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Office of the Inspector General

California Rehabilitation Center
Medical Inspection Results
Cycle 5

October 2017

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

Office of the Inspector General
CALIFORNIA REHABILITATION CENTER
Medical Inspection Results
Cycle 5

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FOREWORD

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

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

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

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

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EXECUTIVE SUMMARY

OVERALL RATING:

Inadequate

The OIG performed its Cycle 5 medical inspection at CRC from April to May 2017. The inspection included in-depth reviews of 44 patient files conducted by clinicians, as well as reviews of documents from 367 patient files, covering 86 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 CRC 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 *CRC Executive Summary Table* on the following page identifies the applicable individual indicators and scores for this institution.

CRC Executive Summary Table

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

*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 1,015 patient care events.[1] Of the 13 indicators applicable to CRC, 10 were evaluated by clinician case review; 9 were *adequate*, and one was *inadequate.* When determining the overall adequacy of care, the OIG paid particular attention to the clinical nursing and provider quality indicators, as adequate health care staff can sometimes overcome suboptimal processes and programs. However, the opposite is not true; inadequate health care staff cannot provide adequate care, even though the established processes and programs onsite may be adequate. The OIG clinicians identify inadequate medical care based on the risk of significant harm to the patient, not the actual outcome.

Program Strengths — Clinical

- As in Cycle 4, CRC continued to provide excellent diagnostic services. During the period reviewed, diagnostic tests were promptly performed, test results were timely reviewed by providers, and patients were informed of their results promptly.

- The institution continued to provide high-quality emergency services, as it did in Cycle 4.

- Nursing performance, as a whole, had improved from the previous Cycle 4 medical inspections. The nursing staff functioned as a highly-organized team to address patient care at CRC.

- Nursing administration was proactive and actively engaged in training and educating the nursing staff.

- CRC was adequately staffed with physician providers. Access to specialists and hospitals was readily available and in close proximity.

Program Weaknesses — Clinical

- Provider care was dichotomous. There were several seasoned providers administering excellent quality care primarily to low or moderate medical risk patients. These providers advocated for the care of CRC patients to be a model for best practice medicine. However, there was another set of providers at CRC who managed the more complex patients. These providers superficially reviewed medical documentation, poorly documented important clinical decisions, and performed at a substandard level.

- Diabetic care continued to be a concern at CRC because providers failed to assertively manage their diabetic patients.

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

- CRC's provider leadership failed to appropriately manage the dichotomy of patient care within the individual medical units. Administration exacerbated this problem by assigning new providers to the medical unit with the most complex patients without creating a system to monitor the new doctors or provide guidance and education of institutional medicine.

- Provider administration failed to conform to the State of California's Prison Health Care Services Pain Management Guidelines. Monitoring of chronic narcotic pain medication failed to occur after the new electronic health records system (EHRS) was implemented in October of 2016.

- Often, nurses triaged patients without performing face-to-face assessments. Patient visits were deferred to providers without prior nursing assessment. This ineffective process was first identified during the Cycle 4 medical inspections, during which the OIG recommended auditing and correcting this process.

Compliance Testing Results

Of the 13 health care indicators applicable to CRC, 10 were evaluated by compliance inspectors.[2] They rated two indicators *proficient*, two *adequate*, and six *inadequate*. There were 86 individual compliance questions within those ten indicators, generating 1,053 data points that tested CRC's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[3] Those 86 questions are detailed in *Appendix A — Compliance Test Results*.

Program Strengths — Compliance

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

- Generally, patients had very good access to medical care, including requests for face-to-face nurse appointments, and provider follow-ups after discharge from a community hospital.

- When patients transferred to CRC from another CDCR institution, nursing staff completed the assessment and disposition sections of the Initial Health Screening form (CDCR Form 7277) properly and within required time frames.

- The institution's pharmacy did well with the timely administration and adequate delivery of medications for patients with new medication orders and patients transferred from one housing unit to another within the institution.

[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.

- CRC was proficient in offering and providing preventive medical services to its patients, including tuberculosis (TB) medication administration and annual screenings, as well as influenza immunizations and colorectal cancer screenings.

Program Weaknesses — Compliance

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

- CRC had issues with the management of its health care information. Problems included poor labeling and filing of documents into patients' charts, and providers not timely reviewing patient hospital discharge reports.

- The institution did not properly store non-narcotic medications, both refrigerated and non-refrigerated.

- The institution's providers did a poor job reviewing high-priority and routine specialty service reports when the institution received the report. Also, CRC did not provide or provided the specialty service late for many sampled patients who arrived at CRC from another institution with a previously approved specialty service appointment.

- The administrative health care oversight functions of the institution failed to properly address a number of issues, including the timely processing of patient appeals, ensuring the accuracy of its CCHCS Dashboard data, and documentary review of emergency response incidents by the institution's Emergency Medical Response Review Committee.

Recommendations

Based on the results of the Cycle 5 medical inspection at CRC, the OIG recommends the following:

- The OIG continues to recommend CRC scan all future radiology reports into the patient's electronic medical record, and CCHCS revise its radiological report scanning policy.

- The OIG recommends CRC focus on improving communication during huddle meetings to share information on patients transferred. Both verbal and written communication templates could be developed to cover clinical details, such as the patient's vital signs and nursing assessment on the transferred patients. In addition, the provider reviewing the previous day's on-call work could use a comprehensive on-call provider note guide instead of a notepad to ensure all relevant information is covered.

- The OIG recommends nursing leadership assess their current sick call audit selection process to include a nursing sick call triage to aid patients in the absence of nursing face-to-face encounters.

- The OIG recommends the medical leadership appropriately match the experience and skill of providers to the level of complexity of CRC's patient population.

- The OIG recommends the medical leadership provide additional provider training and monitoring for diabetic and opioid medication management.

Population-Based Metrics

In general, CRC performed well as measured by population-based metrics. In comprehensive diabetes care, CRC performed better than or comparably to other state and national organizations in most measures. With regard to immunization measures and colorectal cancer screenings, CRC's comparative scores were mixed and negatively affected by a significant patient refusal rate. Overall, CRC's performance demonstrated by the population-based metrics indicated that the chronic care program was operating well, and that the institution had an opportunity to improve by providing patient education about the benefits of immunizations and cancer screenings.

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 Rehabilitation Center (CRC) was the ninth 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

California Rehabilitation Center, located in the city of Norco in Riverside County, is a medium Level II correctional facility, which houses over 2,700 inmates. The institution runs multiple clinics where medical staff handle non-urgent requests for health care services. CRC also treats patients requiring urgent or emergent care in its triage and treatment area (TTA) and houses patients who need assistance with activities of daily living in its outpatient housing unit (OHU). In addition, all patients who arrive at or depart from the institution are screened in the prison's receiving and release (R&R) clinic. CRC has been designated by CCHCS as 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 only limited specialty medical services and consultation for a generally healthy patient population.

On May 22, 2017, 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, CRC's vacancy rate among medical managers, primary care providers, supervisors, and rank-and-file nurses was 7 percent in March 2017. The highest vacancy percentage was among primary care providers at 14 percent, which equated to one primary care provider out of seven authorized positions.

CRC 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	6%	7	8%	10	11%	67	75%	89	100%
Filled Positions	5	100%	6	86%	9	90%	63	94%	83	93%
Vacancies	0	0%	1	14%	1	10%	4	6%	6	7%
Recent Hires (within 12 months)	3	60%	1	17%	2	22%	17	27%	23	28%
Staff Utilized from Registry	0	0%	2	33%	0	0%	7	11%	9	11%
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%	0	0%	3	5%	3	4%

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

As of March 20, 2017, the Master Registry for CRC showed that the institution had a total population of 2,747. Within that total population, 0.4 percent was designated as high medical risk, Priority 1 (High 1), and 1.7 percent was designated as high medical risk, Priority 2 (High 2). Patients' assigned risk levels are based on the complexity of their required medical care related to their specific diagnoses, frequency of higher levels of care, age, and abnormal laboratory results and procedures. High 1 has at least two high-risk conditions; High 2 has only one. Patients at high medical risk are more susceptible to poor health outcomes than those at medium or low medical risk. Patients at high medical risk also typically require more health care services than do patients with lower assigned risk levels. The chart below illustrates the breakdown of the institution's medical risk levels at the start of the OIG medical inspection.

CRC Master Registry Data as of March 20, 2017

Medical Risk Level	# of Patients	Percent age
High 1	12	0.4%
High 2	47	1.7%
Medium	1,382	50.3%
Low	1,306	47.5%
Total	**2,747**	**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 addresses the administrative functions that support a health care delivery system. These 15 indicators are identified in the *CRC Executive Summary Table* on page *iv* 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: CRC Sample Sets*, the OIG clinicians evaluated medical charts for 44 unique patients. *Appendix B, Table B–4: CRC Case Review Sample Summary*, clarifies that both nurses and physicians reviewed charts for 11 of those patients, for 55 reviews in total. Physicians performed detailed reviews of 20 charts, and nurses performed detailed reviews of 11

charts, totaling 31 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 24 patients. These generated 1,015 clinical events for review (*Appendix B, Table B–3: CRC 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., five diabetes patients and one anticoagulation patient (*Appendix B, Table B–1: CRC Sample Sets*), the 44 unique patients sampled included patients with 131 chronic care diagnoses, including 13 additional patients with diabetes (for a total of 18) (*Appendix B, Table B–2: CRC 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 sample size of 30 for detailed physician reviews far exceeded the saturation point necessary for an adequate qualitative review. At the end of Cycle 4 inspections, the case review results were reanalyzed using 50 percent of the cases; there were 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. In Cycle 5, for basic institutions with small high-risk populations, case review will use a sample size of detailed physician-reviewed cases 67 percent as large as that used in Cycle 4 (20 physician detailed case reviews). For intermediate institutions and basic institutions housing many high-risk patients, case review physicians will use a sample 83 percent as large as that in Cycle 4 (25 physician detailed case reviews). Finally, for the most medically complex institution, California Health Care Facility (CHCF), the OIG will continue to use a sample size 100 percent as large as that used in Cycle 4.

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 *CRC 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 April to May 2017, registered nurse inspectors attained answers to 86 objective medical inspection test (MIT) questions designed to assess the institution's compliance with critical policies and procedures applicable to the delivery of medical care. To conduct most tests, inspectors randomly selected samples of patients for whom the testing objectives were applicable and reviewed their electronic medical records. In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed health records for 367 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 April 3, 2017, registered nurse field inspectors conducted a detailed onsite inspection of CRC's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,053 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 CRC's plant infrastructure, protocols for tracking medical appeals and local operating procedures, and staffing resources.

For Cycle 5 medical inspection testing, 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 86 questions for the ten 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 CRC, the OIG reviewed some of the compliance testing results, randomly sampled additional patients' records, and obtained CRC 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 *CRC Executive Summary Table* on page *iv* of this report, 13 of the OIG's primary and secondary indicators were applicable to CRC. Of those 13 indicators, 7 were rated by both the case review and compliance components of the inspection, 3 were rated by the case review component alone, and 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 this analysis and the results of the case review and compliance testing, the OIG made a considered and measured opinion that the quality of health care at CRC was ***inadequate***.

Summary of Case Review Results: The clinical case review component assessed ten primary (clinical) indicators applicable to CRC. Of these ten indicators, OIG clinicians rated none *proficient*, nine *adequate*, and one *inadequate*.

The OIG physicians rated the overall adequacy of care for each of the 20 detailed case reviews they conducted. Of these 20 cases, one was *proficient*, 11 were *adequate*, and 8 were *inadequate*. In the 1,015 events reviewed, there were 239 deficiencies, of which 88 were significant and considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

Adverse Events Identified During Case Review: Adverse events are medical errors which are more likely than not to cause grave patient harm. Medical care is a complex and dynamic process with many moving parts, subject to human error even within the best health care organizations. Adverse events are typically identified and tracked by all major health care organizations for the purpose of quality improvement. They are not generally representative of medical care delivered by the organization. The OIG identified adverse events for the dual purposes of quality improvement and the illustration of problematic patterns of practice found during the inspection. Because of the anecdotal description of these events, the OIG cautions against drawing inappropriate conclusions regarding the institution based solely on adverse events. There were no adverse events identified in the case reviews at CRC.

Summary of Compliance Results: The compliance component assessed 10 of the 13 indicators applicable to CRC. Of these ten indicators, OIG inspectors rated two *proficient*, two *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:
Proficient
(86.9%)
Overall Rating:
Adequate

In this indicator, the OIG case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance review resulting in a *proficient* score. The OIG's internal review process considered those factors that led to both scores and ultimately rated this indicator *adequate*. The main factor for the *adequate* rating was due to the number of significant deficiencies noted during the case review, specifically deficiencies related to nursing sick call access and provider follow-up appointments.

Case Review Results

The OIG clinicians reviewed 543 provider, nurse, specialty, and hospital events that required a follow-up appointment. Out of these events, 30 deficiencies were identified, 20 of which were significant, or likely to cause patient harm. Significant deficiencies were identified in cases 2, 9, 10, 11, 12, 14, 18, 23, and 39; twice in cases 3, 8, 19, and 22; and three in case 15.

Provider Follow-up Appointments

There were 199 provider-generated encounters. The OIG discovered two significant deficiencies.

- In case 2, a provider requested a seven-day follow-up to review an urgent cardiac stress test. However, this appointment was delayed an additional seven days.

- In case 8, a provider requested a one-month follow-up for a patient with diabetes that was not controlled, and required changes to the insulin medication. However, this appointment was delayed an additional month.

RN Sick Call Access

The OIG reviewed 69 nursing sick call events and identified 21 deficiencies, of which 11 were significant. The significant deficiencies were related to inappropriate nursing triage. Nursing sick call performance is further discussed in the *Quality of Nursing Performance* indicator.

RN-to-Provider Referrals

Out of the 34 RN-to-provider referrals reviewed, no deficiencies were noted.

RN Follow-up Appointments

Four RN appointments requiring follow-up were reviewed and no deficiencies were identified.

Provider Follow-up after Specialty Services

There were 140 provider follow-up appointments scheduled after specialty services. The appointments were consistently scheduled and often triggered the providers to evaluate the consultant recommendations at the time of the appointment.

Intra-System Transfers

Out of four intra-system transfer events reviewed, two were significant.

- In case 22, the recently transferred patient's rheumatology appointment was delayed three months.

- In case 23, the patient's two-week chronic care provider appointment was delayed an additional two weeks.

Follow-up after Hospitalization

Out of 24 hospitalization follow-up events reviewed, all occurred timely.

Follow-up after Urgent/Emergent Care

Out of 26 follow-up appointments after emergent care reviewed, one significant deficiency was identified.

- In case 5, a provider ordered a follow-up appointment for a patient with chest pain, but the appointment did not occur.

Specialized Medical Housing

OIG reviewed 34 OHU follow-up appointments and found no deficiencies.

Specialty Access and Follow-up

Access to specialty services was adequate. Of the 140 events reviewed in specialty services, seven significant deficiencies were noted. Five of these deficiencies resulted from either delayed or dropped dermatology or rheumatology appointments.

- In case 18, plastic surgery and surgical oncology consultations were delayed two weeks and one month respectively for a patient with suspected cancer.

- In case 19, a post-operative two-day ophthalmology follow-up appointment was delayed an additional three days.

Diagnostic Results Follow-up

Providers reviewed diagnostic results and either used the Notification of Diagnostic Test Results form (CDCR Form 7393) or, if necessary, personally scheduled a follow-up appointment. CRC providers provided appropriate diagnostic follow-up.

Clinician Onsite Inspection

CRC's medical staff was aware of the importance of patient's access to care. This was evident during huddles and discussions with the medical staff. The outpatient clinics reported no current overdue appointments. As a result of the implementation of the Electronic Health Record System (EHRS), the provider's patient load was reduced to allow for more time to document encounters. The facility continued to perform minor procedures, such as ingrown toenail removals, incision and drainage of abscesses, and minor diabetic foot care, thus efficiently avoiding unwarranted specialty consultations. Patients had sufficient access to address their health needs.

Case Review Conclusion

The OIG clinicians rated the *Access to Care* indicator *adequate*.

Compliance Testing Results

The institution received a *proficient* compliance score of 86.9 in the *Access to Care* indicator. CRC performed in the *proficient* range, scoring 100 percent on three of the five following tests:

- Inspectors sampled 32 Health Care Services Requests (CDCR Form 7362) submitted by patients across all facility clinics. Nursing staff reviewed all patient requests on the same day they were received (MIT 1.003).

- All ten sampled patients who were discharged from a community hospital received timely provider follow-up appointments upon their return to CRC (MIT 1.007).

- Patients at CRC had access to health care services requests at all six housing units the OIG inspected (MIT 1.101).

- For 29 of the 32 sampled patients who submitted a health care services request (91 percent), nursing staff timely completed a face-to-face triage encounter. For two patients, the nurse conducted each visit one day late. For one other patient, there was no evidence that a face-to-face encounter with a nurse ever occurred (MIT 1.004).

- Of 32 sampled patients who submitted a sick call request, 8 required a second provider follow-up visit. Seven of these eight patients received their second follow-up appointments

timely (88 percent). One patient received his second follow-up visit five days late (MIT 1.006).

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

- Among 19 sampled health care services requests on which nursing staff referred the patient for a provider appointment, 16 of the patients (84 percent) received a timely appointment. Two other patients received their appointments six and seven days late, and another patient did not receive a provider visit (MIT 1.005).

- OIG inspectors sampled 27 patients who received a high-priority or routine specialty service and determined 22 of these patients (81 percent) received a timely follow-up appointment with a provider. Three patients received their follow-up appointments from one to four days late, one patient received his follow-up visit 61 days late, and one patient did not receive a follow-up visit at all (MIT 1.008).

The institution showed room for improvement on the following two tests:

- Among 24 sampled patients who transferred into CRC from another institution and were referred to a provider based on nursing staff's initial health care screening, only 16 (67 percent) were seen timely. Five patients received their provider appointment from one to 67 days late, and one other patient received his appointment 118 days late. There was no evidence found in two other patients' medical records to indicate they were ever seen (MIT 1.002).

- Among 25 sampled patients who suffered from one or more chronic care conditions, only 18 patients timely received the follow-up appointments their providers ordered (72 percent). Seven other patients received their appointments late or not at all; five patients received follow-up appointments from 10 to 47 days late. For two patients, there was no evidence the appointments occurred at all (MIT 1.001).

2 — *DIAGNOSTIC SERVICES*

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(73.3%)
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 tests ordered and the clinical response to the results.

For this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *adequate* rating, and the compliance testing resulting in an *inadequate* score. One reason for the compliance testing's score of *inadequate* was that many radiology reports were not initialed and dated by the provider as CCHCS policy requires. However, the providers were aware of the results, which did not affect patient care. The compliance score was also close to *adequate*. The OIG inspection team considered both case review and compliance testing results and concluded that the final rating for the *Diagnostic Services* indicator was *adequate*.

Case Review Results

The OIG clinicians reviewed 166 diagnostic events and identified 11 deficiencies, 6 of which were significant. Most of the time, the institution successfully completed and performed timely diagnostic services, such as onsite electrocardiograms (EKGs), X-rays, and labs. Primary care providers reviewed reports timely and quickly notified patients of their test results. Some deficiencies occurred infrequently due to the institution's failure to perform a provider-ordered diagnostic test or failure to scan a diagnostic result into the electronic medical record. However, since the implementation of the EHRS, nearly all new diagnostic electronic test results were found in the electronic medical records.

Test Completion

Most imaging tests were performed and reviewed timely. Two significant deficiencies resulted from the failure or delay of a provider ordered test.

- In case 3, laboratory tests the provider ordered were not performed.
- In case 14, a provider ordered a chest X-ray for the patient, which occurred five weeks late.

Health Information Management

The OIG found four significant deficiencies related to health information management. Three significant deficiencies resulted from imaging reports not being available in the main electronic medical record. For these three reports, providers reviewed the reports, and provided adequate immediate patient care. However, as the reports are not readily available for future health care staff review, the OIG considers this system flaw as a continued patient risk, and identified it as a significant deficiency. The one other significant deficiency resulted from a failure to retrieve important diagnostic laboratory information timely.

- In case 9, a provider reviewed an abnormal laboratory test result 19 days after the test was performed, which was 17 days late.

- In case 14, the provider noted a review of the results from a chest x-ray and a fibroscan test (specialized liver ultrasound), but the results of both were thereafter unavailable in the patient's electronic medical record, resulting in two diagnostic deficiencies.

- In case 20, the provider noted a review of a magnetic resonance image (MRI) test result, but the result was also absent from the patient's primary electronic medical record.

Pathology Services

The review of pathology services showed no deficiencies.

Clinician Onsite Inspection

Providers and nursing staff reported improvement in the timely performance, retrieval, and scanning of the diagnostic test results with the implementation of the EHRS. However, providers expressed concern in their ability to access diagnostic imaging because the picture archiving communication system (PACS) was not available on every computer, and when available, took five to ten minutes to access. Providers felt these barriers could lead to a delay or even a failure to review results.

Case Review Conclusion

CRC staff did well supporting providers and medical staff in radiology and laboratory services, resulting in timely and appropriate diagnostic services. The OIG clinicians rated this indicator as *adequate.*

Compliance Testing Results

The institution received an *inadequate* compliance score of 73.3 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 nine of ten patients sampled (90 percent). One patient received his test one day late (MIT 2.001). On only one of the ten sampled radiology reports (10 percent) did a provider evidence review by initialing and dating, as required by CCHCS policy (MIT 2.002). However, nine of ten patients (90 percent) received timely communication of their test results from providers. But for one patient, there was no evidence found in his electronic medical record that he ever received his test results (MIT 2.003).

Laboratory Services

- All ten of the laboratory services sampled were timely performed (MIT 2.004). For eight of those ten services sampled (80 percent), providers reviewed the laboratory report within the required time frame. In one case, the provider did not note the date the laboratory report was reviewed, and in another case, the provider did not initial the report (MIT 2.005). Providers timely communicated the results of all ten sampled services (MIT 2.006).

Pathology Services

- CRC timely received nine of ten sampled final pathology reports (90 percent). One report was received 33 days late (MIT 2.007). For seven of ten sampled reports (70 percent), providers properly evidenced review of results. Two reports were reviewed 7 and 20 days late, and one report was not reviewed at all (MIT 2.008). Providers timely communicated pathology results to only three of the ten patients sampled (30 percent). For four patients, the provider communicated the results between 2 to 27 days late. For three additional patients, inspectors did not find evidence in the medical record that patients 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 53 urgent or emergent events and identified 19 deficiencies. The majority of deficiencies were related to incomplete nursing assessments and documentation. Five deficiencies were significant. However, during the OIG review period, most patients requiring urgent or emergent services received timely and appropriate care.

CPR Response

There were no CPR events during the review period.

Provider Performance

CRC's urgent care provider performance was satisfactory. Nearly all urgent care was appropriate in the cases reviewed by OIG clinicians. Providers addressed patients' medical conditions and created concise plans with clear documentation. There were two significant deficiencies identified.

- In case 5, the patient at high risk for heart disease with diabetes and high cholesterol had a new onset of chest pain. The patient was discharged by the provider with no explanation and did not receive a follow-up appointment for another two months.

- In case 13, the high-risk patient had significant symptomatic low blood pressure and an abnormal EKG. The provider failed to see the patient face-to-face or send the patient to a higher level of care for assessment.

Nursing Performance

Nursing deficiencies were often related to deficient documentation and incomplete assessment. Significant deficiencies were identified in the cases below:

- In case 3, a high-risk patient came to the medical clinic with dizziness, nausea, and malaise. A vital sign assessment showed the patient had a fast heart rate and low blood pressure. The licensed vocation nurse (LVN) failed to promptly assess the vital signs and did not report these abnormal findings to a registered nurse (RN) for over a half hour.

- In case 4, the high-risk patient had symptoms that indicated significant blood loss, including a fast heart rate and low blood pressure. The nurse failed to check the patient's vital signs for almost an hour, and did not contact the on-call provider for over an hour. When the provider ordered the immediate transfer of the patient to the emergency room by ambulance, the nurse failed to initiate this transfer for over a half hour.

- In case 11, the patient required an emergency medical services ambulance transport and an emergency room evaluation for face, head, back, and chest injuries. The nurse failed to timely respond to the medical alarm, and did not document the location of the patient's injuries or provide a corresponding assessment. Also, the nurse failed to frequently assess the patient's vital signs. The supervising nurse reviewed the care the following day, but did not identify the deficiencies.

Emergency Medical Response Review

The Emergency Medical Response Review Committee (EMRRC) met regularly and reviewed most emergency transports. The EMRRC or clinical review identified most deficiencies.

Clinician Onsite Inspection

During the onsite visit, one provider was primarily assigned to the TTA and was responsible for patients in the OHU, addressing all non-emergent basic surgical procedures, such as ingrown toenail care, incision and drainage of abscesses, and laceration repair. The provider and staff were adept at triaging urgent cases while addressing scheduled procedures. The two-bed TTA was appropriately equipped and courteous staff was well versed on procedures and protocol. The clinic's first medical responders, and at the beginning of each shift, the clinic LVNs were assigned clear objective roles for a medical alarm. The staff appreciated the clear and precise roles that eliminated confusion.

Case Review Conclusion

CRC staff provided sufficient emergency services. The majority of cases reviewed displayed a well performing emergency system. Therefore, the OIG clinicians rated the *Emergency Services* indicator *adequate.*

4 — *HEALTH INFORMATION MANAGEMENT*

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(64.6%)
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.

For this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance testing resulting in an *inadequate* score. After considering both case review and compliance testing results, the OIG inspection team determined the final rating of *inadequate* was appropriate. The decision was primarily due to an excessive number of health care documents that CRC staff either mislabeled or misfiled in the electronic medical record. In addition, a large percentage of specialty notes inspectors sampled were not scanned timely into the electronic medical record. Both of these conditions could result in important health care records not being identified which could contribute to patient harm. For these reasons, CRC's performance for the *Health Information Management* indicator was rated the lower score of *inadequate.*

At the time of the OIG's testing period (April to May 2017), CRC had recently converted to the new Electronic Health Record System (EHRS) (October 2016); therefore, most testing occurred in the EHRS, with a minor portion of the review occurring in the electronic Unit Health Record (eUHR).

Case Review Results

The OIG clinicians reviewed 1,015 events and identified 30 deficiencies, 13 of which were significant. Significant deficiencies were identified in cases 2, 9, 10, 11, 17, and 20; three times in case 14; and four times in case 19.

Inter-Departmental Transmission

The OIG clinicians identified errors in communication among the institutional departments. Inter-departmental transmission is critical to prevent lost medical information between patient transfers. Two significant deficiencies were identified.

- In case 9, a provider failed to review an abnormal laboratory result for 19 days, which was 17 days after the required time for review.

- In case 14, the patient's assessment from his hospital return and documents from his OHU admission were not scanned into the patient's electronic medical record.

Hospital Records

OIG clinicians reviewed 16 hospital and 8 emergency room events and determined CRC managed the retrieval of community hospital records well. Community hospital discharge summary documentation was timely received and scanned. One significant deficiency was identified.

- In case 19, the patient's electronic medical record had several issues: mislabeled records, untimely scanned documents, superfluous hospital records, and missing records. Missing records and an excessive amount of unnecessary hospital records can be burdensome to the reviewing provider.

Specialty Services

A few instances of incomplete and delayed retrieval of specialist reports and records were identified. Performance in this area is discussed in the *Specialty Services* indicator.

Diagnostic Reports

The majority of diagnostic deficiencies in the *Health Information Management* indicator were due to records not being available in the patients' primary electronic medical record. Performance in this area is discussed in the *Diagnostic Services* indicator.

Urgent/Emergent Records

Staff did not always complete all documentation in the TTA during patient encounters. Performance in this area is also discussed in the *Emergency Services* indicator.

- In case 5, the on-call provider failed to document a telephone communication with nursing staff.

- In cases 1, 2, 3, 11, 13, and 23, nurses did not thoroughly document assessments and interventions for TTA emergent events.

Scanning Performance

Errors can occur from delayed, mislabeled, or unscanned documents. These scanning errors can affect patient care and alter a provider's ability to assess and develop an accurate and timely plan of care. Diagnoses can be missed or delayed, and tests unnecessarily repeated. CRC's medical staff often had to spend a substantial amount of time searching for missing records. Four scanning errors were considered significant because of the importance of the information.

- In case 11, the patient's electronic medical record contained a misfiled note from another patient's endocrinology telemedicine consult.

- In case 14, a fibroscan test was not available in the patient's electronic medical record.
- Also in case 14, an abnormal chest x-ray was not available in the patient's electronic medical record.
- In case 20, the provider reviewed the MRI report, but it was not available in the patient's electronic medical record.

Clinician Onsite Inspection

CRC's medical records department described the workflow of scanned documentation from hospital, specialty consults, and medical staff. They explained that records were scanned into the patient's record and providers received notification when patient records were ready for review. According to some CRC providers, scanned documentation occasionally did not trigger an inbox message notification. This concern was being investigated with the EHRS experts.

Case Review Conclusion

CRC performed well in the retrieval and delivery of community emergency department (ED) and hospital discharge summaries and most records were timely scanned. Some documents were missing, misfiled, or mislabeled, and specialist consults were occasionally delayed. During the OIG clinical review, deficiencies were infrequent and adjustments to the electronic medical records were improving. The OIG clinicians rated this indicator *adequate*.

Compliance Testing Results

The institution received an *inadequate* score of 64.6 percent in the *Health Information Management* indicator, scoring poorly on the following tests:

- Throughout compliance testing, inspectors also review documents to determine if they were accurately scanned into patients' electronic medical records. The OIG scores this test on a scale by which zero errors would result in a 100 percent score, and 24 errors would result in a score of zero. During testing for CRC, inspectors identified 17 documents with scanning errors. Of the 17 documents, 15 were mislabeled, and 2 were missing. As a result, the institution scored 29 percent (MIT 4.006).
- The institution scored 33 percent for the timely scanning of dictated or transcribed provider progress notes into patients' electronic health records. One of three sampled progress notes was timely scanned within five calendar days of the patient encounter. Two other sampled progress notes were scanned 6 and 12 days late (MIT 4.002).
- Inspectors reviewed electronic medical records for ten patients who were admitted to a community hospital and then returned to CRC. For seven of the ten patients (70 percent), the discharge summary reports were reviewed by providers within three calendar days of the

patients' discharge dates. For three patients, providers reviewed the discharge summary reports one to two days late (MIT 4.007).

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

- Staff scanned 15 of 20 specialty service consultant reports sampled (75 percent) into the patients' electronic medical records within five calendar days. Five documents were scanned between one and 13 days late (MIT 4.003).

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

- The institution timely scanned nine of ten non-dictated progress notes (90 percent), initial health screening forms, and health care services requests into the patients' electronic medical records. One health care services request was scanned one day late (MIT 4.001).

- The OIG also tested ten of the patients' discharge records to determine if staff timely scanned the records into the patients' electronic medical records. Nine of the ten sampled records (90 percent) were compliant. One record was scanned one day late (MIT 4.004).

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
(67.3%)

Overall Rating:
Inadequate

This indicator is evaluated entirely by compliance testing. There is no case review portion.

Compliance Testing Results

The institution received an *inadequate* compliance score of 67.3 percent in the *Health Care Environment* indicator, and showed room for improvement on the following tests:

- The non-clinic bulk medical supply storage areas did not meet the supply management process or support the needs of the medical health care program. Medical supplies were stored beyond the manufacturer's guidelines, resulting in a score of zero (MIT 5.106).

- Only two of ten clinic locations (20 percent) met compliance requirements for essential core medical equipment and supplies. The remaining eight 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 exam tables and an operational otoscope. In addition, a pulse oximeter and otoscope-ophthalmoscope did not have calibration stickers, and the automated external defibrillator (AED) had an expired calibration sticker (MIT 5.108).

- Inspectors examined emergency response bags (EMRB) to determine if they were inspected daily, inventoried monthly, and whether they contained all essential items. EMRBs were compliant in only two of the five clinical locations where they were stored (40 percent). In three locations, documentation did not indicate an inventory of the EMRB had been completed in the previous 30 days (MIT 5.111).

- Four of the ten clinics inspected followed appropriate medical supply storage and management protocols (60 percent). At five clinics, medical supplies were not organized or clearly identifiable, and some were stored

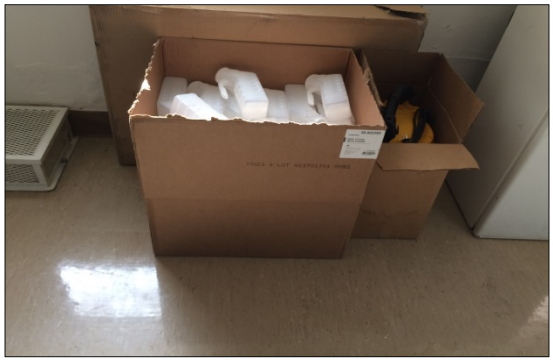

Figure 1: Supplies stored on the floor

directly on the floor (*Figure 1*). In one other clinic, medical supplies were stored in the same area staff kept personal items (MIT 5.107).

- Six of the ten clinic exam rooms observed (60 percent) had appropriate space, configuration, supplies, and equipment to allow clinicians to perform a proper clinical examination. Three clinics did not ensure confidential records were secure. One other clinic lacked auditory privacy by allowing two patients be examined in the same exam room at the same time. One of these four clinics had limited access to the oto-ophthalmoscope, and another used an exam table as a temporary storage space for personal items and confidential records (MIT 5.110).

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

- Staff appropriately disinfected, cleaned, and sanitized all ten sampled clinics; floor and sink areas were clean, and institution staff maintained cleaning logs in the most recent 30-day period reviewed (MIT 5.101).

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

- Nine of the ten clinic locations inspected (90 percent) had operable sinks and sufficient quantities of hand hygiene supplies in the exam areas. At one other clinic location, the patient restroom was missing hand hygiene supplies, such antiseptic soap and disposable towels (MIT 5.103).

- OIG inspectors observed health care clinicians in each clinic to ensure they employed proper hand hygiene protocols. In nine of ten (90 percent) clinics tested, clinicians adhered to universal hand hygiene precautions. In one other clinic, OIG inspectors observed that not all providers sanitized their hands prior to putting on gloves (MIT 5.104).

- Nine of the ten clinics (90 percent) had environments conducive to providing medical services. One other clinic failed to provide auditory privacy during blood-draw procedures (MIT 5.109).

Non-Scored Results

- The OIG gathered information to determine if the institution's physical infrastructure was maintained in a manner that supported health care management's ability to provide timely or effective health care. At the time of the OIG's medical inspection, CRC had not started any infrastructure projects. When OIG inspectors interviewed CRC health care managers, they did not identify any significant infrastructure concerns (MIT 5.999).

6 — *INTER- AND INTRA-SYSTEM TRANSFERS*

Case Review Rating:
Adequate
Compliance Score:
Adequate
(79.5%)
Overall Rating:
Adequate

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

Case Review Results

The OIG clinicians reviewed 44 encounters relating to *Inter- and Intra-System Transfers*, including information from both the sending and receiving institutions. These encounters included 24 hospitalization events, each of which resulted in a transfer back to the institution. Of the 44 encounters reviewed, 17 deficiencies were identified, of which 4 were considered significant.

Transfers In

OIG clinicians reviewed 12 events, and identified six deficiencies, two of which were significant. Both cases are discussed in more detail in the *Access to Care* indicator.

- In case 22, specialty care was delayed almost three months.

Transfers Out

Of the five transfer events reviewed, only one minor nursing documentation deficiency was identified. Otherwise, CRC's nurses appropriately facilitated the transfer process.

Hospitalizations

Patients returning from hospital admissions 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. Of the 24 hospitalization

events reviewed, several deficiencies were attributed to incomplete nursing assessments. Two significant deficiencies were identified regarding health information management:

- In case 14, the patient returned to the institution and was admitted to the OHU after a community hospital admission. Progress notes on the patient's return and OHU admission were not scanned into the patient's medical record.

- In case 19, pertinent community hospital records regarding the patient's hospitalization were not placed in the patient's medical record.

Clinician Onsite Inspection

Patients returning from hospital discharge were assessed by the TTA nurse. For patients who returned after the provider's day shift, the nurse would consult the on-call provider. The on-call provider would then present the patients' returns and other pertinent events at the morning provider meeting during the week. The OIG clinicians attended this meeting and noted this information did not always include important information such as the patient's vital signs and nursing assessment details. Failure to provide a thorough clinical presentation or handoff can lead to a poor patient outcome. The provider presented this information with notes from a note pad instead of a comprehensive on-call provider note.

Case Review Conclusion

Most deficiencies identified by the OIG clinicians were minor for patients transferring or returning to the institution. The *Inter- and Intra-System Transfers* indicator was rated *adequate.*

Compliance Testing Results

The institution obtained an *adequate* score of 79.5 percent in the *Inter- and Intra-System Transfers* indicator, receiving *proficient* scores of 100 percent on the following two tests:

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

- The OIG inspected the transfer package of one patient who was transferring out of the facility to determine whether the package included required medications and support documentation. The transfer package was compliant (MIT 6.101).

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

- The OIG tested 25 patients who transferred into CRC from other CDCR institutions to determine whether they received a complete initial health screening from nursing staff on the day they arrived. Nursing staff timely prepared the screening forms, but neglected to answer all applicable questions for 6 of the 25 patients (76 percent) (MIT 6.001).

CRC showed room for improvement on the following tests:

- Among 20 sampled patients who transferred out of CRC into other CDCR institutions, only 10 had their scheduled specialty service appointments properly included on the health care transfer forms (50 percent) (MIT 6.004).
- Of the 25 sampled patients who transferred into CRC, only 14 had existing medication orders that required nursing staff to administer medications upon the patients' arrival. Ten of the 14 patients (71 percent) received their ordered medications without interruption. Four other patients incurred medication interruptions of one or more dosing periods (MIT 6.003).

7 — *PHARMACY AND MEDICATION MANAGEMENT*

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(68.5%)
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. Compliance testing is a more targeted approach and is heavily relied on for the final rating of this indicator. As a result, the compliance score of *inadequate* was deemed appropriate for the final indicator rating.

Case Review Results

The OIG clinicians evaluate pharmacy and medication management as secondary processes as they relate to the quality of clinical care provided. The OIG clinicians evaluated 31 events related to pharmacy and medication management and identified five deficiencies, two of which were significant.

Medication Continuity

The institution generally performed well with ensuring medication continuity. Only two significant deficiencies were identified:

- In case 2, the patient had a high risk of cardiovascular disease and the provider ordered aspirin. The patient's aspirin was not issued for 13 days.
- In case 13, the patient had a high risk for a reoccurring stroke and was prescribed aspirin for chronic care protection. When the patient's chronic care medication expired, it was not reordered or issued for six weeks. Fortunately, no harm came to the patient.

Medication Administration (Nursing)

CRC nurses performed well administering medication, including keep-on-person (KOP) medication that patients keep in their possession.

Clinician Onsite Inspection

Pharmacy staff was very familiar with the new EHRS. Although they were working with a completely different medical delivery and tracking system, many workflow protocols had been created to ensure medication continuity.

Case Review Conclusion

CRC pharmacy services functioned well. In most clinical cases reviewed, CRC ensured patients received medications timely and accurately. The OIG clinicians rated the *Pharmacy and Medication Management* indicator *adequate*.

Compliance Testing Results

The institution received an *inadequate* compliance score of 68.5 percent in the *Pharmacy and Medication Management* indicator. For discussion purposes, 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 *adequate* score of 79.5 percent, with *proficient* scores in the following two areas:

- Of the 25 sampled patients at CRC who had transferred from one housing unit to another, 24 (96 percent) received their prescribed medications without interruption. One patient did not receive his medication at the next dosing interval after the transfer occurred (MIT 7.005).

- CRC timely administered or delivered new medication as ordered to 22 of the 25 patients sampled (88 percent). Two other patients received their medications one day late. For one other patient, OIG clinicians could not determine when he received his KOP medication because nursing staff did not document the date (MIT 7.002).

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

- CRC's clinical staff timely provided new and previously prescribed medications to six of ten patients sampled (60 percent) upon their return to the institution from a community hospital. Two patients received their medications one and three days late, and one other patient received ordered medication two days late. For another patient, medical records did not reveal the patient ever received his medication (MIT 7.003).

- Among 23 sampled patients, 17 (74 percent) timely received chronic care medications. Two patients missed one or more doses of their medications and did not receive the required provider counseling. One patient received one of his KOP medications eight days late and had not received another one of his KOP medications in the previous month. Three patients did not receive their KOP medications for over a month (MIT 7.001).

Observed Medication Practices and Storage Controls

In this sub-indicator, the institution received an *inadequate* average score of 54.9 percent, showing areas needing improvement on the following tests:

- Non-narcotic refrigerated medications were properly stored in only one of the ten applicable clinics and medication line storage locations (10 percent). In nine locations, one or more of the following deficiencies were observed: the medication area lacked a designated area for return-to-pharmacy refrigerated medications, temperature readings were out of range, multi-use medication was not labeled with the date opened, and personal food items were stored in the medication refrigeration unit (MIT 7.103).

- Non-narcotic medications not requiring refrigeration were properly stored in only one of the nine applicable clinics and medication line storage locations (11 percent). At eight locations, one or more of the following deficiencies were observed: the medication area lacked a designated area for return-to-pharmacy medications, external and internal medications were not stored separately, and multi-use medication was not labeled with the date opened (MIT 7.102).

- Inspectors observed medication preparation and administration processes at medication line locations. At four of the six (67 percent) applicable medication line locations, nursing staff were compliant with proper hand hygiene and contamination control protocols. At two locations, nursing staff did not always wash or sanitize their hands when required, such as before each subsequent re-gloving (MIT 7.104).

- At four of six applicable medication preparation and administration locations (67 percent), nursing staff followed appropriate administrative controls and protocols when distributing mediations to patients. At two other locations, nurses did not follow the manufacturer's guideline for proper administration of insulin to diabetic patients, which requires the sanitation of a multi-dose insulin vial prior to administering the medication (MIT 7.106).

The institution received an *adequate* score on the following test:

- The OIG interviewed nursing staff and inspected storage areas containing narcotics at clinic and medication line locations to assess security controls. CRC nursing staff employed strong security controls over narcotic medications at six of the eight applicable clinic and medication line locations (75 percent). For two other locations, nurses removed the narcotic

medications from storage without promptly updating the narcotic log, which did not allow for correct accounting of the narcotics (MIT 7.101).

CRC received a *proficient* score in the following test area:

- At all six of the inspected medication line locations, nursing staff appropriately employed administrative controls and followed protocols during medication preparation (MIT 7.105).

Pharmacy Protocols

In this sub-indicator, the institution received an *adequate* average score of 76.0 percent, comprised of scores received at the institution's main pharmacy. The institution received *proficient* scores of 100 percent on the following three tests:

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

The institution received an *adequate* score on the following test:

- The institution's pharmacist in charge appropriately followed protocols for 20 of the 25 medication error reports and monthly statistical reports reviewed (80 percent). The monthly medication error statistic report for June 2016 was submitted one business day late to the chief of pharmacy services, accounting for five other untimely reports (MIT 7.111).

CRC showed room for improvement in the following test area:

- OIG inspectors conducted an onsite physical inventory of the pharmacy-controlled substances (narcotics). At the time of the physical count, randomly selected controlled substances were stored beyond the manufacturing guidelines. In addition, the Medication Area Inspection Checklist (CDCR Form 7477) was not appropriately completed by pharmacy staff. The institution scored a zero on this test (MIT 7.110).

Non-Scored Test

- In addition to testing of reported medication errors, OIG inspectors follow up on any significant medication errors identified during the compliance testing to determine whether the errors were properly identified and reported. The OIG provides those results for information purposes only; however, at CRC the OIG did not find any applicable medication errors (MIT 7.998).

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 CRC is a male-only 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
(85.5%)
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 85.5 percent and *proficient* scores in the following test areas:

- All 25 sampled patients timely received or were offered influenza vaccinations during the most recent influenza season (MIT 9.004).
- Colorectal cancer screenings were offered to all 25 sampled patients subject to the annual screening requirement (MIT 9.005).
- The institution scored 97 percent for conducting annual tuberculosis (TB) screenings. Only one patient did not receive the annual TB screening on his birth month as required by CCHCS policy (MIT 9.003).
- CRC timely administered TB medications to 23 of 25 sampled patients (92 percent). One patient missed a dosage of their medication and did not receive the required provider counseling for the missed dosage. For another patient, inspectors were unable to verify whether another patient had ever received their medications because no documentation was found in the patient's electronic health record (MIT 9.001).

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

- The institution scored poorly in monitoring patients receiving TB medications, with only 13 of 25 patients (52 percent) receiving proper TB monitoring. For 12 sampled patients, the institution either failed to complete monitoring at all required intervals, document vital signs and body weight, or timely scan the monitoring form into the patient's medical record (MIT 9.002).

- The OIG inspectors tested whether CRC offered required influenza, pneumonia, and hepatitis vaccinations to patients who suffered from a chronic condition; 13 of 18 sampled patients (72 percent) received vaccinations. For three patients, there was no evidence that they received or refused a pneumococcal immunization. For one other patient, there was no evidence found that he had received or refused a pneumococcal immunization within the last five years. For one other patient, there was no evidence that he ever received or refused the pneumococcal and Hepatitis A and B vaccinations (MIT 9.008).

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10 — *QUALITY OF NURSING PERFORMANCE*

Case Review Rating:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

The *Quality of Nursing Performance* indicator is a qualitative evaluation of the institution's nursing services. The evaluation is completed entirely by OIG nursing clinicians within the case review process and does not have a score under the OIG compliance testing component. Case reviews include face-to-face encounters and indirect activities performed by nursing staff on behalf of the patient. Review of nursing performance includes all nursing services performed on site, such outpatient, inpatient, urgent/emergent, patient transfers, care coordination, and medication management. The key focus areas for evaluation of nursing care include appropriateness and timeliness of patient triage and assessment, identification and prioritization of health care needs, use of the nursing process to implement interventions, and accurate, thorough, and legible documentation. Although nursing services provided in specialized medical housing units are reported in the *Specialized Medical Housing* indicator, and those 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 OIG clinicians reviewed 255 nursing encounters, of which 136 were outpatient nursing encounters. Most outpatient nursing encounters were for sick call requests, walk-in visits, and nurse follow-up visits. In all, there were 88 deficiencies identified related to nursing care performance, 12 of which were significant. Significant deficiencies were identified in cases 3, 15, 39, 40, and 41; three times in case 12; and four times in case 11. The OIG clinicians rated the *Quality of Nursing Performance* indicator *adequate.*

Nursing Assessment and Interventions

Most of CRC's significant nursing assessment and intervention deficiencies occurred in the outpatient areas, most often, within the area of sick call triage. Additionally, the outpatient nurses did not promptly recognize the need for assessment or provide appropriate interventions on a few other occasions. The significant outpatient nursing deficiencies are listed below:

- In case 3, the patient came to the outpatient clinic with dizziness, nausea, malaise, elevated heart rate, and low blood pressure. The LVN failed to promptly assess the patient and did not contact a nurse for 35 minutes. This case is also discussed in the *Emergency Services* indicator.

- In case 11, the nurse, did not assess a patient with very high blood pressure, and did not assess blood pressure medication compliance. In this same case, a provider ordered blood

pressure checks every week for four weeks. The nurses did not obtain blood pressure readings for three of the four weeks ordered.

- In case 12, the diabetic patient had concerns about recent insulin changes and refused sliding scale insulin coverage. The medication line LVN did not address the patient's concern or initiate a primary care team referral.

- In case 15, the patient had leg pain after a fall. The outpatient nurse did not assess the leg wound or the pain severity.

Nursing Sick Call

The OIG clinicians reviewed 69 sick call requests and identified 21 deficiencies. The nurses often demonstrated improper triage. On occasion, the nurses inappropriately referred patients with complaints to the primary care provider instead of providing a nursing assessment. In these cases, the provider appointments occurred days or even weeks later. In other cases, the nurses failed to provide a face-to-face assessment the same day for urgent symptoms. Examples of significant deficiencies are listed below:

- In case 3, the cancer patient submitted a sick call request for abdominal pains. A face-to-face appointment with a nurse did not occur. The patient was seen by a provider four days later.

- In case 11, on three separate occasions, the patient requested to be seen for pain. However, the nurses did not perform a patient assessment.

- In case 12, the diabetic patient requested to be seen for an infected cut. A face-to-face appointment with a nurse did not occur the next business day, but instead, the patient was inappropriately seen two weeks later. Fortunately, the wound had healed. On two separate occasions, the same patient requested appointments for knee pain, and face-to-face nursing appointments did not occur.

- In case 39, the patient submitted a sick call request for ear pain. The form was reviewed by a nurse; however, a face-to-face nursing visit did not occur. Instead, the ear pain was evaluated by a provider almost two weeks later.

- In case 40, the patient submitted a sick call request for eye pain, redness, and drainage. A nurse did not review this request and a face-to-face assessment was not conducted.

- In case 41, an asthmatic patient submitted a sick call request for a breathing problem that did not improve after using his inhaler. The nurse failed to perform an assessment that day and the patient was not seen by the nurse until three days later.

Nursing Services

The CRC nurses provided appropriate nursing care in the areas of *Emergency Services*, *Inter- and Intra-System Transfers, Pharmacy and Medication Management*, *Specialized Medical Housing*, and *Specialty Services.* Additional information is provided within each indicator.

Clinician Onsite Inspection

The OIG clinicians attended the morning huddle in the clinic and found it well organized and thorough. The huddle was attended by the primary care provider, the medication line LVN, the care manager LVN, the provider assistant LVN, a custody officer, and was facilitated by the clinic nurse.

OIG clinicians visited several clinical areas and spoke with various nursing staff, including nurses in specialty services, telemedicine, utilization management, TTA, OHU, R&R, and outpatient clinics. The nursing staff reported having no major barriers in communication with supervisors, providers, and custody officers to meet patient care needs.

The OIG nurse consultant attended the supervising registered nurse (SRN) meeting and learned of the multiple electronic medical records system concerns and leadership's efforts to address these issues. The leadership team had a meeting devoted to managing issues from the transition to the EHRS over the last year. Each problem was recorded and organized by area or discipline, contained an action plan, date of follow-up, and ultimately the date the problem was resolved or closed. Nursing leadership had recently designated a SRN to quality management, who was responsible for huddle quality and consistency, and also assessed and managed quality data information such as the CCHCS Dashboard.

The OIG clinicians noted the proactive approach of the chief nurse executive and director of nursing, who had thoroughly researched the OIG nursing questions, and had a plan for education and training based on their internal review and findings.

Case Review Conclusion

With the exception of the nursing sick call deficiencies, CRC's nursing services performed well. The OIG clinicians rated the *Quality of Nursing Performance* indicator *adequate*.

11 — *QUALITY OF PROVIDER PERFORMANCE*

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

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

Case Review Results

The OIG clinicians reviewed 309 medical provider encounters and identified 73 deficiencies related to provider performance, of which 37 were significant. Significant deficiencies were identified in cases 5, 11, and 18; twice in cases 6, 8, and 17; three times each in cases 4, 13, and 19; four times each in cases 7, 9, and 20; and seven times in case 12. Deficiencies often resulted from superficial medical reviews, ineffective continuity of care, and poor clinical decisions. Opioid management was also of concern because providers inappropriately prolonged opioid treatment without clinical justification.

CRC providers usually made appropriate clinical decisions for their healthy population, but often failed in the management of their medically complex patients. As in Cycle 4, CRC providers continued to have significant difficulty with managing patients' diabetes. Because of these deficiencies, the OIG clinicians rated the *Quality of Provider Performance* indicator *inadequate*.

Assessment and Decision-Making

The OIG identified 19 minor and 8 significant deficiencies, which demonstrated a lack of thoroughness in the medical management of patients.

- In case 4, the patient had liver cirrhosis and low blood platelet count, which increased the risk for spontaneous bleeding. The provider inappropriately prescribed warfarin and aspirin, two medications that further increased the risk of bleeding. Furthermore, the patient had complained of nosebleeds and bruising. Despite all the bleeding risks, the provider inappropriately continued a medication order of ibuprofen, which even further increased the patient's risk for bleeding and stomach ulcers. These errors placed the patient at a very high risk for harm.

- In case 18, the patient had a tumor on his back and saw a surgeon to determine if it was cancerous. The specialist recommended an immediate plastic surgery consultation, axillary ultrasound, and a computed tomography (CT) scan of the chest, abdomen, and pelvis. The provider did not order these services with urgent priority. Subsequently, the plastic surgery

consultation did not occur for six weeks, placing the patient at risk of harm. Fortunately, the surgery found no cancer.

- In case 19, the patient had a kidney stone that blocked his urine flow, causing his kidneys to swell. The provider did not refer the patient urgently to a urologist, but instead ordered a routine consult within three months. This delay increased the patient's risk of permanent kidney damage. Also during this time, the provider inappropriately approved a non-urgent eye surgery for the patient, which increased the patient's risk of surgical complications. The provider should have waited until the kidney problem had improved before ordering the eye surgery.

Opioid Management

Opioid management was also a concern at CRC. Eight significant deficiencies, involving prolonged and unjustified opioid treatment were identified.

- In case 12, providers inappropriately continued the patient on opioids for several months after they were no longer necessary. In addition, providers significantly increased opioid dosages without first evaluating the patient. When providers attempted to decrease, or discontinue the opioids, the patient threatened to refuse his other medications. Instead of making a sound decision, the provider submitted to the patient's threat, and continued to prescribe unnecessarily opioids. This case review had five significant deficiencies identified related to opioid medication usage.

- In case 17, a provider ordered a 200 percent increase in the morphine dose without conducting a face-to-face assessment of the patient's chronic back pain.

- In case 20, the patient had a sports-related knee injury that was improving. There was only mild knee pain and tenderness noted during the physical exam. Despite these findings, the provider ordered an opioid for pain management and continued the patient on this opioid for over four months without re-evaluating the knee or considering a lower dose.

- Also in case 20, three months after a patient had an uncomplicated knee surgery, the provider inappropriately continued the patient on a high-dose opioid for an additional 30 days.

Review of Records

The OIG identified 14 minor and 7 significant deficiencies of CRC providers failing to thoroughly review pertinent medical records, including blood glucose logs, consultation notes, and progress notes. Superficial reviews of patient medical records could delay appropriate management and cause injury to the patient.

- In case 4, a provider did a superficial review of the patient's laboratory results from a community hospital discharge summary record and missed evidence of the patient's recent anemia and low blood pressure. These overlooked findings both would have suggested the patient was actively bleeding.

- In case 9, the diabetic patient was on long-acting insulin. When the pharmacist called the provider to clarify a recent order for the patient, the provider failed to review the medical record and ordered the wrong insulin dose.

Emergency Care

CRC providers performed well in emergency care. Patients were triaged accurately, managed appropriately, and timely sent out to a higher level of care. Only two significant deficiencies occurred within emergency services.

- In case 5, a diabetic patient went to the TTA with chest pain. Nursing consulted the on-call provider and received orders. The patient's history and symptoms suggested heart disease as the cause. However, the provider failed to fully evaluate this patient or document an encounter, and inappropriately sent the patient back to his housing.

- In case 13, the high-risk diabetic patient with a history of strokes had acute weakness, dizziness, severely low blood pressure, and an abnormal EKG. The provider did not perform a face-to-face assessment or send the patient to a higher level of care. Fortunately, the patient did well with only intravenous hydration.

Chronic Care

In a basic institution, chronic care management is the crux of the medical well-being of the majority of its patients. CRC providers did not perform well in this area. Thirteen significant deficiencies occurred in chronic care management. Six of the deficiencies were attributed to the same provider. The majority of chronic care deficiencies, 11 of the 13 significant deficiencies, were identified in chronic pain and diabetic patient management.

- In case 4, the provider repeatedly failed to recognize or treat the patient with liver cirrhosis. The provider's repeated errors increased the risk of complications from the patient's liver disease.

- In case 6, the provider inappropriately ordered only a three month follow-up appointment for the patient with poorly controlled diabetes (blood sugars dangerously elevated). By failing to treat and monitor the patient's abnormal blood sugars, the provider placed the patient at risk for dangerous diabetic complications.

- In case 7, providers recognized the patient's poorly controlled diabetes and elevated blood sugars, but failed to adjust the patient's medications or order appropriate follow-up intervals.

- In case 12, a cholesterol medication had been discontinued after the patient's liver tests were abnormal. Without checking the test results, the provider restarted the patient on the cholesterol medication, placing the patient at risk for liver damage.

Specialty Services

CRC providers appropriately referred patients for specialty services. Please refer to the *Specialty Services* indicator summary for further details.

Health Information Management

CRC providers timely documented patient care with appropriate detail and correct information. Provider notes were legible, especially after the transition to the EHRS.

Clinician Onsite Inspection

The OIG onsite inspection at CRC provided insight into the workflow and complexities of institutional medicine. During the period of review, the institution lost several highly experienced providers, and also transitioned to the EHRS.

The CRC transition to the EHRS in October of 2016 created a new paradigm; providers were now required to acquire additional technological skills to produce all the documentation and orders necessary for medical care. These additional requirements led to many frustrated providers, and to the early retirement of two seasoned providers. CRC staff suggested that the retiring providers had been instrumental in finding flaws with the EHRS, and had also strongly advocated for patient care, voicing their concerns to the institution's health care administration, and on rare occasions, to outside agencies for systems improvement.

Another challenge providers experienced from the transition to the EHRS was the change in process to follow when a patient returned to the institution after a hospital admission. Following the implementation of the EHRS, when patients were admitted to a hospital, all prior orders of the patient within the institution were discontinued, including non-hospital related orders, such as scheduled appointments for consults, provider and nurse appointments, and orders for medication and durable medical equipment. Therefore, providers now had to spend additional time reviewing and re-ordering all prior appointments and medications for returning patients. This was time consuming, and according to providers there had been no modification to their schedule to allot for these critically important tasks.

CRC had a sensitive needs yard (SNY) where patients of higher medical complexity required significant medical management. The SNY population comprised only 30 percent of the total population of CRC, yet accounted for over 50 percent of the high-risk patients within the institution. This dichotomy in the institution made it difficult to assign providers to work the SNY clinic. Often, experienced providers expressed reluctance to work with patients in the SNY, so medical administrators would instead assign newly hired providers to work the SNY clinic. This decision placed new and potentially inexperienced providers with more challenging, high-risk patients. This

decision by the institution's administration may have contributed to several of the deficiencies identified in four of the eight *inadequate* cases identified by the OIG.

The chief physician and surgeon (CP&S) and the chief medical executive were well versed in institutional medicine and workflow, and also with the EHRS. Both were cordial and appeared eager to make adjustments to improve the quality of care at CRC. They were optimistic about filling the current provider vacancies because there were a large pool of provider applicants due to CRC's desirable location.

Case Review Conclusion

The care given by providers at CRC was *inadequate*. Of the 20 cases reviewed, OIG clinicians rated one *proficient*, 11 *adequate*, and 8 *inadequate*. Within this basic institution, there was poor care of patients with diabetes, and poor management of opioids. These deficiencies along with the poor medical record review significantly decreased provider performance from Cycle 4. After considering all factors, the OIG rated the *Quality of Provider Performance* indicator at CRC *inadequate*.

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 CRC does 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. CRC's only specialized medical housing unit is the outpatient housing unit (OHU).

Case Review Rating:
Adequate
Compliance Score:
Adequate
(83.3%)
Overall Rating:
Adequate

Case Review Results

At the time of the OIG's onsite inspection, CRC had a ten-bed OHU onsite. The OIG clinicians reviewed more than 104 events related to the *Specialized Medical Housing* indicator, including 20 provider encounters and 51 nursing encounters. These encounters were reviewed in 12 cases and included admissions (short stays to prepare patients for procedures) to the OHU. Of the 104 events reviewed, 27 deficiencies were identified, of which 2 were significant.

Provider Performance

The OIG case review found the majority of patients in the OHU were seen and cared for appropriately. However, both significant deficiencies identified were in provider performance.

- In case 12, the patient had an elevated heart rate after surgery. The provider took note of this, but failed to perform a physical exam.

- Also in case 12, on a different encounter, the patient refused medications after the provider appropriately began decreasing prescribed morphine. One hour later, without cause, the provider increased the morphine dose. This case is also discussed in the *Quality of Provider Performance* indicator.

Nursing Performance

Nursing performed well in the OHU. Of the 51 nursing events reviewed, 22 minor deficiencies were identified. Most deficiencies were related to incomplete documentation and nursing assessments. There were no significant deficiencies identified.

Clinician Onsite Inspection

During the onsite visit, all ten OHU beds were occupied. The second shift nurse was very familiar with the specialized medical housing unit policy and procedures. At the time of the OIG inspection, the on-call provider was also assigned to the OHU. The nursing staff felt comfortable with provider access which was readily available by phone and face-to-face evaluation. According to the nurse, medical management could be acquired from urgent care staff, the CP&S, or the SRN, if necessary.

Case Review Conclusion

The OIG clinicians rated the *Specialized Medical Housing* indicator *adequate*.

Compliance Testing Results

CRC performed in the *adequate* range in the *Specialized Medical Housing* indicator, with a compliance score of 83.3 percent. The institution received *proficient* scores of 100 percent on the following two tests:

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

- Inspectors observed the working order of sampled call buttons in OHU patient rooms and found all working properly. According to staff members, custody officers and clinicians were able to expeditiously access patients' locked rooms when emergent events occurred (MIT 13.101).

The institution received an *inadequate* score on the following test:

- The OIG tested whether providers completed their Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes at required 14-day intervals. In four of the eight sampled patients (50 percent), providers were compliant. For two patients, the provider SOAPE notes were incomplete, and for two other patients, there was no evidence that the provider ever wrote SOAPE notes (MIT 13.003).

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:
Adequate
Compliance Score:
Inadequate
(72.2%)
Overall Rating:
Adequate

In this indicator, the OIG case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance testing yielding an *inadequate* score. The OIG's internal review process considered the factors leading to both assessments and ultimately rated this indicator *adequate* based on two factors. Compliance testing was close to an *adequate* score. In addition, case review determined the provider review of reports, while often delayed, was usually only slightly delayed. For these reasons, CRC's performance for the *Specialty Services* indicator was *adequate*.

Case Review Results

The OIG clinicians reviewed 182 events related to specialty services, comprised of 140 specialty consultations and procedures, and 42 nursing encounters, and identified 39 deficiencies, 14 of which were significant. Significant deficiencies occurred once in cases 2, 10, 17, 18, and 22; twice in case 11; three times in case 15; and four times in case 19.

Access to Specialty Services

Specialty access to care should not have been a concern for CRC because there were plenty of consultants available, but it was a concern at CRC, and 6 of the 14 significant deficiencies identified were in access to care. There were significant delays in consultant follow-up after a provider order.

- In cases 11, 15, and 22, the patients' rheumatology consultations with an arthritis specialist and follow-up appointments were significantly delayed or failed to occur.
- In case 15, the patient's dermatology follow-up appointments were significantly delayed on several occasions.
- In case 18, the patient's plastic surgery and surgical oncology consultations were delayed two weeks and one month, respectively.

- In case 19, the patient's two-day postoperative ophthalmology appointment was delayed three days.

Nursing Performance

There were no significant deficiencies with nursing performance within specialty services. The 13 minor deficiencies identified occurred most often from incomplete assessments and failure to administer pain medication to patients with pain.

Provider Performance

There were no significant deficiencies with provider performance within the *Specialty Services* indicator, and only three minor deficiencies were identified with no apparent pattern. Providers identified the need for specialist consultations and ordered services within appropriate time frames.

Health Information Management

Out of the 39 deficiencies identified in the *Specialty Services* indicator, 16 were attributed to health information management. A majority of the deficiencies were from mislabeling or misfiling of consultant progress notes in patient medical records. Also, there were significant delays in scanning and missing consultant records. Of the 16 deficiencies identified, 7 were significant.

- In cases 2 and 17, urgent cardiac tests were not available in the patients' primary electronic medical record.

- In case 10, a colonoscopy report was not available in the patient's primary electronic medical record.

- In case 19, an ophthalmology consult was scanned over a month after the patient's evaluation and procedure occurred. The patient's urology report was incomplete and there were no attempts to correct it. Lastly, the requested imaging results did not accompany the patient to the urology consultation, resulting in a change in the patient's monitoring.

Pharmacy and Medical Management

CRC provided specialist-recommended medications timely. No pattern of deficiencies was identified.

Clinician Onsite Inspection

During the onsite visit, CRC providers and ancillary staff were pleased with the quality of specialty services at the institution. Medical staff reported timely scheduling of patient specialty appointments and recommendations being received. Staff were knowledgeable and shared how they processed paperwork to OIG clinicians. Issues with transitioning to the EHRS required staff to develop multiple redundancies in their process in an attempt to capture missing specialty consults, follow-up appointments, progress notes, and imaging results.

Specialty service recommendations made offsite were immediately scanned into the EHRS and an electronic copy was also forwarded to a provider for review and implementation of recommendations.

Case Review Conclusion

CRC performance was affected by the transition to EHRS. New workflows were created and have been applied to provide appropriate and timely delivery of the specialty consults. OIG rated the *Specialty Services* indicator *adequate*.

Compliance Testing Results

The institution received an *inadequate* compliance score of 72.2 percent in the *Specialty Services* indicator, receiving poor scores on the following two tests:

- When patients are approved or scheduled for specialty services at one institution and then transfer to another, policy requires the receiving institution to provide the patient's pending appointment from the sending institution. Only 4 of the 12 sampled patients who transferred to CRC with an approved specialty service (33 percent) received it within the required time frame. Four patients received their appointments from 2 to 58 days late, and for four other patients, there was no evidence found in their medical records that they ever received an appointment (MIT 14.005).

- For routine specialty services, CRC providers timely received and reviewed specialists' reports for only 8 of the 14 patients sampled (57 percent). Three specialty reports were not found in health record files, one report was received 49 days late, and two reports were reviewed 4 and 9 days late (MIT 14.004).

- Providers timely received and reviewed 10 of the 15 routine specialty reports that inspectors sampled (67 percent). For two patients, CRC received their specialty reports one day late, and for one other patient, the provider reviewed his report one day late. For two other patients, there was no evidence found in their medical records that a provider ever reviewed their specialty reports (MIT 14.002).

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

- Among 20 patients sampled who had a specialty service denied by CRC's health care management, 16 patients (80 percent) received timely notification of the denied service, including a provider meeting with the patient within 30 days to discuss alternate treatment strategies. For four other patients, there was no evidence of a provider follow-up to discuss the denial (MIT 14.007).

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

- CRC's health care management timely denied providers' specialty service requests for 19 of 20 sampled patients (95 percent). Management denied one specialty service request 25 days late (MIT 14.006).

- Of the 15 sampled patients, 13 (87 percent) received their high-priority specialty appointments or services within 14 days of the provider's order. Two other patients received their specialty services one day and 15 days late (MIT 14.001).

- For 13 of the 15 patients sampled (87 percent), routine specialty service appointments occurred within 90 days of the provider's order; however, two patients received their specialty service appointments 8 and 49 days late (MIT 14.003).

15 — *ADMINISTRATIVE OPERATIONS (SECONDARY)*

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(66.2%)
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 66.2 percent in the *Administrative Operations* indicator, and showed room for improvement in the following test areas:

- The institution had not taken appropriate steps to ensure the accuracy of its Dashboard data. CRC did not provide evidence of discussion of the methodologies used to conduct periodic data validation or of the results of the data validation testing. The QMC meetings did not discuss methodologies used to train staff who collected Dashboard data. Therefore, CRC received a score of zero (MIT 15.004).

- Medical staff did not timely submit the initial Inmate Death Report (CCDR Form 7229-A) to CCHCS' Death Review Unit for the one applicable death that occurred at the institution in the prior 12-month period. CRC submitted the inmate death report two days late, and as a result, received a score of zero for this test (MIT 15.103).

- Only one of six providers had a proper clinical performance appraisal completed (17 percent) by their supervisor. Five other providers did not have properly completed appraisals because the reviewer did not complete the required 360 Degree Evaluation (MIT 15.106).

- The OIG inspected records for five nurses to determine if their nursing supervisors properly completed monthly performance reviews. Inspectors identified the following deficiencies for the five nurses' monthly nursing reviews (MIT 15.104):
    - The supervisor did not complete the required number of reviews for two nurses.
    - The supervisor's review did not summarize aspects that were well done for four nurses.
    - The supervisor's review did not summarize aspects that were needing improvement for two nurses.
- Inspectors reviewed drill packages for three medical emergency response drills conducted in the prior quarter. Only one of the three drill packages were properly completed (33 percent). Staff did not complete the First Medical Responder – Data Collection Tool (CDCR Form 7463) for two drill packages (MIT 15.101).
- OIG inspectors reviewed data received from CRC to determine if the institution timely processed at least 95 percent of its monthly patient medical appeals during the most recent 12-month period. CRC processed only 8 of the 12 months of appeals within the required time frame (67 percent). Four months that OIG inspectors reviewed had more than five percent of medical appeals in overdue status, with percentages ranging from 7 to 34 percent (MIT 15.001).
- The OIG reviewed incident package documentation for 12 emergency medical responses reviewed by CRC's EMRRC during the prior 12-month period. Only 8 of the 12 sampled packages (67 percent) complied with policy. Two of the incident review packages did not have completed EMRRC checklist forms, and two other incident review packages had EMRRC meeting minutes not signed by the warden and were also missing the EMRRC checklist forms (MIT 15.005).

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

- CRC's QMC met monthly, evaluated program performance, and took action when management identified areas for improvement opportunities (MIT 15.003).
- All ten nurses sampled were current with their clinical competency validations (MIT 15.105).
- All providers at the institution were current with their professional licenses (MIT 15.107).
- All nurses and the pharmacist in charge were current with their professional licenses and certification requirements (15.109).

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

- All pharmacy staff and providers who prescribed controlled substances had current Drug Enforcement Agency registrations (MIT 15.110).

- All nursing staff hired within the previous year received new employee orientation training within 30 days of being hired (MIT 15.111).

- For nine of the ten sampled second-level medical appeals (90 percent), CRC's responses addressed all patients' appealed issues. The medical appeals coordinator was unable to provide the requested medical appeal packet for one patient (MIT 15.102).

Non-Scored Results

- The OIG gathered non-scored data regarding the completion of death review reports by CCHCS's Death Review Committee (DRC). Only one death occurred during the OIG's review period, an expected (Level 2) death. The DRC was required to complete its death review summary report within 30 calendar days from the date of death, and submit the report to the institution's chief executive officer (CEO) within seven calendar days. thereafter. However, the DRC completed its report 53 days late (83 days after the death), and submitted it to CRC's CEO 66 days late (103 days after the death) (MIT 15.998).

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

Recommendations

Based on the results of the Cycle 5 medical inspection at CRC, the OIG recommends the following:

- The OIG continues to recommend CRC scan all future radiology reports into the patient's electronic medical record, and CCHCS revise its radiological report scanning policy.

- The OIG recommends CRC focus on improving communication during huddle meetings to share information on patients transferred. Both verbal and written communication templates could be developed to cover clinical details, such as the patient's vital signs and nursing assessment on the transferred patients. In addition, the provider reviewing the previous day's on-call work could use a comprehensive on-call provider note guide instead of a notepad to ensure all relevant information is covered.

- The OIG recommends nursing leadership assess their current sick call audit selection process to include a nursing sick call triage to aid patients in the absence of nursing face-to-face encounters.

- The OIG recommends the medical leadership appropriately match the experience and skill of providers to the level of complexity of CRC's patient population.

- The OIG recommends the medical leadership provide additional provider training and monitoring for diabetic and opioid medication management.

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 electronic medical record, the Master Registry (maintained by CCHCS), as well as a random sample of patient records analyzed and abstracted by trained personnel. Data obtained from the CCHCS Master Registry and Diabetic Registry was not independently validated by the OIG and is presumed to be accurate. For some measures, the OIG used the entire population rather than statistically random samples. While the OIG is not a certified HEDIS compliance auditor, the OIG uses similar methods to ensure that measures are comparable to those published by other organizations.

Comparison of Population-Based Metrics

For California Rehabilitation Center, nine HEDIS measures were selected and are listed in the following *CRC 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 Metrics 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. CRC performed well with its management of diabetes compared to most state and national plans. However, the OIG clinicians did note some issues concerning the management of some diabetic patients during case review. Please refer to the *Quality of Provider Performance* indicator for specific details.

When compared statewide, CRC outperformed Medi-Cal in all five diabetic measures selected. Further, CRC outperformed Kaiser Permanente (North and South regions) in four of five diabetic measures; with CRC scoring slightly lower for blood pressure control.

When compared nationally, CRC outperformed Medicaid, Medicare, and commercial health plans in all five of the diabetic measures. The institution scored better than the United States Department of Veterans Affairs (VA) in three measures, but performed slightly less well in eye exams.

Immunizations

Comparative data for immunizations was only fully available for the VA and partially available for Kaiser, commercial plans, Medicaid, and Medicare. With respect to administering influenza vaccinations to younger adults, CRC scored significantly lower than all reporting entities except Medicaid, in which CRC scored one point higher. The 60 percent refusal rate negatively affected the institutions score for this measure. However, CRC outperformed both Medicare and the VA for influenza vaccinations for older adults. Lastly, CRC scored lower than the VA and matched Medicare for administration of pneumococcal vaccinations.

Cancer Screening

With respect to colorectal cancer screening, CRC scored lower than Kaiser and the VA. However, CRC scored higher than commercial plans and Medicare. CRC's low score was directly attributed to a 23 percent patient refusal rate.

Summary

CRC's population-based metrics performance reflected a good chronic care program in comparison to the other state and national health care plans reviewed. The institution may improve its scores for immunizations and colorectal cancer screenings by reducing patient refusals through patient education.

CRC Results Compared to State and National HEDIS Scores

Clinical Measures	California				National			
	CRC 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)	**100%**	86%	94%	94%	86%	90%	93%	98%
Poor HbA1c Control (>9.0%)[6, 7]	**13%**	39%	20%	23%	45%	34%	27%	19%
HbA1c Control (<8.0%)[6]	**73%**	49%	70%	63%	46%	55%	63%	-
Blood Pressure Control (<140/90)	**80%**	63%	83%	83%	59%	60%	62%	74%
Eye Exams	**86%**	53%	68%	81%	53%	54%	69%	89%
Immunizations								
Influenza Shots - Adults (18–64)	**40%**	-	56%	57%	39%	48%	-	55%
Influenza Shots - Adults (65+)[6]	**86%**	-	-	-	-	-	72%	76%
Immunizations: Pneumococcal[6]	**71%**	-	-	-	-	-	71%	93%
Cancer Screening								
Colorectal Cancer Screening	**72%**	-	79%	82%	-	63%	67%	82%

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

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

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

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

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

6. For this indicator, the entire applicable CRC 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 Rehabilitation Center Range of Summary Scores: 64.58% - 86.94%	
Indicator	**Compliance Score (Yes %)**
1–*Access to Care*	86.94%
2–*Diagnostic Services*	73.33%
3–*Emergency Services*	Not Applicable
4–*Health Information Management (Medical Records)*	64.58%
5–*Health Care Environment*	67.27%
6–*Inter- and Intra-System Transfers*	79.49%
7–*Pharmacy and Medication Management*	68.49%
8–*Prenatal and Post-Delivery Services*	Not Applicable
9–*Preventive Services*	85.48%
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)*	83.33%
14–*Specialty Services*	72.21%
15–*Administrative Operations*	66.22%

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?	18	7	25	72.00%	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?	16	8	24	66.67%	1
1.003	Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received?	32	0	32	100.00%	0
1.004	Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed?	29	3	32	90.63%	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?	16	3	19	84.21%	13
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?	7	1	8	87.50%	24
1.007	Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame?	10	0	10	100.00%	0
1.008	Specialty service follow-up appointments: Do specialty service primary care physician follow-up visits occur within required time frames?	22	5	27	81.48%	3
1.101	Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms?	6	0	6	100.00%	0
Overall percentage:					**86.94%**	

Reference Number	2–*Diagnostic Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
2.001	Radiology: Was the radiology service provided within the time frame specified in the provider's order?	9	1	10	90.00%	0
2.002	Radiology: Did the primary care provider review and initial the diagnostic report within specified time frames?	1	9	10	10.00%	0
2.003	Radiology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	9	1	10	90.00%	0
2.004	Laboratory: Was the laboratory service provided within the time frame specified in the provider's order?	10	0	10	100.00%	0
2.005	Laboratory: Did the primary care provider review and initial the diagnostic report within specified time frames?	8	2	10	80.00%	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	100.00%	0
2.007	Pathology: Did the institution receive the final diagnostic report within the required time frames?	9	1	10	90.00%	0
2.008	Pathology: Did the primary care provider review and initial the diagnostic report within specified time frames?	7	3	10	70.00%	0
2.009	Pathology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	3	7	10	30.00%	0
Overall percentage:					**73.33%**	

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?	9	1	10	90.00%	0
4.002	Are dictated/transcribed documents scanned into the patient's electronic health record within five calendar days of the encounter date?	1	2	3	33.33%	0
4.003	Are High-Priority specialty notes (either a Form 7243 or other scanned consulting report) scanned within the required time frame?	15	5	20	75.00%	0
4.004	Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge?	9	1	10	90.00%	0
4.005	Are medication administration records (MARs) scanned into the patient's electronic health record within the required time frames?	Not Applicable				
4.006	During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files?	7	17	24	29.17%	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?	7	3	10	70.00%	0
Overall percentage:					**64.58%**	

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?	10	0	10	100.00%	0
5.102	Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	9	1	10	90.00%	0
5.103	Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	9	1	10	90.00%	0
5.104	Does clinical health care staff adhere to universal hand hygiene precautions?	9	1	10	90.00%	0
5.105	Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	10	0	10	100.00%	0
5.106	Warehouse, Conex and other non-clinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program?	0	1	1	0.00%	0
5.107	Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	6	4	10	60.00%	0
5.108	Do clinic common areas and exam rooms have essential core medical equipment and supplies?	2	8	10	20.00%	0
5.109	Do clinic common areas have an adequate environment conducive to providing medical services?	9	1	10	90.00%	0
5.110	Do clinic exam rooms have an adequate environment conducive to providing medical services?	6	4	10	60.00%	0
5.111	Emergency response bags: Are TTA and clinic emergency medical response bags inspected daily and inventoried monthly, and do they contain essential items?	2	3	5	40.00%	5
Overall percentage:					**67.27%**	

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?	19	6	25	76.00%	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?	25	0	25	100.00%	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?	10	4	14	71.43%	11
6.004	For patients transferred out of the facility: Were scheduled specialty service appointments identified on the patient's health care transfer information form?	10	10	20	50.00%	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?	1	0	1	100.00%	2
Overall percentage:					**79.49%**	

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?	17	6	23	73.91%	2
7.002	Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames?	22	3	25	88.00%	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?	6	4	10	60.00%	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?	24	1	25	96.00%	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?	Not Applicable				
7.101	All clinical and medication line storage areas for narcotic medications: Does the Institution employ strong medication security over narcotic medications assigned to its clinical areas?	6	2	8	75.00%	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?	1	8	9	11.11%	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?	1	9	10	10.00%	0
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?	4	2	6	66.67%	4
7.105	Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients?	6	0	6	100.00%	4
7.106	Medication preparation and administration areas: Does the Institution employ appropriate administrative controls and protocols when distributing medications to patients?	4	2	6	66.67%	4
7.107	Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and satellite pharmacies?	1	0	1	100.00%	0

Reference Number	7–*Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.108	Pharmacy: Does the institution's pharmacy properly store non-refrigerated medications?	1	0	1	100.00%	0
7.109	Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications?	1	0	1	100.00%	0
7.110	Pharmacy: Does the institution's pharmacy properly account for narcotic medications?	0	1	1	100.00%	0
7.111	Does the institution follow key medication error reporting protocols?	20	5	25	80.00%	0
Overall percentage:					**68.49%**	

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?	23	2	25	92.00%	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?	13	12	25	52.00%	0
9.003	Annual TB Screening: Was the patient screened for TB within the last year?	29	1	30	96.67%	0
9.004	Were all patients offered an influenza vaccination for the most recent influenza season?	25	0	25	100.00%	0
9.005	All patients from the age of 50 - 75: Was the patient offered colorectal cancer screening?	25	0	25	100.00%	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?	13	5	18	72.22%	7
9.009	Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	Not Applicable				
Overall percentage:					**85.48%**	

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 CRC's Hospice?	10	0	10	100.00%	10
13.002	For CTC and SNF only: Was a written history and physical examination completed within the required time frame?	Not Applicable				
13.003	For OHU, CTC, SNF, and Hospice: Did the primary care provider complete the Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes on the patient at the minimum intervals required for the type of facility where the patient was treated?	4	4	8	50.00%	12
13.101	For OHU and CTC Only: Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter patient's cells?	1	0	1	100.00%	0
Overall percentage:					**83.33%**	

Reference Number	14–*Specialty Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	Did the patient receive the high priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service?	13	2	15	86.67%	0
14.002	Did the primary care provider review the high priority specialty service consultant report within the required time frame?	10	5	15	66.67%	0
14.003	Did the patient receive the routine specialty service within 90 calendar days of the primary care provider order or Physician Request for Service?	13	2	15	86.67%	0
14.004	Did the primary care provider review the routine specialty service consultant report within the required time frame?	8	6	14	57.14%	1
14.005	For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames?	4	8	12	33.33%	8
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	19	1	20	95.00%	0
14.007	Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame?	16	4	20	80.00%	0
Overall percentage:					**72.21%**	

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?	8	4	12	66.67%	0
15.002	Does the institution follow adverse / sentinel event reporting requirements?	Not Applicable				
15.003	Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified?	6	0	6	100.00%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	0	1	1	0.00%	0
15.005	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	8	4	12	66.67%	0
15.006	For institutions with licensed care facilities: Does the Local Governing Body (LGB), or its equivalent, meet quarterly and exercise its overall responsibilities for the quality management of patient health care?	Not Applicable				
15.101	Did the institution complete a medical emergency response drill for each watch and include participation of health care and custody staff during the most recent full quarter?	1	2	3	33.33%	0
15.102	Did the institution's second level medical appeal response address all of the patient's appealed issues?	9	1	10	90.00%	0
15.103	Did the institution's medical staff review and submit the initial inmate death report to the Death Review Unit in a timely manner?	0	1	1	0.00%	0
15.104	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	1	4	5	20.00%	0
15.105	Are nursing staff who administer medications current on their clinical competency validation?	10	0	10	100.00%	0
15.106	Are structured clinical performance appraisals completed timely?	1	5	6	16.67%	0
15.107	Do all providers maintain a current medical license?	11	0	11	100.00%	0
15.108	Are staff current with required medical emergency response certifications?	2	0	2	100.00%	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?	5	0	5	100.00%	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?	1	0	1	100.00%	0
15.111	Are nursing staff current with required new employee orientation?	1	0	1	100.00%	0
Overall percentage:					**66.22%**	

APPENDIX B — CLINICAL DATA

Table B-1: CRC Sample Sets

Sample Set	Total
Anticoagulation	1
Death Review/Sentinel Events	1
Diabetes	5
Emergency Services – Non-CPR	2
High Risk	5
Hospitalization	4
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	18
Specialty Services	2
	44

Table B-2: CRC Chronic Care Diagnoses

Diagnosis	Total
Anemia	2
Anticoagulation	1
Arthritis/Degenerative Joint Disease	1
Asthma	5
COPD	6
Cancer	1
Cardiovascular Disease	7
Chronic Kidney Disease	3
Chronic Pain	13
Cirrhosis/End Stage Liver Disease	3
Diabetes	18
Gastroesophageal Reflux Disease	9
Gastrointestinal Bleed	1
Hepatitis C	7
Hyperlipidemia	16
Hypertension	18
Mental Health	11
Rheumatological Disease	2
Seizure Disorder	2
Sleep Apnea	2
Thyroid Disease	3
	131

Table B-3: CRC Event – Program

Program	Total
Diagnostic Services	162
Emergency Care	53
Hospitalization	27
Intra-System Transfers In	12
Intra-System Transfers Out	7
Not Specified	7
Outpatient Care	457
Specialized Medical Housing	102
Specialty Services	188
	1,015

Table B-4: CRC Review Sample Summary

	Total
MD Reviews Detailed	20
MD Reviews Focused	0
RN Reviews Detailed	11
RN Reviews Focused	24
Total Reviews	55
Total Unique Cases	44
Overlapping Reviews (MD & RN)	11

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

California Rehabilitation Center (CRC)

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 (8 per clinic) (32)	MedSATS	• Clinic (each clinic tested) • Appointment date (2–9 months) • **Randomize**
MIT 1.007	Returns from Community Hospital (10)	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 (10)	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	(3)	OIG Q: 1.001	• Dictated documents • First 20 IPs selected
MIT 4.003	(20)	OIG Qs: 14.002 & 14.004	• Specialty documents • First 10 IPs for each question
MIT 4.004	(10)	OIG Q: 4.007	• Community hospital discharge documents • First 20 IPs selected
MIT 4.005	(0)	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 (24 or more = No)
MIT 4.007	Returns From Community Hospital (10)	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 (10)	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 (3)	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 (10)	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 (0)	SOMS	• Date of transfer (2–8 months) • Sending institution (another CDCR facility) • **Randomize** • NA/DOT meds
MITs 7.101–103	Medication Storage Areas (varies by test)	OIG inspector onsite review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–106	Medication Preparation and Administration Areas (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 (10)	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 (25)	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • **Randomize**
MIT 9.003	TB Codes, Annual Screening (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Codes • **Randomize**
MIT 9.004	Influenza Vaccinations (25)	SOMS	• Arrival date (at least 1 year prior to inspection) • **Randomize** Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening (25)	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • **Randomize**
MIT 9.006	Mammogram *N/A at this institution*	SOMS	• Arrival date (at least 2 yrs prior to inspection) • Date of birth (age 52–74) • **Randomize**
MIT 9.007	Pap Smear *N/A at this institution*	SOMS	• Arrival date (at least three yrs prior to inspection) • Date of birth (age 24–53) • **Randomize**
MIT 9.008	Chronic Care Vaccinations (25)	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • **Randomize** • Condition must require vaccination(s)
MIT 9.009	Valley Fever (number will vary) *N/A at this institution*	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • **All**

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

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Administrative Operations			
MIT 15.001	Medical Appeals (all)	Monthly medical appeals reports	• Medical appeals (12 months)
MIT 15.002	Adverse/Sentinel Events (0)	Adverse/sentinel events report	• Adverse/sentinel events (2–8 months)
MITs 15.003–004	QMC Meetings (6)	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.005	EMRRC (12)	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.006	LGB (0)	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills (3)	Onsite summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	2nd Level Medical Appeals (10)	Onsite list of appeals/closed appeals files	• Medical appeals denied (6 months)
MIT 15.103	Death Reports (1)	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 (6)	OIG Q:16.001	• All required performance evaluation documents
MIT 15.107	Provider licenses (11)	Current provider listing (at start of inspection)	• Review all
MIT 15.108	Medical Emergency Response Certifications (all)	Onsite certification tracking logs	• All staff o Providers (ACLS) o 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 (1)	OIG summary log - deaths	• Between 35 business days & 12 months prior • CCHCS death reviews

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

October 17, 2017

Roy Wesley, Inspector General
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 Rehabilitation Center (CRC) conducted from April 2017 to June 2017. California Correctional Health Care Services (CCHCS) acknowledges the OIG findings.

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

Sincerely,

for

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
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