficiencies were related to documentation and assessment deficits, except for one significant lapse in case 26. Overall, CIM specialty nursing care was adequate.

- In case 26, the telemedicine specialty nurse found a severely elevated blood pressure reading but did not reassess the blood pressure or notify the primary care provider of the patient's condition.

Provider Performance

Providers did not properly review or implement specialists' recommendations in cases 18, 19, 21, 23, 25, and 29. There were ten of these deficiencies, six of which were significant. Some examples of poor provider performance in relation to specialty services are as follows:

- In case 18, the patient with hepatitis C infection was receiving long-term immune suppression therapy. The specialist repeatedly recommended treating the hepatitis C infection because the immune suppression medications could increase the risk of hepatitis C progression and other complications. However, the provider ignored the specialist's recommendation and placed the patient at risk of worsening hepatitis C infection and its related complications.

- In case 19, the specialist found the patient had an enlarging lung nodule suggestive of lung cancer. The specialist recommended an urgent surgical evaluation to remove the nodule. However, the provider did not implement the urgent recommendation promptly, contributing to one of the many delays we found in this case.

- Also in case 19, the surgeon believed the lung nodule was suspicious for cancer and recommended obtaining an imaging test prior to possible surgical removal. The provider should have requested the imaging study with an "urgent" instead of "routine" priority. This delay placed the patient at risk of cancer complications.

- In case 21, the patient had oral cancer, and the specialist recommended obtaining a needle biopsy of the lymph nodes to assess for cancer recurrence. The provider failed to order the biopsy. Subsequently, the specialist evaluated the patient without the needed diagnostic test, resulting in a delay in care.

- In case 29, the patient was diagnosed at his previous CDCR institution with lung cancer. The patient was symptomatic and was coughing up blood. The sending institution transferred the

patient to CIM promptly for urgent treatment because there were no oncology services available near the sending institution. When the patient arrived at CIM, the provider failed to request an urgent oncology consultation. Instead, the provider ordered a routine (90-day) referral, which delayed the patient's cancer treatment. We also discuss this case in the *Quality of Provider Performance* indicator.

Health Information Management

Medical records and specialty services staff performed well. CIM retrieved and promptly scanned into the medical record most specialty reports. However, there were two missing specialty reports:

- In case 19, the PET/CT scan report was missing from the medical record.

- In case 23, staff failed to retrieve the coronary angiogram results and to scan them into the medical record.

Onsite Inspection

At the time of our inspection, there were nursing and clerical staff assigned to offsite, onsite, and telemedicine specialty service areas. They scheduled specialty appointments, prepared medical records for specialists to review, and obtained specialists' reports.

We asked specialty staff why specialty appointments did not occur within clinically appropriate time frames. The specialty nursing supervisor and staff explained that while the providers often wanted specialty appointments to occur within four to six weeks, the specialty request forms (CDCR Form 7243) had only three priority options for providers to choose: emergent (now), urgent (within 14 days), or routine (within 90 days). CIM managers encouraged the providers to select the 90-day option for all specialty services that were not urgent, even if the patient needed the appointment earlier. CIM staff explained that they, along with other CDCR facilities, encouraged the 90-day option to score higher on the CCHCS Health Care Dashboard.

The OIG does not agree with CIM's practice of encouraging providers to order all non-urgent specialty services with routine priority. When a provider orders a specialty service, the provider should consider the patient's clinical condition and should specify the appropriate period in which the specialty service should occur. The provider should not arbitrarily specify a 90-day window for any non-urgent service. Providers now can specify exact time frames for these services within the EHRS, and CCHCS should change its specialty access policies and monitor each institution's ability to provide specialty access based on the provider's order, rather than on "routine" or "urgent" time frames that may not be clinically relevant.

Case Review Conclusion

CIM had numerous significant deficiencies related to specialty services. Specialty staff failed to schedule several critical specialty appointments, and providers often failed to review and implement important specialty recommendations. The case review rating of the *Specialty Services* indicator at CIM was *inadequate.*

Compliance Testing Results

The institution received a *proficient* compliance score of 86.0 percent in this indicator, with the following six tests scoring in the *proficient* range:

- For all 15 patients sampled, high-priority specialty services appointments occurred within 14 calendar days of the provider's order (MIT 14.001).

- Providers timely received and reviewed high-priority specialists' reports for 14 of the 15 patients sampled (93.3 percent). For one patient, the provider reviewed the report seven days late (MIT 14.002).

- CIM provided routine specialty service appointments to 14 of 15 sampled patients within the required time frame (93.3 percent). One patient received the specialty service ten days late (MIT 14.003).

- CIM providers timely reviewed specialists' reports following routine specialty service appointments for 13 of the 14 applicable patients (92.9 percent). The provider reviewed one report one day late (MIT 14.004).

- The institution timely denied providers' specialty services requests for 18 of 20 patients sampled (90.0 percent). For two patients, CIM management denied two specialty services but failed to document the denial date (MIT 14.006).

- For 18 patients sampled who had a specialty service denied by CIM's health care management, 16 (88.9 percent) received timely notification of the denied service, including the provider meeting with the patient within 30 days to discuss alternate treatment strategies. For two sampled patients, providers communicated the denials three and nine days late (MIT 14.007).

One test received an *inadequate* score:

- Among 20 patients sampled who transferred into CIM with an approved specialty service, 9 patients (45.0 percent) received it within the required time frame. Six patients received their specialty services from 5 to 58 days late. Five other patients never received their services at all (MIT 14.005).

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15 — *ADMINISTRATIVE OPERATIONS (SECONDARY)*

Case Review Rating:
Not Applicable
Compliance Score:
Proficient
(85.9%)
Overall Rating:
Proficient

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 relied on for the institution's overall score.

Compliance Testing Results

The institution received a *proficient* compliance score of 85.9 percent in this indicator, with 11 tests scoring in the *proficient* range:

- The institution promptly processed all 12 patient medical appeals in each of the most recent 12 months (MIT 15.001).
- CIM's QMC met monthly, evaluated program performance, and took action when management identified areas for improvement opportunities (MIT 15.003).
- CIM 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 promptly submitted the initial Inmate Death Report (CDCR Form 7229A or 7229B) to CCHCS's Death Review Unit for all nine applicable deaths that occurred at CIM in the prior 12-month period (MIT 15.103).

- All ten nurses sampled 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 pharmacist in charge 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).

Three tests showed room for improvement with *inadequate* scores:

- Of the 12 sampled incident packages for emergency medical responses reviewed by the institution's Emergency Medical Response Review Committee (EMRRC) during the prior 12-month period, five (41.7 percent) complied with policy. The institution's EMRRC failed to provide complete documentation of the EMRRC checklist for seven incident packages (MIT 15.005).

- We reviewed the summary reports and related documentation for three medical emergency response drills conducted in the prior quarter. CIM did not conduct a comprehensive response drill for all three watches. More specifically, there was incomplete documentation on the required Triage and Treatment Services Flow Sheet (CDCR Form 7464), and necessary elements in an emergency response drill lacked completion and consistency. As a result, the institution scored zero on this test (MIT 15.101).

- Supervisors completed a proper clinical performance appraisal for 11 of 18 CIM providers (61.1 percent). Seven other providers did not have either timely or properly completed appraisals, including one or more of the following deficiencies: the supervising physician did not sign the provider's individual development plan; the Unit Health Record Clinical Appraisal (UCA) had incomplete documentation; the UCA did not meet the required number of clinical reviews; and the supervising physician did not discuss the results of the UCA review with the provider (MIT 15.106).

Non-Scored Results

- The OIG gathered non-scored data regarding the completion of death review reports by CCHCS's Death Review Committee (DRC). Eight deaths occurred during the OIG's review period; three were unexpected (Level 1) deaths and five were expected (Level 2) deaths. None of the eight death reviews were completed or communicated to CIM's CEO within the required time frame (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 medical executive (CME) should audit the records of patients returning from the hospital, an emergency department, or from specialty consultations to ensure the providers are addressing all their patients' diagnoses, medications, and recommendations. The CME should also consider designating the chief physician and surgeon (CP&S) or another provider to review each of these records to ensure that the institution implements any urgent recommendations. We found serious lapses in care due to poor provider performance in this area.

- The CME should revamp the methods the institution uses to appraise provider performance. Although we found serious provider quality problems during this inspection, the CME was unaware of any provider performance issues.

- The chief nursing executive (CNE) should also inspect the records of patients returning from a hospital or emergency department to ensure the nurses thoroughly review the discharge summaries, perform complete assessments, and implement essential recommendations.

- The CNE and the pharmacist in charge should launch a quality improvement program to increase medication continuity for patients who return from an outside emergency room or hospital. We found serious problems with medication continuity for these patients during our inspection.

- The CME should instruct the providers to specify the appropriate clinical time frames for specialty services within EHRS orders. The CNE should instruct the specialty department to schedule services according to those time frames. These changes should help ensure that the institution schedules specialty appointments within clinically appropriate time frames.

- CCHCS should modify the specialty access policy and eliminate both "routine" and "urgent" priority time frames. Instead, CCHCS should monitor specialty access by measuring the ability of each institution to provide specialty services within the time frame specified in each EHRS order.

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 Institution for Men (CIM), nine HEDIS measures were selected and are listed in the following *CIM 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. CIM performed very well with its management of diabetes compared to other entities.

When compared statewide, CIM outperformed Medi-Cal in all five diabetic measures, and the institution outperformed Kaiser in four of the five diabetic measures. CIM scored slightly lower in diabetic blood pressure control than Kaiser, North and South regions.

When compared nationally, the institution outperformed Medicaid, commercial plans, and Medicare in all five diabetic measures. The institution also outperformed the United States Department of Veterans Affairs (VA) in two of the four applicable measures, with CIM scoring slightly lower in diabetic blood pressure control and diabetic eye exams.

Immunizations

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

Cancer Screening

With respect to colorectal cancer screening, CIM scored higher than commercial plans and Medicare. However, the institution scored lower than Kaiser (North and South) and the VA. The 26 percent refusal rate for colorectal cancer screening at the institution negatively affected the score for this measure.

Summary

CIM's population-based metrics performance reflected a well-functioning chronic care program in comparison to the other health care plans reviewed. CIM may improve its scores in colorectal screenings by reducing patient refusals through educating patients on the benefits of these preventive services.

CIM Results Compared to State and National HEDIS Scores

Clinical Measures	California					National		
	CIM Cycle 5 Results[1]	HEDIS Medi-Cal 2016[2]	HEDIS Kaiser (No. CA) 2016[3]	HEDIS Kaiser (So. CA) 2016[3]	HEDIS Medicaid 2016[4]	HEDIS Com-mercial 2016[4]	HEDIS Medicare 2016[4]	VA Average 2016[5]
Comprehensive Diabetes Care								
HbA1c Testing (Monitoring)	**100%**	86%	94%	94%	86%	90%	93%	98%
Poor HbA1c Control (>9.0%)[6, 7]	**3%**	39%	20%	23%	45%	34%	27%	19%
HbA1c Control (<8.0%)[6]	**89%**	49%	70%	63%	46%	55%	63%	-
Blood Pressure Control (<140/90)[6]	**73%**	63%	83%	83%	59%	60%	62%	74%
Eye Exams	**85%**	53%	68%	81%	53%	54%	69%	89%
Immunizations								
Influenza Shots - Adults (18–64)	**72%**	-	56%	57%	39%	48%	-	55%
Influenza Shots - Adults (65+)	**81%**	-	-	-	-	-	72%	76%
Immunizations: Pneumococcal	**90%**	-	-	-	-	-	71%	93%
Cancer Screening								
Colorectal Cancer Screening	**74%**	-	79%	82%	-	63%	67%	82%

1. Unless otherwise stated, data was collected in November 2017 by reviewing medical records from a sample of CIM's population of applicable patients. These random statistical sample sizes were based on a 95 percent confidence level with a 15 percent maximum margin of error.

2. HEDIS Medi-Cal data was obtained from the California Department of Health Care Services *2015 HEDIS Aggregate Report for Medi-Cal Managed Care*.

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

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

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

6. For this indicator, the entire applicable CIM 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 Institution for Men Range of Summary Scores: 55.0% – 100.0%	
Indicator	**Compliance Score (Yes %)**
1–***Access to Care***	86.2%
2–***Diagnostic Services***	87.8%
3–***Emergency Services***	Not Applicable
4–***Health Information Management (Medical Records)***	75.5%
5–***Health Care Environment***	55.0%
6–***Inter- and Intra-System Transfers***	74.3%
7–***Pharmacy and Medication Management***	63.2%
8–***Prenatal and Post-Delivery Services***	Not Applicable
9–***Preventive Services***	78.0%
10–***Quality of Nursing Performance***	Not Applicable
11–***Quality of Provider Performance***	Not Applicable
12–***Reception Center Arrivals***	88.1%
13–***Specialized Medical Housing (OHU, CTC, SNF, Hospice)***	100.0%
14–***Specialty Services***	86.2%
15–***Administrative Operations***	85.9%

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?	22	3	25	88.0%	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?	20	5	25	80.0%	0
1.003	Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received?	30	0	30	100.0%	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?	29	1	30	96.7%	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?	2	1	3	66.7%	27
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?	Not Applicable				
1.007	Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame?	25	0	25	100.0%	0
1.008	Specialty service follow-up appointments: Do specialty service primary care physician follow-up visits occur within required time frames?	21	7	28	75.0%	2
1.101	Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms?	5	1	6	83.3%	0
Overall percentage:					**86.2%**	

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?	10	0	10	100.0%	0
2.002	Radiology: Did the primary care provider review and initial the diagnostic report within specified time frames?	9	1	10	90.0%	0
2.003	Radiology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	10	0	10	100.0%	0
2.004	Laboratory: Was the laboratory service provided within the time frame specified in the provider's order?	8	2	10	80.0%	0
2.005	Laboratory: Did the primary care provider review and initial the diagnostic report within specified time frames?	8	2	10	80.0%	0
2.006	Laboratory: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	6	4	10	60.0%	0
2.007	Pathology: Did the institution receive the final diagnostic report within the required time frames?	10	0	10	100.0%	0
2.008	Pathology: Did the primary care provider review and initial the diagnostic report within specified time frames?	9	1	10	90.0%	0
2.009	Pathology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	9	1	10	90.0%	0
Overall percentage:					**87.8%**	

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 health care documents (provider progress notes) scanned within 3 calendar days of the patient encounter date?	8	3	11	72.7%	0
4.002	Are dictated/transcribed documents scanned into the patient's electronic health record within five calendar days of the encounter date?	7	3	10	70.0%	0
4.003	Are High-Priority specialty notes (either a Form 7243 or other scanned consulting report) scanned within the required time frame?	19	1	20	95.0%	0
4.004	Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge?	24	1	25	96.0%	0
4.005	Are medication administration records (MARs) scanned into the patient's electronic health record within the required time frames?	19	1	20	95.0%	0
4.006	During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files?	0	27	27	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?	25	0	25	100.0%	0
Overall percentage:					**75.5%**	

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?	12	2	14	85.7%	0
5.102	Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	13	1	14	92.9%	0
5.103	Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	11	3	14	78.6%	0
5.104	Does clinical health care staff adhere to universal hand hygiene precautions?	11	3	14	78.6%	0
5.105	Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	10	4	14	71.4%	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?	5	9	14	35.7%	0
5.108	Do clinic common areas and exam rooms have essential core medical equipment and supplies?	7	7	14	50.0%	0
5.109	Do clinic common areas have an adequate environment conducive to providing medical services?	5	6	11	45.5%	3
5.110	Do clinic exam rooms have an adequate environment conducive to providing medical services?	5	8	13	38.5%	1
5.111	Emergency response bags: Are TTA and clinic emergency medical response bags inspected daily and inventoried monthly, and do they contain essential items?	2	5	7	28.6%	7
Overall percentage:					**55.0%**	

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?	16	9	25	64.0%	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?	25	0	25	100.0%	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?	16	0	16	100.0%	9
6.004	For patients transferred out of the facility: Were scheduled specialty service appointments identified on the patient's health care transfer information form?	9	11	20	45.0%	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?	5	3	8	62.5%	0
Overall percentage:					**74.3%**	

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?	15	8	23	65.2%	2
7.002	Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames?	24	1	25	96.0%	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?	14	11	25	56.0%	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?	6	5	11	54.6%	9
7.005	Upon the patient's transfer from one housing unit to another: Were medications continued without interruption?	24	1	25	96.0%	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?	7	3	10	70.0%	0
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?	1	9	10	10.0%	4
7.102	All clinical and medication line storage areas for non-narcotic medications: Does the Institution properly store non-narcotic medications that do not require refrigeration in assigned clinical areas?	2	12	14	14.3%	0
7.103	All clinical and medication line storage areas for non-narcotic medications: Does the institution properly store non-narcotic medications that require refrigeration in assigned clinical areas?	3	5	8	37.5%	6
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%	6
7.105	Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients?	6	2	8	75.0%	6
7.106	Medication preparation and administration areas: Does the Institution employ appropriate administrative controls and protocols when distributing medications to patients?	3	5	8	37.5%	6

Reference Number	7–*Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.107	Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and satellite pharmacies?	1	0	1	100.0%	0
7.108	Pharmacy: Does the institution's pharmacy properly store non-refrigerated medications?	1	0	1	100.0%	0
7.109	Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications?	1	0	1	100.0%	0
7.110	Pharmacy: Does the institution's pharmacy properly account for narcotic medications?	1	0	1	100.0%	0
7.111	Does the institution follow key medication error reporting protocols?	0	25	25	0.0%	0
Overall percentage:					**63.2%**	

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?	15	6	21	71.4%	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?	12	9	21	57.1%	0
9.003	Annual TB Screening: Was the patient screened for TB within the last year?	25	5	30	83.3%	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?	24	1	25	96.0%	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?	6	4	10	60.0%	15
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:					**78.0%**	

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.

Reference Number	12–*Health Information Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
12.001	For patients received from a county jail: Did nursing staff complete the initial health screening and answer all screening questions on the same day the patient arrived at the institution?	16	4	20	80.0%	0
12.002	For patients received from a county jail: When required, did the RN complete the assessment and disposition section of the health screening form, and sign and date the form on the same day staff completed the health screening?	20	0	20	100.0%	0
12.003	For patients received from a county jail: If, during the assessment, the nurse referred the patient to a provider, was the patient seen within the required time frame?	19	1	20	95.0%	0
12.004	For patients received from a county jail: Did the patient receive a history and physical by a primary care provider within seven calendar days?	19	1	20	95.0%	0
12.005	For patients received from a county jail: Were all required intake tests completed within specified timelines?	20	0	20	100.0%	0
12.006	For patients received from a county jail: Did the primary care provider review and communicate the intake test results to the patient within specified timelines?	13	7	20	65.0%	0
12.007	For patients received from a county jail: Was a tuberculin test both administered and read timely?	20	0	20	100.0%	0
12.008	For patients received from a county jail: Was a Coccidioidomycosis (Valley Fever) skin test offered, administered, read, or refused timely?	14	6	20	70.0%	0
Overall percentage:					**88.1%**	

Reference Number	13–*Specialized Medical Housing*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient on the day of admission, or within eight hours of admission to CMF's Hospice?	10	0	10	100.0%	
13.002	For CTC and SNF only: Was a written history and physical examination completed within the required time frame?	Not Applicable				
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?	7	0	7	100.0%	3
13.101	For OHU and CTC Only: Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter patient's cells?	1	0	1	100.0%	0
Overall percentage:					**100.0%**	

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?	15	0	15	100.0%	0
14.002	Did the primary care provider review the high priority specialty service consultant report within the required time frame?	14	1	15	93.3%	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?	14	1	15	93.3%	0
14.004	Did the primary care provider review the routine specialty service consultant report within the required time frame?	13	1	14	92.9%	1
14.005	For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames?	9	11	20	45.0%	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?	16	2	18	88.9%	2
Overall percentage:					**86.2%**	

Reference Number	15–*Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.001	Did the institution promptly process inmate medical appeals during the most recent 12 months?	12	0	12	100.0%	0
15.002	Does the institution follow adverse / sentinel event reporting requirements?	Not Applicable				
15.003	Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified?	6	0	6	100.0%	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?	5	7	12	41.7%	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?	Not Applicable				
15.101	Did the institution complete a medical emergency response drill for each watch and include participation of health care and custody staff during the most recent full quarter?	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	0	9	100.0%	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?	11	7	18	61.1%	0
15.107	Do all providers maintain a current medical license?	20	0	20	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–*Administrative Operations*	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:					**85.9%**	

APPENDIX B — CLINICAL DATA

Table B-1: CIM Sample Sets

Sample Set	Total
Anticoagulation	3
Death Review/Sentinel Events	3
Diabetes	3
Emergency Services - CPR	3
Emergency Services - Non-CPR	3
High Risk	5
Hospitalization	4
Intra-system Transfers-In	3
Intra-system Transfers-Out	3
RN Sick Call	20
Reception Center Transfers	4
Specialty Services	4
	58

Table B-2: CIM Chronic Care Diagnoses

Diagnosis	Total
Anemia	7
Anticoagulation	4
Arthritis/Degenerative Joint Disease	7
Asthma	9
COPD	10
Cancer	14
Cardiovascular Disease	7
Chronic Kidney Disease	7
Chronic Pain	15
Cirrhosis/End Stage Liver Disease	6
Deep Venous Thrombosis/Pulmonary Embolism	3
Diabetes	19
Gastroesophageal Reflux Disease	14
Gastrointestinal Bleed	1
HIV	3
Hepatitis C	16
Hyperlipidemia	28
Hypertension	39
Mental Health	7
Seizure Disorder	3
Sleep Apnea	7
Thyroid Disease	5
	231

Table B-3: CIM Event – Program

Diagnosis	Total
Diagnostic Services	166
Emergency Care	42
Hospitalization	73
Intra-system Transfers-In	15
Intra-system Transfers-Out	7
Outpatient Care	380
Reception Center Care	23
Specialized Medical Housing	91
Specialty Services	231
	1,028

Table B-4: CIM Review Sample Summary

	Total
MD Reviews Detailed	27
MD Reviews Focused	0
RN Reviews Detailed	14
RN Reviews Focused	33
Total Reviews	74
Total Unique Cases	58
Overlapping Reviews (MD & RN)	16

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

California Institution for Men (CIM)

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Access to Care			
MIT 1.001	Chronic Care Patients (25)	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • **Randomize**
MIT 1.002	Nursing Referrals (25)	OIG Q: 6.001	• See ***Intra-system Transfers***
MITs 1.003-006	Nursing Sick Call (5 per clinic) (30)	MedSATS	• Clinic (each clinic tested) • Appointment date (2–9 months) • **Randomize**
MIT 1.007	Returns from Community Hospital (25)	OIG Q: 4.007	• See ***Health Information Management (Medical Records)*** (returns from community hospital)
MIT 1.008	Specialty Services Follow-up (30)	OIG Q: 14.001 & 14.003	• See ***Specialty Services***
MIT 1.101	Availability of Health Care Services Request Forms (6)	OIG onsite review	• Randomly select one housing unit from each yard
Diagnostic Services			
MITs 2.001–003	Radiology (10)	Radiology Logs	• Appointment date (90 days–9 months) • **Randomize** • Abnormal
MITs 2.004–006	Laboratory (10)	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • **Randomize** • Abnormal
MITs 2.007–009	Pathology (10)	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • **Randomize**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Health Information Management (Medical Records)			
MIT 4.001	Timely Scanning (11)	OIG Qs: 1.001, 1.002, & 1.004	• Non-dictated documents • 1st 10 IPs MIT 1.001, 1st 5 IPs MITs 1.002, 1.004
MIT 4.002	(10)	OIG Q: 1.001	• Dictated documents • First 20 IPs selected
MIT 4.003	(20)	OIG Qs: 14.002 & 14.004	• Specialty documents • First 10 IPs for each question
MIT 4.004	(25)	OIG Q: 4.007	• Community hospital discharge documents • First 20 IPs selected
MIT 4.005	(20)	OIG Q: 7.001	• MARs • First 20 IPs selected
MIT 4.006	(27)	Documents for any tested inmate	• 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	• 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 (14)	OIG inspector onsite review	• Identify and inspect all onsite clinical areas.
Inter- and Intra-System Transfers			
MIT 6.001-003	Intra-System Transfers (25)	SOMS	• Arrival date (3–9 months) • Arrived from (another CDCR facility) • Rx count • **Randomize**
MIT 6.004	Specialty Services Send-Outs (20)	MedSATS	• Date of transfer (3–9 months) • **Randomize**
MIT 6.101	Transfers Out (8)	OIG inspector onsite review	• R&R IP transfers with medication

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Pharmacy and Medication Management			
MIT 7.001	Chronic Care Medication (25)	OIG Q: 1.001	*See **Access to Care*** • At least one condition per patient—any risk level • **Randomize**
MIT 7.002	New Medication Orders (25)	Master Registry	• Rx count • **Randomize** • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns from Community Hospital (25)	OIG Q: 4.007	• See ***Health Information Management (Medical Records)*** *(returns from community hospital)*
MIT 7.004	RC Arrivals – Medication Orders (20)	OIG Q: 12.001	• See ***Reception Center Arrivals***
MIT 7.005	Intra-Facility Moves (25)	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • **Randomize**
MIT 7.006	En Route (10)	SOMS	• Date of transfer (2–8 months) • Sending institution (another CDCR facility) • **Randomize** • NA/DOT meds
MITs 7.101-103	Medication Storage Areas (varies by test)	OIG inspector onsite review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–106	Medication Preparation and Administration Areas (varies by test)	OIG inspector onsite review	• Identify and inspect onsite clinical areas that prepare and administer medications
MITs 7.107-110	Pharmacy (1)	OIG inspector onsite review	• Identify & inspect all onsite pharmacies
MIT 7.111	Medication Error Reporting (25)	Monthly medication error reports	• All monthly statistic reports with Level 4 or higher • Select a total of 5 months
MIT 7.999	Isolation Unit KOP Medications (6)	Onsite active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in isolation units
Prenatal and Post-Delivery Services			
MIT 8.001-007	Recent Deliveries *(N/A at this institution)*	OB Roster	• Delivery date (2–12 months) • **Most recent** deliveries (within date range)
	Pregnant Arrivals *(N/A at this institution)*	OB Roster	• Arrival date (2–12 months) • **Earliest** arrivals (within date range)

	Sample Category		

Quality Indicator	(number of samples)	Data Source	Filters
Preventive Services			
MITs 9.001–002	TB Medications (21)	Maxor	• 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	• Arrival date (at least 1 year prior to inspection) • Birth Month • **Randomize**
MIT 9.004	Influenza Vaccinations (25)	SOMS	• Arrival date (at least 1 year prior to inspection) • **Randomize** • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening (25)	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • **Randomize**
MIT 9.006	Mammogram *(N/A at this institution)*	SOMS	• Arrival date (at least 2 yrs prior to inspection) • Date of birth (age 52–74) • **Randomize**
MIT 9.007	Pap Smear *(N/A at this institution)*	SOMS	• Arrival date (at least three yrs prior to inspection) • Date of birth (age 24–53) • **Randomize**
MIT 9.008	Chronic Care Vaccinations (25)	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • **Randomize** • Condition must require vaccination(s)
MIT 9.009	Valley Fever (number will vary) *(N/A at this institution)*	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • **All**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Reception Center Arrivals			
MITs 12.001–008	RC (20)	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • **Randomize**
Specialized Medical Housing			
MITs 13.001–003	OHU (10)	CADDIS	• Admit date (1–6 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • **Randomize**
MIT 13.101	Call Buttons OHU (all)	OIG inspector onsite review	• Review by location
Specialty Services			
MITs 14.001–002	High-Priority (15)	MedSATS	• Approval date (3–9 months) • **Randomize**
MITs 14.003–004	Routine (15)	MedSATS	• Approval date (3–9 months) • Remove optometry, physical therapy or podiatry • **Randomize**
MIT 14.005	Specialty Services Arrivals (20)	MedSATS	• Arrived from (other CDCR institution) • Date of transfer (3–9 months) • **Randomize**
MIT 14.006-007	Denials (12)	InterQual	• Review date (3–9 months) • **Randomize**
	  (8)	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • **Randomize**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Administrative Operations			
MIT 15.001	Medical Appeals (all)	Monthly medical appeals reports	• Medical appeals (12 months)
MIT 15.002	Adverse/Sentinel Events (0)	Adverse/sentinel events report	• Adverse/sentinel events (2–8 months)
MITs 15.003–004	QMC Meetings (6)	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.005	EMRRC (12)	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.006	LGB (0)	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills (3)	Onsite summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	2nd Level Medical Appeals (10)	Onsite list of appeals/closed appeals files	• Medical appeals denied (6 months)
MIT 15.103	Death Reports (9)	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.104	RN Review Evaluations (0)	Onsite supervisor periodic RN reviews	• RNs who worked in clinic or emergency setting six or more days in sampled month • **Randomize**
MIT 15.105	Nursing Staff Validations (10)	Onsite nursing education files	• On duty one or more years • Nurse administers medications • **Randomize**
MIT 15.106	Provider Annual Evaluation Packets (18)	Onsite provider evaluation files	• All required performance evaluation documents
MIT 15.107	Provider licenses (20)	Current provider listing (at start of inspection)	• Review all

MIT 15.108	Medical Emergency Response Certifications (all)	Onsite certification tracking logs	• All staff
			  ○ 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	• All required licenses and certifications

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Administrative Operations			
MIT 15.110	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations (all)	Onsite listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 15.111	Nursing Staff New Employee Orientations (all)	Nursing staff training logs	• New employees (hired within last 12 months) •
MIT 15.998	Death Review Committee (8)	OIG summary log - deaths	• Between 35 business days & 12 months prior • CCHCS death reviews

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

December 19, 2018

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 Institution for Men (CIM) conducted from November 2017 to June 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
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