Roy W. Wesley
Inspector General
(Acting)

Office of the Inspector General

California State Prison, Corcoran
Medical Inspection Results
Cycle 5

September 2017

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

Office of the Inspector General
CALIFORNIA STATE PRISON, CORCORAN
Medical Inspection Results
Cycle 5

Roy W. Wesley
Inspector General (Acting)

Shaun R. Spillane
Public Information Officer

September 2017

TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

EXECUTIVE SUMMARY

Pursuant to California Penal Code Section 6126 et seq., which assigns the Office of the Inspector General (OIG) responsibility for oversight of the California Department of Corrections and Rehabilitation (CDCR), the OIG conducts a comprehensive inspection program to evaluate the delivery of medical care at each of CDCR's 35 adult prisons. The OIG **explicitly** makes no determination regarding the constitutionality of care in the prison setting. That determination is left to the Receiver and the federal court. The assessment of care by the OIG is just one factor in the court's determination whether care in the prisons meets constitutional standards. In Cycle 5, for the first time, the OIG will be inspecting institutions that have been delegated back to CDCR from the Receivership. There will be no difference in the standards used for assessment of a delegated institution versus those for an institution not yet delegated.

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

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

Overall Rating: Adequate

The OIG performed its Cycle 5 medical inspection at California State Prison, Corcoran (COR) from March to May 2017. The inspection included in-depth reviews of 56 patient files conducted by clinicians, as well as reviews of documents from 428 patient files covering 91 objectively scored tests of compliance with policies and procedures applicable to the delivery of medical care. The OIG assessed the case review and compliance results at COR using 13 health care quality indicators applicable to the institution. To conduct clinical case reviews, the OIG employs a clinician team consisting of a physician and a registered nurse consultant, while compliance testing is done by a team of registered nurses trained in monitoring medical policy compliance. Of the indicators, seven were rated by both case review clinicians and compliance inspectors, three were rated by case review clinicians only, and three were rated by compliance inspectors only. The *COR Executive Summary Table* on the following page identifies the applicable individual indicators and scores for this institution.

COR Executive Summary Table

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

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

Clinical Case Review and OIG Clinician Inspection Results

The clinicians' case reviews sampled patients with high medical needs and included a review of 1,103 patient care events.[1] Of the 13 indicators applicable to COR, 10 were evaluated by clinician case review; one was *proficient*, and nine were *adequate.* When determining the overall adequacy of care, the OIG paid particular attention to the clinical nursing and provider quality indicators, as adequate health care staff can sometimes overcome suboptimal processes and programs. However, the opposite is not true; inadequate health care staff cannot provide adequate care, even though the established processes and programs onsite may be adequate. The OIG clinicians identify inadequate medical care based on the risk of significant harm to the patient, not the actual outcome.

Program Strengths — Clinical

- The COR leadership implemented successful training in chronic care for providers, correcting a prior weakness identified by the OIG in its Cycle 4 medical inspection.

- The COR leadership implemented successful improvement processes to remove a recent access to care backlog for provider appointments. The chief physician and surgeon (CP&S) recruited additional provider resources from other institutions to achieve this, along with scheduling additional medical clinics on the weekend.

- The specialty services nurse and supervisor implemented successful improvement processes to correct the weak areas contributing to the *inadequate* performance in the *Specialty Services* indicator in Cycle 4.

- Despite the lack of a chief medical executive (CME) for years, the strong leadership of the CP&S helped improve processes in provider chronic care training and in access to care.

- The new nursing leadership contributed to improved morale among nursing staff. The nursing leadership recognized and appreciated nurses' efforts with events to improve morale among the nursing ranks at the institution.

- The chief nurse executive (CNE) improved communications by providing cell phones to the supervisors and hand radios to the second and third watch, which improved emergency response.

Program Weaknesses — Clinical

- Patients often did not receive important medications timely.

- Often, there was a delay in transferring patients to the TTA due to yard gate malfunctions.

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

Compliance Testing Results

Of the 13 health care indicators applicable to COR, 10 were evaluated by compliance inspectors; one was *proficient*, three were *adequate*, and six were *inadequate*.[2] There were 91 individual compliance questions within those 10 indicators, generating 1,227 data points, that tested COR's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[3] Those 91 questions are detailed in *Appendix A — Compliance Test Results*.

Program Strengths — Compliance

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

- Patients' access to medical care, including nurse sick call assessments, and provider follow-up appointments after nurse sick call assessments, community hospital returns, and returns from specialty services were done well by the institution's health care staff.

- The institution performed well in providing timely laboratory services to patients, and providers reviewed and communicated laboratory results to patients within required time frames.

- COR did an excellent job of offering and providing preventive services to its patients, including vaccination administration and colorectal cancer screening, as well as the treatment and monitoring of patients taking tuberculosis medications.

- The institution did a good job of ensuring that appropriate policies and procedures were followed when patients were admitted to onsite inpatient facilities, including completion of timely nursing and provider assessments.

- The institution provided pending specialty service appointments to patients who transferred in from other CDCR institutions within required time frames.

Program Weaknesses — Compliance

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

- Several clinic locations at COR did not have essential core medical equipment and supplies; clinic locations had equipment that was not properly calibrated, and several locations did not have the necessary supplies available to staff.

[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.

- COR did a poor job of managing patients' medical needs and providing continuity of patient care during the inter- and intra-facility transfer process. This included problems with the initial health screening process and delivery of patients' previously existing medication orders from the previous institution.

- The institution had significant issues with the timely distribution and administration of medications for patients with chronic care conditions as well as patients receiving new medication orders. Also, the main pharmacy at COR did not properly store narcotic medications and non-narcotic medication that did not require refrigeration.

- The administrative health care oversight functions of the institution were inadequate; this included the failure to timely address patient appeals as well as deficiencies with the performance of COR's Quality Management and Emergency Medical Response Review Committees.

RECOMMENDATIONS

No specific recommendations.

POPULATION-BASED METRICS

In general, COR performed well as measured by population-based metrics. In comprehensive diabetes care, COR performed comparably to other state and national entities, outscoring in some measures and scoring less well than other plans in some measures. The diabetic eye exam score was negatively affected by patient refusals.

With regard to immunization measures, COR's rates were also mixed, and COR's rates for colorectal cancer screening were poorer than other entities', but, again, patient refusals had a severely negative affect on influenza immunization for younger adults and colorectal cancer screenings. Overall, COR's performance demonstrated by the population-based metrics indicated that the chronic care program was functioning properly in comparison to other health care entities reviewed, and the institution has opportunities to improve its comparable scores by educating patients on the benefits of influenza immunizations and preventive screenings for colorectal cancer.

INTRODUCTION

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

California State Prison, Corcoran (COR), was the seventh medical inspection of Cycle 5. During the inspection process, the OIG assessed the delivery of medical care to patients using the primary clinical health care indicators applicable to the institution. The Administrative Operations indicator is purely administrative and is not reflective of the actual clinical care provided.

ABOUT THE INSTITUTION

Located in the City of Corcoran in Kings County, COR is a complex, multi-mission institution comprised of multiple facilities. COR was the first California prison with a separate facility built exclusively to house security housing unit (SHU) inmates. The institution houses over 3,400 inmates and is comprised of the following facilities: a Minimum Support Facility (MSF), a Level III facility for Sensitive Needs Yard (SNY) inmates, a Level IV yard that houses high security inmates, and the SHU, which houses maximum security inmates, the majority of whom have committed serious rules violations and cannot be housed in a general population setting.

COR operates multiple facility clinics and one specialty clinic where staff members handle non-urgent requests for medical services. The institution also conducts screenings in its receiving and release clinical area (R&R); treats patients requiring urgent or emergency care in its triage and treatment area (TTA); houses patients requiring inpatient health services in the correctional treatment centers (CTC); and treats patients who require assistance with activities of daily living, but who do not require a higher level of inpatient care, in its outpatient housing unit (OHU). California Correctional Health Care Services (CCHCS) has designated COR a "basic" care institution. Basic institutions are located in rural areas away from tertiary care centers and specialty care providers whose services would likely be used frequently by higher-risk patients. Basic institutions have the capability to provide limited specialty medical services and consultation for a generally healthy patient population.

On August 16, 2015, the institution received national accreditation from the Commission on Accreditation for Corrections. This accreditation program is a professional peer review process based on national standards set by the American Correctional Association.

Based on staffing data the OIG obtained from the institution, COR's vacancy rate among medical managers, primary care providers, supervisors, and rank-and-file nurses was 10 percent in February 2017, with the highest vacancy percentage among management with a 60 percent vacancy rate, which equated to three out of five authorized positions. Lastly, the CEO reported that as of March 2017, there were three medical staff members currently working at COR who were under CDCR disciplinary review.

COR Health Care Staffing Resources as of March 2017

	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff		Totals	
Description	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Authorized Positions	5	3%	10	6%	20.8	11%	146	80%	181.8	100%
Filled Positions	2	40%	7	70%	18	87%	137.5	94%	164.5	90%
Vacancies	3	60%	3	30%	2.8	13%	8.5	6%	17.3	10%
Recent Hires (within 12 months)	0	0%	2	29%	8	44%	8	6%	18	11%
Staff Utilized from Registry	0	0%	2.5	36%	0	0%	0	0%	2.5	2%
Redirected Staff (to Non-Patient Care Areas)	0	0%	0	0%	0	0%	0	0%	0	0%
Staff on Long-term Medical Leave	0	0%	0	0%	2	11%	3	2%	5	3%

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

As of March 6, 2017, the Master Registry for COR showed that the institution had a total population of 3,444. Within that total population, 2.7 percent were designated as high medical risk, Priority 1 (High 1), and 5.3 percent were designated as high medical risk, Priority 2 (High 2). Patients' assigned risk levels are based on the complexity of their required medical care related to their specific diagnoses, frequency of higher levels of care, age, and abnormal laboratory results and procedures. High 1 has at least two high-risk conditions; High 2 has only one. Patients at high medical risk are more susceptible to poor health outcomes than those at medium or low medical risk. Patients at high medical risk also typically require more health care services than do patients with lower assigned risk levels. The chart below illustrates the breakdown of the institution's medical risk levels at the start of the OIG medical inspection.

COR Master Registry Data as of March 6, 2017

Medical Risk Level	# of Patients	Percentage
High 1	94	2.7%
High 2	182	5.3%
Medium	1,772	51.5%
Low	1,396	40.5%
Total	**3,444**	**100.0%**

OBJECTIVES, SCOPE, AND METHODOLOGY

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

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

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

Consistent with the OIG's agreement with the Receiver, this report only addresses the conditions found related to medical care criteria. The OIG does not review for efficiency and economy of operations. Moreover, if the OIG learns of a patient needing immediate care, the OIG notifies the chief executive officer of health care services and requests a status report. Additionally, if the OIG learns of significant departures from community standards, it may report such departures to the institution's chief executive officer or to CCHCS. Because these matters involve confidential medical information protected by State and federal privacy laws, specific identifying details related to any such cases are not included in the OIG's public report.

In all areas, the OIG is alert for opportunities to make appropriate recommendations for improvement. Such opportunities may be present regardless of the score awarded to any particular

quality indicator; therefore, recommendations for improvement should not necessarily be interpreted as indicative of deficient medical care delivery.

CASE REVIEWS

The OIG added case reviews to the Cycle 4 medical inspections at the recommendation of its stakeholders, which continues in Cycle 5 medical inspections. The OIG's clinicians perform a retrospective chart review of selected patient files to evaluate the care given by an institution's primary care providers and nurses. Retrospective chart review is a well-established review process used by health care organizations that perform peer reviews and patient death reviews. Currently, CCHCS uses retrospective chart review as part of its death review process and in its pattern-of-practice reviews. CCHCS also uses a more limited form of retrospective chart review when performing appraisals of individual primary care providers.

Patient Selection for Retrospective Case Reviews

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

1. The goal of retrospective chart review is to evaluate all aspects of the health care system. Statewide, high-risk and high-utilization patients consume medical services at a disproportionate rate; 11 percent of the total patient population are considered high-risk and account for more than half of the institution's pharmaceutical, specialty, community hospital, and emergency costs.

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

Underlying the choice of high-risk patients for detailed case review, the OIG clinical experts made the following three assumptions:

1. If the institution is able to provide adequate clinical care to the most challenging patients with multiple complex and interdependent medical problems, it will be providing adequate care to patients with less complicated health care issues. Because clinical expertise is required to determine whether the institution has provided adequate clinical care, the OIG utilizes experienced correctional physicians and registered nurses to perform this analysis.

2. The health of less complex patients is more likely to be affected by processes such as timely appointment scheduling, medication management, routine health screening, and

immunizations. To review these processes, the OIG simultaneously performs a broad compliance review.

3. Patient charts generated during death reviews, sentinel events (unexpected occurrences involving death or serious injury, or risk thereof), and hospitalizations are mostly of high-risk patients.

Benefits and Limitations of Targeted Subpopulation Review

Because the selected patients utilize the broadest range of services offered by the health care system, the OIG's retrospective chart review provides adequate data for a qualitative assessment of the most vital system processes (referred to as "primary quality indicators"). Retrospective chart review provides an accurate qualitative assessment of the relevant primary quality indicators as applied to the targeted subpopulation of high-risk and high-utilization patients. While this targeted subpopulation does not represent the prison population as a whole, the ability of the institution to provide adequate care to this subpopulation is a crucial and vital indicator of how the institution provides health care to its whole patient population. Simply put, if the institution's medical system does not adequately care for those patients needing the most care, then it is not fulfilling its obligations, even if it takes good care of patients with less complex medical needs.

Since the targeted subpopulation does not represent the institution's general prison population, the OIG cautions against inappropriate extrapolation of conclusions from the retrospective chart reviews to the general population. For example, if the high-risk diabetic patients reviewed have poorly-controlled diabetes, one cannot conclude that the entire diabetic population is inadequately controlled. Similarly, if the high-risk diabetic patients under review have poor outcomes and require significant specialty interventions, one cannot conclude that the entire diabetic population is having similarly poor outcomes.

Nonetheless, the health care system's response to this subpopulation can be accurately evaluated and yields valuable systems information. In the above example, if the health care system is providing appropriate diabetic monitoring, medication therapy, and specialty referrals for the high-risk patients reviewed, then it can be reasonably inferred that the health care system is also providing appropriate diabetic services to the entire diabetic subpopulation. However, if these same high-risk patients needing monitoring, medications, and referrals are generally not getting those services, it is likely that the health care system is not providing appropriate diabetic services to the greater diabetic subpopulation.

Case Reviews Sampled

As indicated in *Appendix B, Table B–1: COR Sample Sets*, the OIG clinicians evaluated medical charts for 56 unique patients. *Appendix B, Table B–4: COR Case Review Sample Summary* clarifies that both nurses and physicians reviewed charts for 18 of those patients, for 74 reviews in total. Physicians performed detailed reviews of 25 charts, and nurses performed detailed reviews of 17

charts, totaling 42 detailed reviews. For detailed case reviews, physicians or nurses looked at all encounters occurring in approximately six months of medical care. Nurses also performed a limited or focused review of medical records for an additional 30 patients. These generated 1,103 clinical events for review (*Appendix B, Table B–3: COR Event–Program*). The inspection tool provides details on whether the encounter was adequate or had significant deficiencies, and identifies deficiencies by programs and processes to help the institution focus on improvement areas.

While the sample method specifically pulled only six chronic care patient records, i.e., three diabetes patients and three anticoagulation patients (*Appendix B, Table B–1: COR Sample Sets*), the 56 unique patients sampled included patients with 174 chronic care diagnoses, including 10 additional patients with diabetes (for a total of 13) (*Appendix B, Table B–2: COR Chronic Care Diagnoses*). The OIG's sample selection tool allowed evaluation of many chronic care programs because the complex and high-risk patients selected from the different categories often had multiple medical problems. While the OIG did not evaluate every chronic disease or health care staff member, the overall operation of the institution's system and staff were assessed for adequacy.

The OIG's case review methodology and sample size matched other qualitative research. The empirical findings, supported by expert statistical consultants, showed adequate conclusions after 10 to 15 charts had undergone full clinician review. In qualitative statistics, this phenomenon is known as "saturation." The OIG found the Cycle 4 medical inspection physician sample size of 30 detailed reviews far exceeded the saturation point necessary for an adequate qualitative review. At the end of Cycle 4 inspections, the case review results were re-analyzed using 50 percent of the cases, finding no significant differences in the ratings. To improve inspection efficiency, while preserving the quality of the inspection, the samples for Cycle 5 medical inspections were reduced in number of cases. For Cycle 5 inspections, basic institutions, with low high-risk populations, case review will use 67 percent (20 detailed physician reviews) of the case review samples used in Cycle 4 inspection, for both physician and nurse reviewed cases. For intermediate institutions, or basic institutions housing many high-risk patients, the case review samples will use 83 percent (25 detailed physician reviews). Finally, the most medically complex institution, CHCF, has retained the full 100 percent samples of Cycle 4 inspections. For COR, the OIG used a case review sample size of 83 percent compared to Cycle 4 because the institution had a large number of high-risk patients.

With regard to reviewing charts from different providers, the case review is not intended to be a focused search for poorly performing providers; rather, it is focused on how the system cares for those patients who need care the most. Nonetheless, while not sampling cases by each provider at the institution, the OIG inspections adequately review most providers. Providers would only escape OIG case review if institutional management successfully mitigated patient risk by having the more poorly performing providers care for the less complicated, low-utilizing, and lower-risk patients. The OIG's clinicians concluded that the case review sample size was more than adequate to assess the quality of services provided.

Based on the collective results of clinicians' case reviews, the OIG rated each quality indicator as either *proficient* (excellent), *adequate* (passing), *inadequate* (failing), or *not applicable*. A separate confidential *COR Supplemental Medical Inspection Results: Individual Case Review Summaries* report details the case reviews OIG clinicians conducted and is available to specific stakeholders. For further details regarding the sampling methodologies and counts, see *Appendix B — Clinical Data, Table B–1; Table B–2; Table B–3;* and *Table B–4*.

COMPLIANCE TESTING

Sampling Methods for Conducting Compliance Testing

From March to May 2017, registered nurse inspectors attained answers to 91 objective medical inspection test (MIT) questions designed to assess the institution's compliance with critical policies and procedures applicable to the delivery of medical care. To conduct most tests, inspectors randomly selected samples of patients for whom the testing objectives were applicable and reviewed their electronic unit health records. In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed health records for 428 individual patients and analyzed specific transactions within their records for evidence that critical events occurred. Inspectors also reviewed management reports and meeting minutes to assess certain administrative operations. In addition, during the week of March 20, 2017, field registered nurse inspectors conducted a detailed onsite inspection of COR's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,227 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 COR's plant infrastructure, protocols for tracking medical appeals and local operating procedures, and staffing resources.

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

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

Scoring of Compliance Testing Results

After compiling the answers to the 91 questions for the 10 applicable indicators, the OIG derived a score for each quality indicator by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Based on those results, the OIG assigned a rating to each quality indicator of *proficient* (greater than 85 percent), *adequate* (between 75 percent and 85 percent), or *inadequate* (less than 75 percent).

OVERALL QUALITY INDICATOR RATING FOR CASE REVIEWS AND COMPLIANCE TESTING

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

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

POPULATION-BASED METRICS

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

MEDICAL INSPECTION RESULTS

The quality indicators assess the clinical aspects of health care. As shown on the *COR Executive Summary Table* on page *ii* of this report, 13 of the OIG's indicators were applicable to COR; 7 were rated by both the case review and compliance components of the inspection, 3 were rated by the case review component alone, and 3 were rated by the compliance component alone. The *Administrative Operations* indicator is a secondary indicator, and, therefore, was not relied upon for the overall score for the institution. Based on the analysis and results in the primary indicators, the OIG experts made a considered and measured opinion that the quality of health care at COR was ***adequate***.

Summary of Case Review Results

The clinical case review component assessed 10 of the indicators applicable to COR. Of these 10 indicators, OIG clinicians rated one *proficient*, nine *adequate*, and none *inadequate*.

The OIG physicians rated the overall adequacy of care for each of the 25 detailed case reviews they conducted. Of these 25 cases, 2 were proficient, 21 were *adequate*, and 2 were *inadequate*. In the 1,103 events reviewed, there were 330 deficiencies, of which 20 were considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

Adverse Events Identified During Case Review

Adverse events are medical errors that are more likely than not to cause grave patient harm. Medical care is a complex dynamic process with many moving parts, subject to human error even within the best health care organizations. Adverse events are typically identified and tracked by all major health care organizations for the purpose of quality improvement. They are not generally representative of medical care delivered by the organization. The OIG identified adverse events for the dual purposes of quality improvement and the illustration of problematic patterns of practice found during the inspection. Because of the anecdotal description of these events, the OIG cautions against drawing inappropriate conclusions regarding the institution based solely on adverse events. There were two adverse events at COR during the OIG's case review:

- In case 5, the patient was discharged after hospital care for a gastrointestinal hemorrhage. An acid-blocking medication was advised by the hospital physicians to prevent future bleeding. This information was available on the day of discharge, and written on the hospital instruction sheet. However, health information management at COR failed to share this with the provider, and this medication was never started. Six days later, the patient died of a recurrent gastrointestinal bleed.

- In case 33, the patient had uncontrolled inflammatory bowel disease, and was experiencing abdominal pain and blood in his stool. On two occasions, the delivery of a steroid medication to reduce the inflammation was delayed, once for 7 days and once for 11 days, before the patient received the medication.

Summary of Compliance Results

The compliance component assessed 10 of the 13 indicators applicable to COR. Of these ten indicators, OIG compliance inspectors rated one *proficient*, three *adequate*, and six *inadequate*. The results of those assessments are summarized within this section of the report. The test questions used to assess compliance for each indicator are detailed in *Appendix A*.

1 — *ACCESS TO CARE*

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

Case Review Rating:
Adequate
Compliance Score:
Adequate
(81.1%)
Overall Rating:
Adequate

Case Review Results

The OIG clinicians reviewed 264 provider, nurse, specialty, and hospital events that required a follow-up appointment and identified 22 deficiencies relating to *Access to Care*¸ of which four were significant (more likely than not to cause patient harm if not rectified). Significant deficiencies were identified in cases 1 (twice), 2, and 33. The OIG clinicians rated the *Access to Care* indicator at COR *adequate.*

Sick Call Access

COR did well in scheduling and completing most nursing sick call appointments. There was only one minor deficiency.

Follow-up Appointments

Access to follow-up care was excellent at COR. The institution performed well with provider-to-provider follow-up care, with only two minor deficiencies whereby the follow-up care was one or two days late. COR also did well with scheduling and completing nursing appointments that were generated by a provider or nurse. The OIG reviewed 23 provider follow-up appointments after a specialty service, 26 provider appointments scheduled after a patient returned from an offsite hospital or emergency department, and 28 provider appointments scheduled after a patient was treated in the TTA, all of which were free of deficiencies. COR did well with diagnostic services access, with no deficiencies in scheduling and completing provider follow-up appointments in response to review of diagnostic tests.

Nurse-to-Provider Referrals

COR did well in scheduling and completing most nurse-requested provider appointments. There were three deficiencies, one of which was significant:

- In case 33, the nurse referred the patient to a provider for management of abdominal pain and rectal bleeding. The scheduler incorrectly recorded the provider appointment was

completed when, in fact, the patient had refused the provider visit. Fortunately, the provider had provided appropriate treatment during the initial nurse visit and telephone consultation.

Intra-System Transfers and Reception Center

Among the four reviewed provider appointments scheduled after a patient transferred into COR, no deficiencies were found.

Specialized Medical Housing

There were three significant deficiencies (two in case 1 and one in case 21). These are also discussed in the *Specialized Medical Housing* indicator.

Specialty Access

COR did well with specialty service access. The three minor deficiencies are discussed in the *Specialty Services* indicator.

Clinician Onsite Inspection

The OIG met with the correctional health services administrator during the onsite inspection. There had been improvement processes over the last year to address a backlog in areas such as provider appointments. The schedulers were guided to improve appointment efficiency with bundling appointments and removing duplicate ones. The CP&S had implemented additional clinics on Saturdays and used providers from other institutions to improve access to care. The improvement plan included monthly meetings with the office technicians and an audit tool to ensure the backlog elimination would continue. Some major problems in specialty appointments identified in the OIG's Cycle 4 inspection report were also corrected, and this is further discussed in the *Specialty Services* indicator.

Case Review Conclusion

COR demonstrated sufficient ability to provide access to care in all areas. The OIG clinicians rated this indicator *adequate*.

Compliance Testing Results

The institution received an *adequate* compliance score of 81.1 percent in the *Access to Care* indicator, with scores in the *proficient* range in the following five areas:

- Of the five applicable patients sampled who were referred to and seen by a provider and for whom the provider subsequently ordered a follow-up appointment, all five received their follow-up appointments timely (MIT 1.006).

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

- Inspectors sampled 40 health services requests submitted by patients across all facility clinics. Nursing staff completed a timely face-to-face encounter for 37 patients (93 percent). For one patient, the nurse conducted the visit one day late. For two others, there was no medical record evidence that a face-to-face encounter occurred (MIT 1.004).

- Among 25 sampled patients who were discharged from a community hospital, 22 (88 percent) received a timely provider follow-up appointment upon their return to COR. Two patients received their appointments one and 13 days late, and, for one other patient, there was no medical record evidence found of a follow-up appointment (MIT 1.007).

- Of the 22 applicable patients sampled who received a high-priority or routine specialty service, 19 (86 percent) received a timely follow-up appointment with a provider. Two patients received follow-up appointments 4 and 14 days late, and one did not receive an appointment at all (MIT 1.008).

One test in this indicator earned COR an *adequate* score:

- Inspectors sampled 40 health care services request forms and found that nursing staff reviewed 33 of them on the same day they were received (83 percent). Nursing staff reviewed five of the forms one day late. Two sampled forms were not properly completed (MIT 1.003).

COR showed room for improvement in the following areas:

- Among 25 patients sampled who transferred into COR from other institutions and were referred to a provider based on nursing staff's initial health care screening, only 14 (56 percent) were seen timely. Seven patients received their provider appointment from one day to over four months late, while four other patients did not receive a primary care provider appointment (MIT 1.002).

- Inspectors sampled 25 patients who suffered from one or more chronic care conditions; only 15 patients timely received their ordered follow-up appointments (60 percent). Six patients' follow-up appointments occurred from 2 to 10 days late; three patients' appointments were from 20 to 41 days late; and there was no evidence found that one patient was seen (MIT 1.001).

- Among the 14 applicable health care service requests sampled on which the nursing staff referred the patient for a provider appointment, 9 of the patients (64 percent) received a timely appointment. For one patient, the follow-up appointment occurred one day late. For four other patients, there was no medical record evidence found that the appointments occurred (MIT 1.005).

2 — *DIAGNOSTIC SERVICES*

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(74.8%)
Overall Rating:
Adequate

This indicator addresses several types of diagnostic services. Specifically, it addresses whether radiology and laboratory services were timely provided to patients, whether the primary care provider timely reviewed the results, and whether the results were communicated to the patient within the required time frames. In addition, for pathology services, the OIG determines whether the institution received a final pathology report and whether the provider timely reviewed and communicated the pathology results to the patient. The case reviews also factor in the appropriateness, accuracy, and quality of the diagnostic test(s) ordered and the clinical response to the results.

In this indicator, the OIG's case review and compliance review process yielded different results, with the case review giving an *adequate* rating and the compliance review resulting in an *inadequate* score. The OIG's internal review process considered those factors that led to both scores and ultimately rated this indicator *adequate*. The compliance score was nearly *adequate*, and the areas of deficiency did not negatively affect patient care.

Case Review Results

The OIG clinicians reviewed 109 diagnostic events and found 36 deficiencies, two of which were significant (both in case 11). Of the 36 deficiencies, 23 related to health information management.

Test Completion

With respect to test completion, COR's performance was excellent. All laboratory and radiology orders were completed.

Health Information Management

In general, COR was able to retrieve and timely scan most documents. Most minor deficiencies were due to a slight delay in scanning the reports. Among the 23 deficiencies, one was significant:

- In case 11, the patient had worsening control of his diabetes. Medical records staff failed to retrieve, to have the provider review and sign, and to scan the laboratory report into the electronic medical record.

Provider Performance

The providers performed well with diagnostics services. There was one significant deficiency in case 11, which is discussed in *Quality of Provider Performance* indicator.

Case Review Conclusion

Diagnostic services at COR were performed well, and this indicator was rated *adequate.*

Compliance Testing Results

The institution received an *inadequate* compliance score of 74.8 percent in the *Diagnostic Services* indicator, which encompasses radiology, laboratory, and pathology services. For clarity, each type of diagnostic service is discussed separately below:

Radiology Services

- Radiology services were timely performed for the nine applicable patients sampled (MIT 2.001); however, providers evidenced timely review of the corresponding diagnostic services reports for only two of the ten patients (20 percent). For eight patients, the OIG did not find evidence in the medical record that the providers reviewed the diagnostic services reports by initialing and dating the report per CCHCS policy (MIT 2.002). Providers timely communicated the test results to all ten patients sampled (MIT 2.003).

Laboratory Services

- Nine of ten sampled patients (90 percent) received their provider-ordered laboratory services timely; one patient received his service 12 days late (MIT 2.004). For all ten of those services, the provider timely reviewed the diagnostic report and timely reported the results to the patient (MIT 2.005, 2.006).

Pathology Services

- Clinicians at COR timely received the final pathology report for seven of ten patients sampled (70 percent). One of the remaining reports was received 13 days late, and for the remaining two, there was no evidence found in the electronic medical record that the final reports were received (MIT 2.007). Providers timely reviewed the pathology results for only four of eight applicable patients sampled (50 percent). Two reports were reviewed one and two days late; and two reports did not show evidence of clinician review (MIT 2.008). Providers timely communicated the final pathology results to three of the seven applicable patients sampled (43 percent). Results were communicated to three patients from one to 19 days late. For one additional patient, inspectors did not find evidence in the electronic medical record that the patient received notification of the test results (MIT 2.009).

3 — *EMERGENCY SERVICES*

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

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

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

Case Review Results

The OIG clinicians reviewed 80 urgent or emergent events and found 37 deficiencies. All of the deficiencies were in nursing care and were minor and did not significantly affect patient care. COR performed well in initiating BLS care and with 9-1-1 activation during emergency medical responses. In general, patients requiring urgent or emergent services received timely and sufficient care.

Provider Performance

Provider performance in emergency services at COR was excellent. There was only one minor deficiency with electronic medical record documentation.

Nursing Performance

The nursing deficiencies identified in emergency medical services were in nursing assessment, delays in emergency medical response, and transfers of patients to a higher level of care. Documentation by some TTA nurses was incomplete and disorganized. The OIG clinicians identified 22 minor nursing deficiencies. The following cases are examples for quality improvement strategies:

- In case 7, the patient was in an altercation and fractured his hand. The patient was assessed in the TTA, but the nursing staff did not provide basic nursing measures, such as elevating the hand and applying ice to reduce swelling.

- In case 15, the patient was sent to the TTA for nausea, dizziness, and headaches. The nurse did not assess the patient for signs of dehydration or contact the provider before sending the patient back to his housing unit.

- Also in case 15, there were two events with 20-minute delays in emergency response and transfer to the TTA. The first was after a seizure, and the second was after a fall when the patient required intravenous fluids and was transferred to a higher level of care.

- In case 41, the patient was in an altercation and had lost consciousness and suffered a facial laceration requiring transfer to a higher level of care. The first emergency medical responder who arrived on scene did not document a description of the injuries.

CPR Response

The first responders to medical emergencies were licensed vocational nurses (LVNs), psychiatric technicians (PTs), and custody staff. In the majority of the cases reviewed, medical responders and custody staff promptly and appropriately initiated BLS measures. In general, nurses at COR provided good care during emergency medical response incidents. The nursing deficiencies were not significant and did not affect patients' outcomes.

Patient Care Environment

This following case involved the emergency response of the custody staff, and included one minor deficiency, as follows:

- In case 4, the patient was found hanging in the cell. The custody staff were unable to cut down the ligature from the neck with the available scissors, which were faulty. This caused a delay in rescue measures. The officer manually removed the ligature to start CPR. Fortunately, the patient survived and was transferred to a mental health institution.

Emergency Medical Response Review Committee

The committee generally reviewed all emergency medical response incidents and took necessary actions to improve the institution's emergency medical response. Review of the EMRRC minutes indicated that the incorrect practice of TTA staff completing first responder forms had been identified, and training of the first responders to complete the form themselves had been implemented. The nursing administrative staff was responsive to the deficiencies that were presented with the exception of the following case:

- In case 15, the EMRRC committee failed to identify errors in event time documentation.

Clinician Onsite Inspection

The TTA had ample space for patient evaluation and working areas for both nurses and providers. The TTA had 24-hour registered nursing coverage. First responders on the yard were custody staff and clinic yard nurses. The new nursing administrator informed the OIG clinicians that previously, nursing staff on second and third watch did not have hand radios for communication with custody regarding emergencies. The administrator was able to acquire hand radios. The CNE also obtained cell phones for supervisors to further improve communications. The CNE informed the OIG clinicians that the TTA staff had received training and education on urgent/emergent protocols. There was a new third watch TTA supervisor to assist staff during this watch. The CEO had recently trained staff on the time frames for emergent transfers, including activation of 9-1-1.The OIG clinicians asked the TTA staff if there were barriers to patient transfer to the TTA from the yard. Their response was that there were occasional gate malfunctions or delays for safety concerns from custody. The TTA staff stated that otherwise, their expected response time to the yard was two to three minutes. A review of 11 nursing files revealed that two of the nurses had current ACLS certification, and all of the nurses had current BLS certification, with the exception of one nurse with an expired card on file. Clinic yard staff stated that they recently received education and training on a new policy for administration of naloxone (narcotic overdose antidote) spray, and the medication was available on the yard, when needed.

Case Review Conclusion

COR generally provided prompt and appropriate basic life support care during medical emergencies, and this indicator was rated *adequate*.

4 — *HEALTH INFORMATION MANAGEMENT*

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(67.2%)
Overall Rating:
Inadequate

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

In this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance testing resulting in an *inadequate* score—each area's results are discussed in detail below. After considering both case review and compliance testing results, the OIG inspection team determined the final overall rating of *inadequate* was appropriate. This decision was due to the following two factors: an excessive number of health care documents that COR staff either mislabeled or misfiled in the electronic medical records and untimely provider review of hospital discharge reports. These deficiencies could result in important health care records not being identified and contribute to patient harm and delays in the delivery of patient care, warranting the lower overall indicator score.

During the OIG's testing period, COR had not converted to the new Electronic Health Record System (EHRS); therefore, all testing occurred in the electronic Unit Health Record (eUHR) system.

Case Review Results

The OIG clinicians reviewed 1,103 events and found 63 deficiencies related to health information management, two of which were significant (cases 5 and 11). The OIG rated this indicator *adequate*.

Patient Death

- In case 5, the patient returned from being hospitalized for gastrointestinal bleeding. The discharge summary was not available to the provider for the follow-up visit. The provider was not given the information on the discharge summary, and did not see the recommendation from the hospital to start a medication to reduce the risk of future bleeding. The patient died six days later from recurrent bleeding.

Hospital Records

The OIG reviewed 25 outside emergency department (ED) and community hospital events. COR did well in retrieving and scanning hospital discharge summaries and ED reports. The OIG identified 15 deficiencies, one of which was significant (case 5, discussed above). Of the 14 minor deficiencies, 11 were for health information management issues, which included five hospital discharge reports being scanned into the electronic medical records without a provider signature. The one significant deficiency in case 5 (discussed above) also involved a health information management issue.

Specialty Services

COR did well with retrieving and scanning specialty services reports. There were seven minor deficiencies. These are discussed further in the *Specialty Services* indicator.

Diagnostic Reports

Among the health information management deficiencies, 23 involved diagnostic services, one of which was significant:

- In case 11, medical records staff failed to retrieve and scan a report showing that the patient's diabetes was worsening.

Urgent/Emergent Records

There were eight minor deficiencies in the TTA provider and nurse documentation as well as on-call provider documentation. These are discussed in the *Emergency Services* indicator.

Scanning Performance

While COR displayed only two significant deficiencies in health information management, patterns of minor deficiencies showed opportunities for improvement. Missing documents were identified in cases 5, 7, 11, 21, 25, 28, and 55, and twice in case 2. Scanning occurred prior to provider signature in cases 1, 7, 21, 25, and 52, and three times in case 5. There were minor delays in scanning in cases 5, 7, 9, and 20, four times in case 15, and seven times in case 10. Scanned documents were incorrectly labelled in cases 7, 10, 19, and 43; twice each in cases 8, 9, 15, 20, and 23; and four times each in cases 1 and 2. The patient was not notified of the laboratory results in cases 9 and 10.

Clinician Onsite Inspection

The OIG met with the medical records supervisors. They discussed their quality improvements efforts to reduce scanning delays. The specialty services supervisor also discussed recent improvements in obtaining reports. While deficiencies were still identified, the OIG noted fewer significant deficiencies in Cycle 5 than in Cycle 4.

Case Review Conclusion

COR did well with the retrieval of outside ED reports and hospital discharge summaries. Scanning time frames were acceptable, but improvement was needed in scanning accuracy. Missing, misfiled, or mislabeled documents were common throughout the case reviews. The OIG clinicians rated this indicator *adequate.*

Compliance Testing Results

The institution received an *inadequate* compliance score of 67.2 percent in the *Health Information Management* indicator. The following tests showed areas for needed improvement:

- The institution scored zero in its labeling and filing of documents scanned into patients' electronic medical records. Most errors included mislabeled and incorrect patient documents. For this test, once the OIG identifies 24 mislabeled or incorrect patient documents, the maximum points are lost and the resulting score is zero (MIT 4.006).

- Among 25 sampled patients admitted to a community hospital and then returned to the institution, COR's providers timely reviewed only 12 patients' corresponding hospital discharge reports within three calendar days of the patient's discharge (48 percent). For the other 13 patients, providers did not timely review the discharge reports; one was reviewed one day late, and 12 reports had no evidence of review (MIT 4.007).

- For 12 of 18 specialty service consultant reports sampled (67 percent), COR staff scanned the reports into the patient's electronic medical record within five calendar days. However, three documents were scanned from one to four days late, and for another three, there was no evidence that the specialty reports were scanned into the medical record (MIT 4.003).

The following tests earned *proficient* scores:

- The institution timely scanned 19 of 20 sampled non-dictated progress notes, patients' initial health screening forms, and requests for health care services into the electronic medical records (95 percent). One initial health screening form was scanned one day late (MIT 4.001).

- COR scored 91 percent for the timely scanning of dictated or transcribed provider progress notes into patients' electronic medical record files. Timely scanning occurred within five days of the provider visit with the patient for 10 of the 11 sampled documents; the one exception was scanned four days late (MIT 4.002).

- Institution staff timely scanned 18 of 20 sampled specialty service consultant reports into the patients' electronic health care records (88 percent). The other two specialty reports were scanned one day late (MIT 4.004).

- COR medical records staff timely scanned medication administration records (MARs) into 12 of 15 sampled patients' electronic medical records (80 percent). Three MARs were scanned from two to three days late (MIT 4.005).

5 — *HEALTH CARE ENVIRONMENT*

This indicator addresses the general operational aspects of the institution's clinics, including certain elements of infection control and sanitation, medical supplies and equipment management, the availability of both auditory and visual privacy for patient visits, and the sufficiency of facility infrastructure to conduct comprehensive medical examinations. Rating of this component is based entirely on the compliance testing results from the visual observations inspectors make at the institution during their onsite visit.

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(70.7%)

Overall Rating:
Inadequate

This indicator is evaluated entirely by compliance testing. The OIG conducts no case review component.

Compliance Testing Results

The institution received an *inadequate* compliance score of 70.7 percent in the *Health Care Environment* indicator, showing room for improvement in the following areas:

- The non-clinic bulk medical supply storage areas did not meet the supply management process and support the needs of the medical health care program. Several expired medical supplies were found stored beyond the manufacturing guidelines, earning the institution a score of zero (MIT 5.106).

- Only 4 of the 14 clinic locations (29 percent) met compliance requirements for essential core medical equipment and supplies. The remaining ten clinics were missing one or more functional pieces of properly calibrated core equipment or other medical supplies necessary to conduct a comprehensive exam. The missing items included a demarcation line for the Snellen eye exam chart, a nebulization unit, an oto-ophthalmoscope and tips, tongue depressors, and a biohazard receptacle or labeled bags. In addition, an automatic external defibrillator, oto-ophthalmoscope, nebulization unit, and weight scale were missing calibration stickers (MIT 5.108).

- Of 14 clinic exam rooms observed, 9 (64 percent) had appropriate space, configuration, supplies, and equipment to allow clinicians to perform a proper clinical examination. In five clinics, the following deficiencies were identified: torn vinyl cover on the exam table (*Figure 1*), exam room supplies that were not clearly identifiable, and confidential records that were not shredded on a daily basis. In

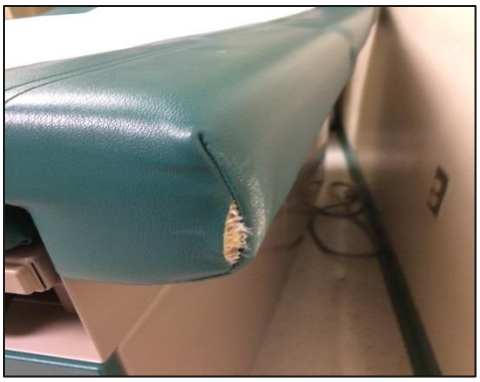

Figure 1: Exam table with torn vinyl

addition, in the receiving and release clinic, the exam room did not have adequate space to provide medical services (MIT 5.110).

- The institution scored 70 percent when inspectors examined emergency response bags in ten applicable clinics to determine if clinical staff inspected the bags daily and inventoried them monthly, and whether the bags contained all essential items. At three clinics, the following deficiencies were identified: staff on each watch did not always conduct daily inspections of the bags; the emergency medical response bags were missing non-latex gloves; and the crash cart in the TTA had expired medical supplies (MIT 5.111).

One test scored in the *adequate* range:

- Clinicians whom inspectors observed in 11 of 14 clinics adhered to universal hand hygiene precautions; however, in three clinics, providers did not sanitize or wash their hands prior to putting on gloves and after physically assessing patients (79 percent) (MIT 5.104).

The following tests earned *proficient* scores:

- All fourteen clinics had environments adequately conducive to providing medical services; they provided reasonable auditory privacy, appropriate waiting areas, wheelchair accessibility, and sufficient non-exam-room workspace (MIT 5.109).

- Clinical health care staff at 13 of the 14 applicable clinics (93 percent) ensured that reusable invasive and non-invasive medical equipment was properly sterilized or disinfected. One clinic had previously sterilized medical equipment that was missing a date stamp on its packaging (MIT 5.102).

- Of the 14 clinics examined, 12 (86 percent) were appropriately disinfected, cleaned, and sanitized. In two clinics, cleaning logs were not maintained (MIT 5.101); 12 of the 14 (86 percent) also had operable sinks and sufficient quantities of hand hygiene supplies in the exam areas. However, two clinics' patient restrooms did not have soap or disposable hand towels available (MIT 5.103).

- Regarding proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste, 12 of the 14 clinics (86 percent) were compliant. In two clinics, the exam rooms did not have puncture-resistant containers available to medical staff for expended needles and sharps; and one of those two clinics was also missing personal protective equipment (MIT 5.105).

- Inspectors found that 12 of the 14 clinics (86 percent) followed adequate medical supply storage and management protocols. Two clinics' storage rooms for bulk medical supplies were not clearly identifiable, and medical supplies were found stored in the same area with cleaning products (MIT 5.107).

Non-Scored Areas

- The OIG gathered information to determine if the institution's physical infrastructure was maintained in a manner that supported health care management's ability to provide timely or adequate health care. The OIG did 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, COR had several significant infrastructure projects underway, which included increasing clinic space at seven yards and renovating the central health services building. These projects started in the fall of 2014, and the institution estimated that these projects would be completed by the end of spring 2018 (MIT 5.999).

6 — *INTER- AND INTRA-SYSTEM TRANSFERS*

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(43.0%)
Overall Rating:
Inadequate

This indicator focuses on the management of patients' medical needs and continuity of patient care during the inter- and intra-facility transfer process. The patients reviewed for *Inter- and Intra-System Transfers* include patients received from other CDCR facilities and patients transferring out of COR to another CDCR facility. The OIG review includes evaluation of the institution's ability to provide and document health screening assessments, initiation of relevant referrals based on patient needs, and the continuity of medication delivery to patients arriving from another institution. For those patients, the OIG clinicians also review the timely completion of pending health appointments, tests, and requests for specialty services. For patients who transfer out of the facility, the OIG evaluates the ability of the institution to document transfer information that includes pre-existing health conditions, pending appointments, tests and requests for specialty services, medication transfer packages, and medication administration prior to transfer. The OIG clinicians also evaluate the care provided to patients returning to the institution from an outside hospital and check to ensure appropriate implementation of the hospital assessment and treatment plans.

In this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance review resulting in an *inadequate* score. The OIG's internal review process considered those factors that led to both scores and ultimately rated this indicator *inadequate*. The deficiency of transfer packets for patients transferring to other institutions from COR was a key factor; specifically, regional inspectors found that all transfer packets examined were missing required medical records. There were also issues noted with the timeliness and completion of the Initial Health Screening form (CDCR Form 7277) by registered nurses as well as with the receipt of previously ordered medication for patients transferring into COR from other institutions. The seriousness of these errors rendered the compliance score of *inadequate* the more appropriate overall rating.

Case Review Results

Clinicians reviewed encounters relating to inter- and intra-system transfers, including information from both the sending and receiving institutions. These included 64 events, of which 55 were hospital related. There were 23 hospitalizations, all of which resulted in a transfer back to COR. The cases reviewed displayed only minor deficiencies.

Transfers In and Out

Three events relating to transfers out were reviewed, and there was only one minor deficiency. The OIG clinicians reviewed six events regarding patients transferring into COR, and deficiencies were identified in one case, as follows:

- In case 28, the nurse made health care referrals without indicating the time frame and did not document the patient's need for a Spanish-speaking interpreter. The provider evaluated the patient seven days later and needed to reschedule the appointment with an interpreter to complete an in-depth assessment.

Hospitalizations

Patients returning from hospitalizations or from outside emergency departments 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, e.g., from the hospital to the institution. At COR, 15 hospital transfer deficiencies were identified, one of which was significant, primarily related to health information management. These are further discussed in the *Health Information Management* indictor.

Case Review Conclusion

The OIG rated the case review portion of the *Inter- and Intra-System Transfers* indicator *adequate*.

Compliance Testing Results

The institution obtained an *inadequate* score of 43.0 percent in the *Inter- and Intra-System Transfers* indicator, with five of the six tests earning *inadequate* scores, as follows:

- COR scored zero when the OIG tested seven patients who transferred out of COR during the onsite inspection to determine whether the patients' transfer packages included required medications and related documentation. Seven patients' transfer packets were missing MARs (MIT 6.101).

- The OIG tested 25 patients who transferred into COR from other CDCR institutions to determine whether they received a complete initial health screening assessment from nursing staff on their day of arrival. COR received a score of 28 percent on this test because nursing staff timely completed the Initial Health Screening forms (CDCR Form 7277) for only 7 of the 25 sampled patients. For 18 patients, nurses neglected to answer one or more of the screening form questions (MIT 6.001).

- The OIG reviewed the initial health screening forms for 25 patients who transferred into COR from other CDCR institutions to determine if nursing staff completed the assessment and disposition sections of the form on the same day staff completed an initial screening of the patient. Nursing staff properly completed the documents for 13 of the patients sampled (52 percent). For 11 patients, nursing staff signed the RN assessment and disposition sections of the form from one to three days late. For one sampled patient, the RN failed to date the screening form (MIT 6.002).

- Of the 25 sampled patients who transferred into COR, 20 had an existing medication order that required nursing staff to issue or administer medications upon arrival; 12 of the applicable 20 patients (60 percent) received their medications timely. Three patients received their direct observation therapy (DOT) medication from one to 21 days late. For five patients, there was no evidence that they received their medication (MIT 6.003).

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

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

7 — *PHARMACY AND MEDICATION MANAGEMENT*

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(56.1%)
Overall Rating:
Inadequate

This indicator is an evaluation of the institution's ability to provide appropriate pharmaceutical administration and security management, encompassing the process from the written prescription to the administration of the medication. By combining both a quantitative compliance test with case review analysis, this assessment identifies issues in various stages of the medication management process, including ordering and prescribing, transcribing and verifying, dispensing and delivering, administering, and documenting and reporting. Because effective medication management is affected by numerous entities across various departments, this assessment considers internal review and approval processes, pharmacy, nursing, health information systems, custody processes, and actions taken by the prescriber, staff, and patient.

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

Case Review Results

The OIG clinicians evaluated 100 events and found 19 deficiencies regarding pharmacy and medication management. Significant deficiencies were identified in cases 2, 9 (twice), 18 (twice), and 33.

Medication Process and Continuity

Patients at COR generally received their medications as prescribed and as scheduled. However, four cases had significant medication management deficiencies whereby the patient did not receive the medication as ordered:

- In case 2, the patient returned from the hospital after having a seizure. When the patient returned to the institution, the seizure medication was delayed two days while the pharmacist waited for a clarification on the medication dosage. Also in case 2, the patient had another delay when a different seizure medication dosage was changed.

- In case 18, the physician ordered a medication to reduce heartburn, but the patient did not receive the medication until it was reordered the following month. Also in case 18, on two

different occasions, the provider ordered an antibiotic solution for the patient's eye infection to be started the same day it was ordered, which did not occur on either occasion.

- In case 23, the provider changed the patient's blood pressure medication dosage but did not specify how the medication was to be administered. Because of the absence of this information, the pharmacy delayed the order. This was a minor deficiency.

- In case 33, the patient had inflammatory bowel disease and was actively bleeding. A provider ordered a steroid to reduce intestinal inflammation. The patient did not receive the medication until another order was written 17 days later.

Medication Administration (Nursing)

Nursing staff performed adequately regarding accurate and timely administration of keep-on-person (KOP) and nurse-administered medications. Although the overall performance was adequate, there were deficiencies in the medication administration at COR:

- In case 2, the nurse did not inform the provider of the patient's refusal of a seizure medication.

- In case 35, there were multiple refusals of the patient's seizure medications, but the nurse did not document the reason for the refusals.

Clinician Onsite Inspection

The sick call nurses' work area did not provide privacy for confidential assessments of patients. The windows surrounding the room were uncovered, so the area was visible to everyone outside the room. The medication nurses worked in a very small area in the program office, and the patients walked up to the medication cart without a medication window.

The LVNs and PTs responsible for medications were knowledgeable about their patients, medication preparation and administration safety, and operational processes on their assigned yards. They were located in close proximity to the clinic primary care nurses and provider. These LVNs and PTs described an appropriate process at COR for verifying new medication orders and reconciling continuing medication orders. Nurses notified providers about patient medication issues during the morning huddles. The LVNs and PTs were an integral part of the primary care team, and they also served as first medical responders for medical emergencies during hours of clinic operations.

Case Review Conclusion

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

Compliance Testing Results

The institution received an *inadequate* compliance score of 56.1 percent in the *Pharmacy and Medication Management* indicator. For discussion purposes below, this indicator is divided into three sub-indicators: medication administration, observed medication practices and storage controls, and pharmacy protocols.

Medication Administration

In this sub-indicator, the institution received an *inadequate* score of 57.9 percent, with poor scores in the following tests:

- Nursing staff administered medications without interruption to only two of ten patients who were en route from one institution to another with a temporary layover at COR (20 percent). For eight patients, there was no medical record evidence that medications were administered as ordered (MIT 7.006).

- COR timely provided hospital discharge medications to only 12 of 25 patients sampled (48 percent). Nursing staff provided discharge medications from one to three days late for ten patients; for three other patients, no evidence was found in the medical record that DOT or KOP medications were provided (MIT 7.003).

- Among 15 applicable patients, 8 (53 percent) timely received chronic care medications. One patient did not receive provider counseling, two did not receive their medications, and four received their DOT and KOP medications from two to four days late (MIT 7.001).

- COR ensured that 17 of 25 patients sampled (68 percent) received their medications without interruption when they transferred from one housing unit to another. Nursing staff did not properly document refusals in the MAR for seven patients, and for the remaining patient, there was no evidence the patient received his medication (MIT 7.005).

One test in this sub-indicator earned a *proficient* score:

- Inspectors found that all 25 patients sampled received their newly ordered medication in a timely manner (MIT 7.002).

Observed Medication Practices and Storage Controls

The compliance score for this sub-indicator was an *inadequate* 68.0 percent. The following tests revealed room for improvement:

- The institution employed adequate security controls over narcotic medications in 4 of the 12 applicable clinic and medication line locations where narcotics were stored (33 percent). At six clinics, the narcotics log book lacked evidence on multiple dates over a one-month period that a controlled substance inventory was performed by two licensed nursing staff. At

two other locations, the narcotics were stored under one lock control only, and the medication nurse did not immediately update the narcotics logbook after administering narcotics (MIT 7.101).

- Only four of seven inspected medication preparation and administration areas demonstrated appropriate administrative controls and protocols (57 percent). At two different locations, the following deficiencies were identified: the medication nurse did not always ensure the patient swallowed DOT medications; the medication nurse did not consistently verify patients' identification by using picture identification; and the medication nurse did not appropriately administer medication by crushing and floating as ordered by the primary care provider. At a third medication line location, patients waiting to receive their medications did not have sufficient outdoor cover to protect them from heat or inclement weather (MIT 7.106).

- COR properly stored non-narcotic medications not requiring refrigeration in 8 of the 13 applicable clinic and medication line storage locations (62 percent). In five locations, one or more of the following deficiencies were observed: the medication area lacked a designated area for return-to-pharmacy medications; a multi-use medication was not labeled with the date it was opened; and the crash cart monthly inventory was not available for review (MIT 7.102).

- Inspectors observed the medication preparation and administration processes at seven applicable medication line locations. Nursing staff were compliant regarding proper hand hygiene and contamination control protocols at five locations (71 percent). At two locations, not all nursing staff washed or sanitized their hands when required, such as prior to putting on gloves (MIT 7.104).

One test in this sub-indicator received an *adequate* score:

- Non-narcotic refrigerated medications were properly stored in 11 of 13 clinics and medication line storage locations (85 percent). One location did not have designated area for return-to-pharmacy refrigerated medications, and at another location, the medication refrigerator was found unlocked at the time of inspection (MIT 7.103).

The following test earned COR a *proficient* score:

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

Pharmacy Protocols

In this sub-indicator, the institution received an *inadequate* average score of 40.0 percent, comprised of scores received at the institution's main pharmacy. Three tests showed areas for improvement:

- In its main pharmacy, the institution did not follow general security, organization, and cleanliness management protocols. The narcotics storage area was found unlocked at the time of inspection. Medication preparation areas were also found cluttered and disorganized (MIT 7.107).

- In its main pharmacy, COR did not properly store non-refrigerated medication. Inspectors found medication boxes stored on the floor of the pharmacy (MIT 7.108).

- OIG inspectors examined 25 medication error follow-up reports and five monthly medication error statistics reports generated by the institution's pharmacist in charge (PIC). All 25 reports were untimely or incorrectly processed. The following deficiencies were identified (MIT 7.111):

    - The PIC was unable to confirm whether the monthly medication error statistics were reported to the chief of pharmacy services in a timely manner.

    - Among the 25 medication error follow-up reports provided for inspectors' review, two were completed by the institution's PIC between one and 25 days late.

The following two tests earned *proficient* scores of 100 percent:

- The main pharmacy properly stored refrigerated and frozen medications (MIT 7.109).

- The institution's PIC properly accounted for narcotic medications stored in COR's pharmacy and reviewed monthly inventories of controlled substances in the institution's clinical and medication line storage locations (MIT 7.110).

Non-Scored Tests

- In addition to testing reported medication errors, OIG inspectors follow up on any significant medication errors found during compliance testing to determine whether the errors were properly identified and reported. The OIG provides those results for information purposes only; however, at COR, none of the medication errors identified during testing were deemed to be at or above the necessary severity level, so there were no applicable errors for this test (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 20 of the sampled patients had access to their asthma inhalers or nitroglycerin medications (MIT 7.999).

8 — *PRENATAL AND POST-DELIVERY SERVICES*

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

Because COR was an all-male institution, this indicator did not apply.

Case Review Rating:
Not Applicable
Compliance Score:
Not Applicable

Overall Rating:
Not Applicable

9 — *PREVENTIVE SERVICES*

This indicator assesses whether various preventive medical services are offered or provided to patients. These include cancer screenings, tuberculosis 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:
Proficient
(87.0%)
Overall Rating:
Proficient

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

Compliance Testing Results

The institution performed in the *proficient* range in the *Preventive Services* indicator, with a compliance score of 87.0 percent. Five tests in this indicator received *proficient* scores, including four scores of 100 percent, as follows:

- COR timely administered tuberculosis (TB) medications to patients. All eight sampled patients received their required doses of TB medications in the most recent three-month period reviewed (MIT 9.001).
- OIG found that all eight sampled patients received monthly or weekly monitoring while taking TB medications (MIT 9.002).
- All 25 patients sampled timely received or were offered influenza vaccinations during the most recent influenza season (MIT 9.004).
- The OIG tested whether patients who suffered from certain chronic care conditions were offered vaccinations for influenza, pneumonia, and hepatitis. All 24 applicable patients sampled were timely offered the vaccinations (MIT 9.008).
- COR offered colorectal cancer screenings to 23 of the 25 sampled patients subject to the annual screening requirement (92 percent). For two patients, there was no medical record evidence either that health care staff offered a colorectal cancer screening within the previous 12 months or that the patient had a normal colonoscopy within the last ten years (MIT 9.005).

Two tests in this indicator revealed areas for improvement at COR:

- The OIG sampled 17 patients at high risk for contracting the coccidioidomycosis infection (valley fever), who were medically restricted and ineligible to reside at COR, to determine if

the patients were transferred out of the institution within 60 days from the time they were initially determined ineligible. The institution was compliant for 12 of the 17 patients sampled (71 percent). Of the five for whom COR was not compliant, one was transferred out 58 days late; as of May 23, 2017, the four remaining patients exceeded their eligibility dates at COR by 58 days to nearly two years (MIT 9.009).

- OIG inspectors sampled 30 patients to determine whether they received a TB screening within the last year; 15 of the sampled patients were classified as a Code 22 (requiring a TB skin test in addition to a signs and symptoms check), and 15 sampled patients were classified as Code 34 (subject only to an annual signs and symptoms check). Of the 30 sample patients, nursing staff timely and appropriately conducted those screenings for only 14 (47 percent). More specifically, nurses properly screened seven of the Code 22 patients and seven of the Code 34 patients. Inspectors identified the following deficiencies (MIT 9.003):

    - For seven of the Code 22 patients, an LVN or PT read the test results rather than an RN, public health nurse, or primary care provider as required by the CCHCS policy in place at the time of the OIG's review; for one other Code 22 patient, nursing staff did not complete the Tuberculin Testing/Evaluation Report (CDCR Form 7331).

    - For eight Code 34 patients, nursing staff did not complete the TB testing and evaluation report.

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 on site, such as outpatient, inpatient, urgent or emergent, patient transfers, care coordination, and medication management. The key focus areas for evaluation of nursing care include appropriateness and timeliness of patient triage and assessment, identification and prioritization of health care needs, use of the nursing process to implement interventions, and accurate, thorough, and legible documentation. Although nursing services provided in the CTC or OHU are reported in the *Specialized Medical Housing* indicator, and nursing services provided in the TTA or related to emergency medical responses are reported in the *Emergency Services* indicator, all areas of nursing services are summarized in this *Quality of Nursing Performance* indicator.

Case Review Results

The overall quality of nursing performance at COR was *adequate*. The OIG clinicians reviewed 269 nursing encounters, of which 120 were outpatient nursing encounters. Most outpatient nursing encounters were for sick call requests, walk-in visits, and RN care manager follow-up visits. In all, there were 161 deficiencies related to nursing care performance, of which two (cases 37 and 45) were significant.

Sick Call

A major part of adequate nursing care is the quality of nursing assessments, which include both the subjective (patient interview) and the objective (evaluation and observation) portions. The majority of nurses at COR included both subjective and objective nursing assessments when assessing patients. Most nurses utilized the CCHCS nursing protocols and encounter forms, and their assessments were usually complete and adequate. There were two cases displaying significant deficiencies:

- In case 37, the patient presented with an irregular heartbeat. The sick call nurse did not examine the patient's heart or consult with a provider. Instead, the nurse referred the patient for a routine (14-day) appointment with a provider. The provider saw the patient 14 days later and ordered an urgent cardiology consult. The nurse should have consulted with the provider the same day of the face-to-face nursing assessment.

- In case 45, the patient complained that his head felt like it was swollen, his jaw was tightening, and he had a burning sensation in his head, spine, and face. The sick call nurse did not assess the patient face to face and documented on the sick call request form that the primary care provider would follow up with the patient in the TTA. An evaluation by a provider did not occur that day. Instead, the patient was evaluated by a provider six days later.

The nursing process involves reviewing each sick call request, describing symptoms, and determining whether the patient requires urgent or routine nursing assessment. However, at COR, some nurses did not recognize that a patient's symptoms were potentially urgent. Although not considered a significant deficiency, case 16 demonstrated an example of delayed access to care due to nurse not recognizing the potential need for urgent care:

- In case 16, the patient submitted two sick call requests, one stating that he had issues (not described in the request) and the other, almost 20 days later, requesting to have fluid drained from his genitals following recent hernia surgery. The nurse did not assess the patient, and documented that the patient would be seen the same day by the provider. The provider did not see the patient.

Specialized Medical Housing

Nurses generally provided good nursing care services in the CTC and OHU, as is further described in the *Specialized Medical Housing* indicator.

Care Management

The care coordinator role at COR was assigned to an LVN in each clinic. The primary function of the LVN care coordinator was providing education to patients with specific conditions, coordinating and facilitating the delivery of durable medical equipment and supplies, and collaborating with health care team members to minimize care fragmentation. The LVN care coordinators performed appropriately in their roles had a clinic RN available for consultation.

Medication Administration

System processes in place at COR generally supported nursing and pharmacy staff in providing timely medication administration to patients, as is further discussed in the *Pharmacy and Medication Management* indicator.

Urgent/Emergent

The emergency medical response at COR was efficient. However, two areas were identified as needing process improvement interventions: documentation by first medical responders, and evaluation of potential delays in emergency medical responders. These are further discussed in the *Emergency Services* indicator.

Inter- and Intra-System Transfers

Nurses in the receiving and release center generally provided good nursing care and documentation. Patients returning to COR after a hospital discharge were assessed by a TTA nurse and received appropriate nursing assessment and appropriate follow-up referrals. The TTA nurses reconciled discharge recommendations from the hospital with the provider, and most patients received medications and treatments as recommended, as discussed in the *Inter- and Intra-System Transfers* indicator.

Clinician Onsite Inspection

The OIG clinicians visited the nursing and medication staff on all yards. The clinical staff on two of the three yards continued to operate out of the program office due to construction, as documented in the Cycle 4 inspection report. Although this confined space did not adequately allow for confidential nursing interviews or assessments, nurses stated they were able to make the appropriate accommodations when necessary. Morning huddles were organized and well attended by clinic staff. The primary care RNs did not have patient backlogs. The clinic care coordinators did not have a designated space, and continued to work through inadequate workspace barriers by coordinating with other clinic staff. Nursing staff meetings were organized by the supervisors and usually occurred monthly. The majority of the staff stated that the morale at COR had improved greatly since the arrival of the newly appointed CNE. The supervisors stated that there was good teamwork. The staff appreciated the recognition they were given by their leadership during National Nurse's week.

Case Review Conclusion

The OIG rated the *Quality of Nursing Performance* indicator *adequate.*

11 — *QUALITY OF PROVIDER PERFORMANCE*

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

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

Case Review Results

The OIG clinicians reviewed 253 medical provider encounters and identified 46 deficiencies identified related to provider performance, four of which were significant (cases 1, 9, and 11 (twice)). The OIG performed 25 detailed physician case reviews and found 2 *proficient*, 21 *adequate*, and 2 *inadequate*.

Assessment and Decision-Making

At COR, the providers performed adequately without patterns of deficiencies identified. One case review showed proficient provider care:

- In case 26, the physician provided excellent care over six months. Multiple chronic care illnesses were thoroughly documented and well managed, with each illness being addressed at each visit. In addition, the patient's complex eye condition required frequent and timely specialty care consultations, which were accommodated without deficiency.

There were occasional minor deficiencies identified which would not pose a risk of serious harm to the patient. The following are examples of some minor deficiencies:

- In case 20, the patient had end-stage liver disease, and was, therefore, at risk for confusion as his liver failed to remove metabolic toxins. However, the provider failed to order a medication, lactulose, to reduce the toxin levels.

- In case 23, the patient had a known malignant tumor. While the provider noted a 15-pound weight loss over the prior two months, the provider failed to address it in the assessment or management plan.

- Also in case 23, the provider increased the dose of gabapentin (seizure medication used for chronic pain) to a maximum level, and prescribed a high dose of codeine (narcotic pain medication). However, the provider failed to document a progress note as to why the changes were made.

- Also in case 23, the provider failed to address the patient's elevated blood pressure.

Review of Records

In general, providers at COR reviewed medical records well. There were four minor deficiencies noted when providers failed to adequately review past records. The OIG identified one significant deficiency:

- In case 11, the provider reviewed the patient's laboratory results showing worsening control of diabetes (rising HbA1c to 8.5). The provider failed to order an earlier chronic care appointment, and the patient was not seen until three months later.

Chronic Care

COR provided adequate outpatient medical care, especially in chronic care. While the OIG noted 33 deficiencies in provider performance, only two were significant:

- In case 9, the primary care provider failed to resume warfarin (blood thinner) after the patient agreed to take it to prevent blood clots. There was a 13-day delay before another provider noted the order was not written.

- In case 11, the provider noted a laboratory result showing poor control of diabetes (HemA1C 9.9). The provider, however, failed to adjust any medications, and also failed to note the average glucose level also was rising.

Urgent/Emergent Care

The OIG noted one minor deficiency in provider emergency care. This is discussed in the *Emergency Services* indicator.

Specialty Services

The providers performed well in referring to appropriate specialists when necessary and ordering within appropriate time frames. The providers timely reviewed the specialty reports after patients returned from specialists. The OIG found no deficiencies.

Specialized Medical Housing

COR showed much improvement in provider performance since the Cycle 4 inspection. There were fewer deficiencies and only one significant deficiency, which is also discussed in the *Specialized Medical Housing* indicator:

- In case 1, the patient had an unwitnessed fall. The on-call provider ordered the CTC provider to evaluate the patient that morning. Despite the nurse reminding the CTC provider to see the patient, the patient was not seen. Fortunately, there were no significant injuries to the patient.

Provider Continuity

COR had good provider continuity of care. In addition, despite the fact that it was a large CTC, one provider was primarily responsible for the day-to-day care of CTC patients.

Documentation Quality

Most providers demonstrated good documentation quality.

Clinician Onsite Inspection

The OIG interviewed the CP&S, who had provided medical leadership without a CME for several years. CCHCS had occasionally rotated in other executive medical staff to help. A major focus for COR had been to correct an access to care backlog over the last year for provider appointments. This was corrected by filling provider vacancies and conducting additional weekend medical clinics to catch up. Providers from other institutions assisted in the weekend clinics. They developed new processes to ensure sustained compliance performance, such as monitoring patients who were close to the compliance scheduling deadlines. In addition, communication with custody was improved to help improve patient attendance in the clinics. The morale of the providers was good, especially after adequate staffing was reached. The providers felt supported by their CP&S, and reported that he was an excellent leader. The CP&S also highlighted working to improve the weak provider areas identified in the OIG's Cycle 4 inspection. COR had the providers work on chronic care training, CCHCS guidelines review, and patient registry review for their quality improvement measures.

Case Review Conclusion

The OIG noted substantial improvement in the provider performance since the Cycle 4 inspection. The previously weak areas, such as chronic care and specialized medical housing, had marked improvement. With these findings, the OIG rated the *Quality of Provider Performance* indicator *adequate*.

---

12 — *RECEPTION CENTER ARRIVALS*

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

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

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

13 — *SPECIALIZED MEDICAL HOUSING*

This indicator addresses whether the institution follows appropriate policies and procedures when admitting patients to onsite inpatient facilities, including completion of timely nursing and provider assessments. The chart review assesses all aspects of medical care related to these housing units, including quality of provider and nursing care. COR's specialized medical housing units consisted of a CTC and an OHU.

Case Review Rating:
Adequate
Compliance Score:
Adequate
(76.7%)
Overall Rating:
Adequate

Case Review Results

The specialized medical housing at COR consisted of a 50-bed CTC and a 14-bed OHU. There were 25 CTC beds assigned to mental health patients. The OIG clinicians reviewed 256 specialized medical housing events, which included 72 provider and 37 nursing encounters, some of which included several consecutive days of inpatient care. There were a total of 107 deficiencies, of which four were significant. Three of the significant deficiencies were delays in appointments and scheduling for provider evaluation, and one was in provider performance. There were no significant deficiencies found in nursing care in the cases reviewed, and the OIG clinicians rated this indicator *adequate*.

Provider Performance

In general, the providers at COR gave good care to patients in the CTC and OHU. The OIG reviewed 72 provider events in specialized medical housing. There were five deficiencies, one of which was significant, also discussed in the *Quality of Provider Performance* indicator:

- In case 1, the patient had an unwitnessed fall. The on-call provider ordered the CTC provider to evaluate the patient that morning. Despite the nurse reminding the CTC provider to see the patient, the patient was not seen. Fortunately, there were no significant injuries to the patient.

Nursing Performance

The nursing staff at COR provided good care to patients in the CTC and OHU. There were six admissions to either the CTC or the OHU. The nurses conducted physical examinations upon admission, patient assessments that included the general status regarding activities of daily living, and re-assessment after providing interventions such as pain medication. Nursing documentation was fairly thorough. However, improvements could be made in documenting ongoing assessment of peripherally inserted central catheter (PICC) intravenous lines (case 1), potential for falls (case 2), fluid retention status (case 5), and wound condition (case 21).

Access to Care

At COR, the OIG reviewed the care in specialized medical housing for four admissions and 71 follow-up visits. There were three significant missed or late follow-up visits:

- In case 1, the provider follow-up visit was one month overdue for this patient receiving care for his stroke and other medical problems.
- Also in case 1, another provider follow-up visit was one month overdue.
- In case 21, a patient was seen seven days late after returning from an outside emergency department for seizure management.

Clinician Onsite Inspection

During the onsite visit, the OIG clinicians found the CTC to be well staffed with experienced nurses, providers, and sufficient custody staff to support the timely provision of needed care to patients. There was one physician assigned full time to the CTC, with other providers assisting as needed. This provided excellent continuity of patient care in this CTC with 25 medical beds. There was also 24-hour RN coverage. Patients were only admitted with a physician's order. The staff was familiar with the patients' right to refuse and generally contacted the physician if the patient refused care. In the Cycle 4 inspection, COR was found deficient for the lack of nursing care plans. However, nursing care plans were documented in all CTC admissions reviewed in Cycle 5.

Case Review Conclusion

The OIG clinicians found improved care in specialized medical housing since Cycle 4, and rated this indicator *adequate.*

Compliance Testing Results

The institution received and *adequate* compliance score of 76.7 percent in the *Specialized Medical Housing* indicator, with *proficient* scores in two tests, as follows:

- Nursing staff completed an initial assessment for fifteen of sixteen sampled patients on the day the patient was admitted to the specialized medical housing (94 percent). For one OHU admission, there was no RN initial assessment found in the electronic medical record (MIT 13.001).
- Among ten sampled patients admitted to the CTC, nine (90 percent) were provided timely, complete history and physical examinations by a provider within 24 hours of admission. One patient's examination was completed one day late (MIT 13.002).

COR showed room for improvement in two areas:

- When the OIG tested whether providers completed Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes for patients at required intervals, providers were compliant for only 9 of 16 sampled patients (56 percent). Two patients had provider notes that were 14 days late, and providers did not complete SOAPE notes for five sampled patients (MIT 13.003).

- When inspectors observed the working order of call buttons in patient rooms in the CTC and the OHU, inspectors 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. However in the OHU, staff did not maintain a call system log to confirm if daily tests were performed and logged, resulting in a score of 67 percent on this test (MIT 13.101).

14 — *SPECIALTY SERVICES*

This indicator focuses on specialist care from the time a request for services or physician's order for specialist care is completed to the time of receipt of related recommendations from specialists. This indicator also evaluates the providers' timely review of specialist records and documentation reflecting the patients' care plans, including course of care when specialist recommendations were not ordered, and whether the results of specialists' reports are communicated to the patients. For specialty services denied by the institution, the OIG determines whether the denials are timely and appropriate, and whether the patient is updated on the plan of care.

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

For this indicator, the OIG's case review and compliance review process yielded different results, with the case review giving a *proficient* rating and the compliance review resulting in an *adequate* score. The OIG's internal review process considered those factors that led to both scores and ultimately rated this indicator *adequate*. The main factors preventing the *proficient* overall rating was the compliance results found some poor reviews of routine specialty reports and late denials of specialty services.

Case Review Results

The OIG clinicians reviewed 113 events related to specialty services, which included 66 specialty consultations and procedures, 27 provider encounters, and 20 nursing encounters. Twelve minor deficiencies were found in this category. The OIG rated the *Specialty Services* indicator at COR *proficient.*

Access to Specialty Services

COR did well providing access to specialty care. There were two minor deficiencies:

- In case 21, the patient had an offsite surgical procedure to remove an implanted heart monitor. There was no provider follow-up visit to check on the patient until 11 days later. During that encounter, the provider failed to address the procedure.

- In case 36, the patient with chronic pain refused an offsite neurology appointment. The provider was not notified of the patient's refusal.

Nursing Performance

Nursing did well with supporting specialty services. There were two minor deficiencies:

- In case 33, the telemedicine nurse failed to notify the provider about the gastroenterologist's medication recommendations. This resulted in a 13-day delay for medications needed by the patient with inflammatory bowel disease.

- In case 45, the patient had rectal bleeding and an imaging procedure was scheduled, but the patient refused the procedure. Nursing completed the refusal form five days after the refusal.

Provider Performance

Providers did very well with specialty services. No deficiencies were found**.**

Health Information Management

There were eight minor deficiencies regarding health information management in specialty services. Two were when documents were scanned without a provider signature. The others were minor delays in scanning or mislabeling of electronic files. Only one of these errors delayed care, but not significantly:

- In case 33, the gastroenterology consultation report was received 12 days late. This contributed to a delay in starting medications for a patient with inflammatory bowel disease.

Clinician Onsite Inspection

The OIG met with the utilization management RN tasked with specialty services at COR. This person had started in this position approximately eight months earlier. This nurse identified a high workload, which prevented effective care in this area. The nurse requested and obtained an office technician to assist with the workload. In addition, moving a previously relocated fax machine back to the specialty services area greatly improved operational efficiency. During the next eight months, the two problem areas that led to the poor rating of this indicator in Cycle 4, delay of specialty appointments and missing reports, were corrected.

Case Review Conclusion

The OIG rated the *Specialty Services* indicator at COR *proficient*.

Compliance Testing Results

The institution received an *adequate* compliance score of 77.3 percent in the *Specialty Services* indicator, with *proficient* scores in the following three areas:

- COR provided routine specialty service appointments to 14 of 15 patients tested within the required time frame (93 percent). For one patient, there was no evidence found that the patient received the specialty service (MIT 14.003).

- Providers timely received and reviewed the specialists' reports for 12 of the 13 applicable patients sampled (92 percent). For one patient, the provider received and reviewed the report 14 days late (MIT 14.002).

- When patients are approved or scheduled for specialty services appointments at one institution and then transfer to another institution, policy requires that the receiving institution ensure that the patient's appointment is timely rescheduled or scheduled, and held. Eighteen of the 20 patients sampled (90 percent) received their specialty services appointment timely. Two patients received their specialty appointment 56 and 65 days late (MIT 14.005).

Two tests received *adequate* scores in this indicator:

- Twelve of the 15 patients sampled (80 percent) received or refused their high priority specialty services appointment or service within 14 calendar days of the provider's order. Three patients received their specialty service from one to six days late (MIT 14.001).

- For 18 applicable patients sampled who had a specialty service denied by COR's health care management, 14 patients (78 percent) received timely notification of the denied service, including a provider meeting with the patient within 30 days to discuss alternate treatment strategies. For two sampled patients, the specialty service denial notification occurred 21 and 26 days late. For the remaining two sampled patients, there was no evidence of provider follow-up to discuss the denial (MIT 14.007).

The following tests received *inadequate* scores and showed areas for improvement:

- Providers timely received and reviewed 3 of the 8 applicable routine specialists' reports that inspectors sampled (38 percent). For five patients, providers reviewed the reports from one to ten days late (MIT 14.004).

- The institution' administration timely denied providers' specialty service requests for 14 of 20 patients sampled (70 percent). Four of the specialty service request denials were between one and 6 days late. Two other denials were issued 15 and 25 days late (MIT 14.006).

15 — *ADMINISTRATIVE OPERATIONS (SECONDARY)*

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(65.2%)
Overall Rating:
Inadequate

This indicator focuses on the institution's administrative health care oversight functions. The OIG evaluates whether the institution promptly processes patient medical appeals and addresses all appealed issues. Inspectors also verify that the institution follows reporting requirements for adverse/sentinel events and patient deaths. 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, OIG examines whether the institution adequately manages its health care staffing resources by evaluating whether job performance reviews are completed as required; specified staff possess current, valid credentials and professional licenses or certifications; nursing staff receive new employee orientation training and annual competency testing; and clinical and custody staff have current medical emergency response certifications. The *Administrative Operations* indicator is a secondary indicator, and, therefore, was not relied on for the overall score for the institution.

Compliance Testing Results

The institution received an *inadequate* compliance score of 65.2 percent in the *Administrative Operations* indicator, showing room for improvement in the following areas:

- The pharmacist in charge (PIC) at COR was not able to describe the Drug Enforcement Agency (DEA) registration process for COR providers, and the PIC only provided an outdated DEA registration list. The PIC relied on the CEO's assistant to monitor DEA registration compliance. As a result, COR received a zero on this test (MIT 15.110).

- COR's two nurses hired within the most recent 12 months did not receive timely new employee orientation trainings. They each received their orientation ten days late, for a score of zero (MIT 15.111).

- The OIG reviewed data received from the institution to determine if COR timely processed at least 95 percent of its monthly patient medical appeals during the most recent 12 month period. COR timely processed only one of the 12 months' appeals reviewed (8 percent). Of the 11 months with more than 5 percent of medical appeals in overdue status, the percentages late ranged from 4 to 100 percent (MIT 15.001).

- The OIG reviewed documentation for 12 emergency medical response incidents addressed by the institution's EMRRC during the prior six-month period; only three (25 percent) were

compliant because the required EMRRC Event Checklist forms were not fully completed (MIT 15.005).

- COR's local governing body met quarterly during the four-quarter period ending January 2017, but only one of the quarter's corresponding meeting minutes were sufficiently detailed and timely approved (25 percent). Three of the four quarterly meeting minutes were not approved timely by either the CEO or the warden (MIT 15.006).

- Inspectors reviewed six recent months' QMC meeting minutes and confirmed that the QMC evaluated program performance and took action when the committee identified improvement opportunities. Four of the six meetings (67 percent) were held properly; in the other two meetings, subcommittee reports were not submitted and no scorecard performance data was provided (MIT 15.003).

- COR had three patient deaths occur during the OIG's sample test period; for one of the deaths, the institution did not timely notify the CCHCS Death Review Unit. The notification was required to be made by noon on the business day following the date of death. As a result, the institution received a score of 67 percent on this test (MIT 15.103).

- Five of seven COR providers had a proper clinical performance appraisal completed by their supervisor (71 percent). Two other providers did not have either timely or properly completed appraisals, including the following (MIT 15.106):

    - One provider's evaluation was overdue by 48 calendar days.

    - Another provider's evaluation had not been completed since the provider passed probation. In addition, the provider's review packet did not include a recent Unit Health Clinic Appraisal, a core competency-based evaluation, or a 360 Degree evaluation.

One test in this indicator scored in the *adequate* range:

- When inspectors examined records to determine if nursing supervisors were completing the required number of monthly case reviews on subordinate nurses as well as discussing the results of those reviews, four of five sampled nurse supervisors properly completed their reviews. As a result, COR scored 80 percent on this test. One nursing supervisor did not complete the required number of nursing reviews for the month of January 2017 (MIT 15.104).

The institution received *proficient* scores of 100 percent on seven tests in this indicator, as follows:

- COR took adequate steps to ensure the accuracy of its Dashboard data reporting (MIT 15.004).

- Inspectors reviewed drill packages for three medical emergency response drills conducted in the prior quarter, and all contained required summary reports and related documentation. In addition, the drills included participation by both health care and custody staff (MIT 15.101).

- Based on a sample of ten second-level medical appeals, the institution's responses addressed all of the patients' appealed issues (MIT 15.102).

- All ten nurses' records 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 PIC were current with their professional licenses and certification requirements (MIT 15.107, 15.109).

- All active duty providers, nurses, and custody staff were current with their emergency response certifications (MIT 15.108).

Non-Scored Results

- The OIG gathered non-scored data regarding the completion of death review reports by CCHCS's Death Review Committee (DRC). Three deaths occurred during the OIG's review period, two unexpected (Level 1) deaths and one expected (Level 2) death. The DRC was required to complete its death review summary report within 60 days from the date of death for the Level 1 death and within 30 days from the date of death for the Level 2 deaths; the reports should then have been submitted to the institution's chief executive officer (CEO) within seven calendar days thereafter. However, for the two Level 1 deaths, the DRC completed its reports 46 and 74 days late (106 and 134 days after death) and submitted them to COR's CEO 2 and 13 days late; for the one Level 2 death, the DRC completed its report 52 days late (82 days after death) and submitted it to the CEO 12 days late (MIT 15.998).

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

RECOMMENDATIONS

No specific recommendations.

POPULATION-BASED METRICS

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

The Healthcare Effectiveness Data and Information Set is a set of standardized performance measures developed by the National Committee for Quality Assurance with input from over 300 organizations representing every sector of the nation's health care industry. It is used by over 90 percent of the nation's health plans as well as many leading employers and regulators. It was designed to ensure that the public (including employers, the Centers for Medicare and Medicaid Services, and researchers) has the information it needs to accurately compare the performance of health care plans. Healthcare Effectiveness Data and Information Set data is often used to produce health plan report cards, analyze quality improvement activities, and create performance benchmarks.

Methodology

For population-based metrics, the OIG used a subset of HEDIS measures applicable to the CDCR patient population. Selection of the measures was based on the availability, reliability, and feasibility of the data required for performing the measurement. The OIG collected data utilizing various information sources, including the eUHR, the Master Registry (maintained by CCHCS), as well as a random sample of patient records analyzed and abstracted by trained personnel. Data obtained from the CCHCS Master Registry and Diabetic Registry was not independently validated by the OIG and is presumed to be accurate. For some measures, the OIG used the entire population rather than statistically random samples. While the OIG is not a certified HEDIS compliance auditor, the OIG uses similar methods to ensure that measures are comparable to those published by other organizations.

Comparison of Population-Based Metrics

For the California State Prison, Corcoran, nine HEDIS measures were selected and are listed in the following *COR 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. COR outperformed two entities in the diabetic measures selected, but scored lower than some of the other entities in diabetic monitoring, blood pressure control, and conducting required dilated eye exams for diabetic patients.

When compared statewide, COR outperformed Med-Cal in all five diabetic measures. The institution also outperformed Kaiser Permanente in three of the five measures, scoring lower than Kaiser, both North and South regions, in diabetic blood pressure control, and lower than Kaiser, South, in diabetic eye exams. When compared nationally, COR outperformed Medicaid, Medicare, and commercial health plans in all five diabetic measures. COR outperformed or closely matched the U.S Department of Veterans Affairs (VA) in all applicable measures except diabetic eye exams, in which it scored 20 percentage points lower than the VA. However, inspectors noted that 20 percent of COR's sampled patients were offered the eye exams but refused; these refusals adversely affected the institution's score in this measure.

Immunizations

Comparative data for immunizations was only fully available for the VA and partially available for Kaiser, commercial plans, Medicaid, and Medicare. With respect to administering influenza vaccinations to younger adults, COR outperformed Medicaid. However, COR scored lower than Kaiser, both North and South, commercial health plans, and the VA. The 55 percent patient refusal rate negatively affected the institution's score in this measure. However, COR outperformed both Medicare and the VA in influenza vaccinations for older adults. With regard to administering pneumococcal vaccines to older adults, COR scored higher than Medicare but slightly lower than the VA.

Cancer Screening

With respect to colorectal cancer screening, COR scored lower than all reporting entities except commercial health plans. Similar to the immunization measures, patient refusals (28 percent) negatively affected the institution's score.

Summary

The population-based metrics performance of COR reflected an adequate chronic care program in comparison to the other statewide and national health care plans. The institution has an opportunity to improve its scores for immunizations and colorectal cancer screening through patient education about the benefits of these preventive services.

COR Results Compared to State and National HEDIS Scores

Clinical Measures	California					National		
	COR Cycle 5 Results[1]	HEDIS Medi-Cal 2015[2]	HEDIS Kaiser (No. CA) 2016[3]	HEDIS Kaiser (So.CA) 2016[3]	HEDIS Medicaid 2016[4]	HEDIS Com-mercial 2016[4]	HEDIS Medicare 2016[4]	VA Average 2015[5]
Comprehensive Diabetes Care								
HbA1c Testing (Monitoring)	**97%**	86%	94%	94%	86%	90%	93%	98%
Poor HbA1c Control (>9.0%)[6, 7]	**10%**	39%	20%	23%	45%	34%	27%	19%
HbA1c Control (<8.0%)[6]	**80%**	49%	70%	63%	46%	55%	63%	-
Blood Pressure Control (<140/90)[6]	**78%**	63%	83%	83%	59%	60%	62%	74%
Eye Exams	**69%**	53%	68%	81%	53%	54%	69%	89%
Immunizations								
Influenza Shots - Adults (18–64)	**45%**	-	56%	57%	39%	48%	-	55%
Influenza Shots - Adults (65+)	**77%**	-	-	-	-	-	72%	76%
Immunizations: Pneumococcal	**87%**	-	-	-	-	-	71%	93%
Cancer Screening								
Colorectal Cancer Screening	**65%**	-	79%	82%	-	63%	67%	82%

1. Unless otherwise stated, data was collected in Month 2017 by reviewing medical records from a sample of COR'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 2015 *State of Health Care Quality Report*, available on the NCQA website: www.ncqa.org. The results for commercial plans were based on data received from various health maintenance organizations.

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

6. For this indicator, the entire applicable COR 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 State Prison, Corcoran (COR) Range of Summary Scores: 43.00% - 87.04%	
Indicator	**Compliance Score (Yes %)**
1–***Access to Care***	81.07%
2–***Diagnostic Services***	74.76%
3–***Emergency Services***	Not Applicable
4–***Health Information Management (Medical Records)***	67.23%
5–***Health Care Environment***	70.65%
6–***Inter- and Intra-System Transfers***	43.00%
7–***Pharmacy and Medication Management***	56.09%
8–***Prenatal and Post-Delivery Services***	Not Applicable
9–***Preventive Services***	87.04%
10–***Quality of Nursing Performance***	Not Applicable
11–***Quality of Provider Performance***	Not Applicable
12–***Reception Center Arrivals***	Not Applicable
13–***Specialized Medical Housing (OHU, CTC, SNF, Hospice)***	76.67%
14–***Specialty Services***	77.27%
15–***Administrative Operations***	65.19%

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?	15	10	25	60.00%	0
1.002	For endorsed patients received from another CDCR institution: If the nurse referred the patient to a provider during the initial health screening, was the patient seen within the required time frame?	14	11	25	56.00%	0
1.003	Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received?	33	7	40	82.50%	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?	37	3	40	92.50%	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?	9	5	14	64.29%	26
1.006	Sick call follow-up appointments: If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified?	5	0	5	100%	35
1.007	Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame?	22	3	25	88.00%	0
1.008	Specialty service follow-up appointments: Do specialty service primary care physician follow-up visits occur within required time frames?	19	3	22	86.36%	8
1.101	Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms?	6	0	6	100%	0
Overall percentage:					**81.07%**	

Reference Number	2–*Diagnostic Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
2.001	Radiology: Was the radiology service provided within the time frame specified in the provider's order?	9	0	9	100%	1
2.002	Radiology: Did the primary care provider review and initial the diagnostic report within specified time frames?	2	8	10	20.00%	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
2.004	Laboratory: Was the laboratory service provided within the time frame specified in the provider's order?	9	1	10	100%	0
2.005	Laboratory: Did the primary care provider review and initial the diagnostic report within specified time frames?	10	0	10	100%	0
2.006	Laboratory: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	10	0	10	100%	0
2.007	Pathology: Did the institution receive the final diagnostic report within the required time frames?	7	3	10	70.00%	0
2.008	Pathology: Did the primary care provider review and initial the diagnostic report within specified time frames?	4	4	8	50.00%	2
2.009	Pathology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	3	4	7	42.86%	3
Overall percentage:					**74.76%**	

3–*Emergency Services*

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

Reference Number	4–*Health Information Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated healthcare documents (provider progress notes) scanned within 3 calendar days of the patient encounter date?	19	1	20	95.00%	0
4.002	Are dictated/transcribed documents scanned into the patient's electronic health record within five calendar days of the encounter date?	10	1	11	90.91%	0
4.003	Are High-Priority specialty notes (either a Form 7243 or other scanned consulting report) scanned within the required time frame?	12	6	18	66.67%	0
4.004	Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge?	18	2	20	90.00%	0
4.005	Are medication administration records (MARs) scanned into the patient's electronic health record within the required time frames?	12	3	15	80.00%	0
4.006	During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files?	0	24	24	0.00%	0
4.007	For patients discharged from a community hospital: Did the preliminary hospital discharge report include key elements and did a primary care provider review the report within three calendar days of discharge?	12	13	25	48.00%	0
Overall percentage:					**67.23%**	

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	85.71%	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	92.86%	0
5.103	Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	12	2	14	85.71%	0
5.104	Does clinical health care staff adhere to universal hand hygiene precautions?	11	3	14	78.57%	0
5.105	Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	12	2	14	85.71%	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	0.00%	0
5.107	Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	12	2	14	85.71%	0
5.108	Do clinic common areas and exam rooms have essential core medical equipment and supplies?	4	10	14	28.57%	0
5.109	Do clinic common areas have an adequate environment conducive to providing medical services?	14	0	14	100%	0
5.110	Do clinic exam rooms have an adequate environment conducive to providing medical services?	9	5	14	64.29%	0
5.111	Emergency response bags: Are TTA and clinic emergency medical response bags inspected daily and inventoried monthly, and do they contain essential items?	7	3	10	70.00%	4
Overall percentage:					**70.65%**	

Reference Number	6–*Inter- and Intra-System Transfers*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
6.001	For endorsed patients received from another CDCR institution or COCF: Did nursing staff complete the initial health screening and answer all screening questions on the same day the patient arrived at the institution?	7	18	25	28.00%	0
6.002	For endorsed patients received from another CDCR institution or COCF: When required, did the RN complete the assessment and disposition section of the health screening form; refer the patient to the TTA, if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening?	13	12	25	52.00%	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?	12	8	20	60.00%	5
6.004	For patients transferred out of the facility: Were scheduled specialty service appointments identified on the patient's health care transfer information form?	15	5	20	75.00%	0
6.101	For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents?	0	7	7	0.00%	0
Overall percentage:					**43.00%**	

Reference Number	*7–Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.001	Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows?	8	7	15	53.33%	10
7.002	Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames?	25	0	25	100%	0
7.003	Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames?	12	13	25	48.00%	0
7.004	For patients received from a county jail: Were all medications ordered by the institution's reception center provider administered, made available, or delivered to the patient within the required time frames?	Not Applicable				
7.005	Upon the patient's transfer from one housing unit to another: Were medications continued without interruption?	17	8	25	68.00%	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?	2	8	10	20.00%	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?	4	8	12	33.33%	2
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?	8	5	13	61.54%	1
7.103	All clinical and medication line storage areas for non-narcotic medications: Does the institution properly store non-narcotic medications that require refrigeration in assigned clinical areas?	11	2	13	84.62%	1
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	2	7	71.43%	7
7.105	Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients?	7	0	7	100%	7
7.106	Medication preparation and administration areas: Does the Institution employ appropriate administrative controls and protocols when distributing medications to patients?	4	3	7	57.14%	7
7.107	Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and satellite pharmacies?	0	1	1	0.00%	0

Reference Number	7–*Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.108	Pharmacy: Does the institution's pharmacy properly store non-refrigerated medications?	0	1	1	0.00%	0
7.109	Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications?	1	0	1	100%	0
7.110	Pharmacy: Does the institution's pharmacy properly account for narcotic medications?	1	0	1	100%	0
7.111	Does the institution follow key medication error reporting protocols?	0	25	25	0.00%	0
Overall percentage:					**56.09%**	

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?	8	0	8	100%	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?	8	0	8	100%	0
9.003	Annual TB Screening: Was the patient screened for TB within the last year?	14	16	30	46.67%	0
9.004	Were all patients offered an influenza vaccination for the most recent influenza season?	25	0	25	100%	0
9.005	All patients from the age of 50 - 75: Was the patient offered colorectal cancer screening?	23	2	25	92.00%	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?	24	0	24	100%	1
9.009	Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	12	5	17	70.59%	0
Overall percentage:					**87.04%**	

10–*Quality of Nursing Performance*

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

11–*Quality of Provider Performance*

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

12–*Reception Center Arrivals*

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

Reference Number	13–*Specialized Medical Housing*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient on the day of admission, or within eight hours of admission to CMF's Hospice?	15	1	16	93.75%	0
13.002	For CTC and SNF only: Was a written history and physical examination completed within the required time frame?	9	1	10	90.00%	6
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?	9	7	16	56.25%	0
13.101	For OHU and CTC Only: Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter patient's cells?	2	1	3	66.67%	0
Overall percentage:					**76.67%**	

Reference Number	14–*Specialty Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service?	12	3	15	80.00%	0
14.002	Did the primary care provider review the high-priority specialty service consultant report within the required time frame?	12	1	13	92.31%	2
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	93.33%	0
14.004	Did the primary care provider review the routine specialty service consultant report within the required time frame?	3	5	8	37.50%	7
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?	18	2	20	90.00%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	14	6	20	70.00%	0
14.007	Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame?	14	4	18	77.78%	2
Overall percentage:					**77.27%**	

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?	1	11	12	8.33%	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?	4	2	6	66.67%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	1	0	1	100%	0
15.005	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	3	9	12	25.00%	0
15.006	For institutions with licensed care facilities: Does the Local Governing Body (LGB), or its equivalent, meet quarterly and exercise its overall responsibilities for the quality management of patient health care?	1	3	4	25.00%	0
15.101	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?	3	0	3	100%	0
15.102	Did the institution's second level medical appeal response address all of the patient's appealed issues?	10	0	10	100%	0
15.103	Did the institution's medical staff review and submit the initial inmate death report to the Death Review Unit in a timely manner?	2	1	3	66.67%	0
15.104	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	4	1	5	80.00%	0
15.105	Are nursing staff who administer medications current on their clinical competency validation?	10	0	10	100%	0
15.106	Are structured clinical performance appraisals completed timely?	5	2	7	71.43%	0
15.107	Do all providers maintain a current medical license?	8	0	8	100%	0
15.108	Are staff current with required medical emergency response certifications?	2	0	2	100%	1
15.109	Are nursing staff and the Pharmacist-in-Charge current with their professional licenses and certifications, and is the pharmacy licensed as a correctional pharmacy by the California State Board of Pharmacy?	6	0	6	100%	0

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?	0	1	1	0.00%	0
15.111	Are nursing staff current with required new employee orientation?	0	3	3	0.00%	0
Overall percentage:					**65.19%**	

APPENDIX B — CLINICAL DATA

Table B-1: COR Sample Sets

Sample Set	Total
Anticoagulation	3
Death Review/Sentinel Events	3
Diabetes	3
Emergency Services – CPR	1
Emergency Services – Non-CPR	3
High Risk	5
Hospitalization	4
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	24
Specialty Services	4
	56

Table B-2: COR Chronic Care Diagnoses

Diagnosis	Total
Anemia	4
Anticoagulation	3
Arthritis/Degenerative Joint Disease	3
Asthma	14
COPD	6
Cancer	3
Cardiovascular Disease	5
Chronic Kidney Disease	1
Chronic Pain	14
Cirrhosis/End Stage Liver Disease	7
Diabetes	13
Gastroesophageal Reflux Disease	9
Hepatitis C	27
Hyperlipidemia	17
Hypertension	25
Mental Health	11
Seizure Disorder	6
Sickle Cell Anemia	1
Sleep Apnea	1
Thyroid Disease	4
	174

Table B-3: COR Event – Program

Program	Total
Diagnostic Services	115
Emergency Care	80
Hospitalization	53
Intra-System Transfers In	6
Intra-System Transfers Out	3
Not Specified	4
Outpatient Care	458
Specialized Medical Housing	252
Specialty Services	132
	1,103

Table B-4: COR Review Sample Summary

	Total
MD Reviews Detailed	25
MD Reviews Focused	2
RN Reviews Detailed	17
RN Reviews Focused	30
Total Reviews	74
Total Unique Cases	56
Overlapping Reviews (MD & RN)	18

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

California State Prison, Corcoran (COR)

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) 40	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 (20)	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	(11)	OIG Q: 1.001	• Dictated documents • First 20 IPs selected
MIT 4.003	(18)	OIG Qs: 14.002 & 14.004	• Specialty documents • First 10 IPs for each question
MIT 4.004	(20)	OIG Q: 4.007	• Community hospital discharge documents • First 20 IPs selected
MIT 4.005	(15)	OIG Q: 7.001	• MARs • First 20 IPs selected
MIT 4.006	(24)	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (12 or more = No)
MIT 4.007	Returns From Community Hospital (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 (9)	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 *N/A at this institution*	OIG Q: 12.001	• See ***Reception Center Arrivals***
MIT 7.005	Intra-Facility Moves (25)	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • **Randomize**
MIT 7.006	En Route (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 (20)	Onsite active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in isolation units
Prenatal and Post-Delivery Services			
MIT 8.001-007	Recent Deliveries *N/A at this institution*	OB Roster	• Delivery date (2–12 months) • **Most recent** deliveries (within date range)
	Pregnant Arrivals *N/A at this institution*	OB Roster	• Arrival date (2–12 months) • **Earliest** arrivals (within date range)

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Preventive Services			
MITs 9.001–002	TB Medications (8)	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • **Randomize**
MIT 9.003	TB Code 22, Annual TST (15)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (22) • **Randomize**
	TB Code 34, Annual Screening (15)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (34) • **Randomize**
MIT 9.004	Influenza Vaccinations (25)	SOMS	• Arrival date (at least 1 year prior to inspection) • **Randomize** • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening (25)	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • **Randomize**
MIT 9.006	Mammogram *N/A at this institution*	SOMS	• Arrival date (at least 2 yrs prior to inspection) • Date of birth (age 52–74) • **Randomize**
MIT 9.007	Pap Smear *N/A at this institution*	SOMS	• Arrival date (at least three yrs prior to inspection) • Date of birth (age 24–53) • **Randomize**
MIT 9.008	Chronic Care Vaccinations (25)	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • **Randomize** • Condition must require vaccination(s)
MIT 9.009	Valley Fever (number will vary)	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • **All**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Reception Center Arrivals			
MITs 12.001–008	RC *N/A at this institution*	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • **Randomize**
Specialized Medical Housing			
MITs 13.001–004	CTC & OHU (16)	CADDIS	• Admit date (1–6 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • **Randomize**
MIT 13.101	Call Buttons CTC & 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 (20)	InterQual	• Review date (3–9 months) • **Randomize**
	 (0)	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 (4)	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 (3)	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.104	RN Review Evaluations (5)	Onsite supervisor periodic RN reviews	• RNs who worked in clinic or emergency setting six or more days in sampled month • **Randomize**
MIT 15.105	Nursing Staff Validations (10)	Onsite nursing education files	• On duty one or more years • Nurse administers medications • **Randomize**
MIT 15.106	Provider Annual Evaluation Packets (7)	Onsite provider evaluation files	• All required performance evaluation documents
MIT 15.107	Provider licenses (8)	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 (3)	OIG summary log - deaths	• Between 35 business days & 12 months prior • CCHCS death reviews

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

September 11, 2017

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

Dear Mr. Wesley:

The purpose of this letter is to inform you that the Office of the Receiver has reviewed the draft report of the Office of the Inspector General (OIG) Medical Inspection Results for California State Prison, Corcoran (COR) conducted from March 2017 to May 2017. California Correctional Health Care Services (CCHCS) acknowledges all OIG findings.

Thank you for preparing the report. Your efforts have advanced our mutual objective of ensuring transparency and accountability in CCHCS operations. If you have any questions or concerns, please contact me at (916) 691-9573.

Sincerely,

Janet Lewis

JANET LEWIS
Deputy Director
Policy and Risk Management Services
California Correctional Health Care Services

cc: Clark Kelso, Receiver
Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Richard Kirkland, Chief Deputy Receiver
Ryan Baer, Senior Deputy Inspector General, OIG
Stephen Tseng, M.D., Chief Physician and Surgeon, OIG
Penny Horper, R.N., MSN, CPHQ, Nurse Consultant Program Review, OIG
Yulanda Mynhier, Director, Health Care Policy and Administration, CCHCS
R. Steven Tharratt, M.D., MPVM, FACP, Director, Health Care Operations, CCHCS
Roscoe Barrow, Chief Counsel, CCHCS Office of Legal Affairs, CCHCS
Renee Kanan, M.D., Deputy Director, Medical Services, CCHCS
Jane Robinson, R.N., Deputy Director, Nursing Services, CCHCS
Annette Lambert, Deputy Director, Quality Management, Clinical Information and Improvement Services, CCHCS
Christopher Podratz, Regional Health Care Executive, Region III, CCHCS
Felix Igbinosa, M.D., Regional Deputy Medical Executive, Region III, CCHCS
Steven A. Jones, R.N., Regional Nursing Executive, Region III, CCHCS
Celia Bell, Chief Executive Officer, COR
Lara Saich, Chief, Health Care Regulations and Policy Section, CCHCS
Dawn DeVore, Staff Services Manager II, Program Compliance Section, CCHCS
Amanda Oltean, Staff Services Manager I, Program Compliance Section, CCHCS