

# Ironwood State Prison Medical Inspection Results Cycle 4



May 2016

**Fairness ♦ Integrity ♦ Respect ♦  
Service ♦ Transparency**

# Office of the Inspector General IRONWOOD STATE PRISON Medical Inspection Results Cycle 4



Robert A. Barton  
*Inspector General*

Roy W. Wesley  
*Chief Deputy Inspector General*

Shaun R. Spillane  
*Public Information Officer*

May 2016

# TABLE OF CONTENTS

---

Executive Summary .....	i
Overall Assessment: <i>Inadequate</i> .....	iii
Clinical Case Review and OIG Clinician Inspection Results .....	iii
Compliance Testing Results.....	iv
Population-Based Metrics .....	x
Introduction.....	1
About the Institution .....	1
Objectives, Scope, and Methodology.....	5
Case Reviews.....	6
Patient Selection for Retrospective Case Reviews .....	6
Benefits and Limitations of Targeted Subpopulation Review .....	7
Case Reviews Sampled .....	8
Compliance Testing .....	9
Sampling Methods for Conducting Compliance Testing .....	9
Scoring of Compliance Testing Results .....	10
CCHCS Dashboard Comparisons .....	10
Overall Quality Indicator Rating for Case Reviews and Compliance Testing .....	11
Population-Based Metrics.....	11
Medical Inspection Results .....	12
Primary (Clinical) Quality Indicators of Health Care.....	12
<i>Access to Care</i> .....	14
Case Review Results.....	14
Compliance Testing Results.....	15
Recommendations.....	16
<i>Diagnostic Services</i> .....	17
Case Review Results.....	17
Compliance Testing Results.....	18
Recommendation for CCHCS.....	19
Recommendations for ISP .....	19
<i>Emergency Services</i> .....	20
Case Review Results.....	20
Recommendations.....	21
<i>Health Information Management (Medical Records)</i> .....	22
Case Review Results.....	22
Compliance Testing Results.....	23
Recommendations.....	24
<i>Health Care Environment</i> .....	25
Compliance Testing Results.....	25
Recommendations.....	28

<i>Inter- and Intra-System Transfers</i> .....	30
Case Review Results .....	30
Compliance Testing Results .....	32
Recommendations .....	33
<i>Pharmacy and Medication Management</i> .....	34
Case Review Results .....	34
Compliance Testing Results .....	35
Recommendations .....	38
<i>Preventive Services</i> .....	39
Compliance Testing Results .....	39
Recommendations .....	40
<i>Quality of Nursing Performance</i> .....	41
Case Review Results .....	41
Recommendation .....	43
<i>Quality of Provider Performance</i> .....	44
Case Review Results .....	44
Recommendations .....	50
<i>Specialized Medical Housing (OHU, CTC, SNF, Hospice)</i> .....	52
Case Review Results .....	52
Compliance Testing Results .....	53
Recommendations .....	54
<i>Specialty Services</i> .....	55
Case Review Results .....	55
Compliance Testing Results .....	57
Recommendations .....	58
Secondary (Administrative) Quality Indicators of Health Care .....	59
<i>Internal Monitoring, Quality Improvement, and Administrative Operations</i> .....	60
Compliance Testing Results .....	60
Recommendations .....	62
<i>Job Performance, Training, Licensing, and Certifications</i> .....	63
Compliance Testing Results .....	63
Recommendations .....	64
Population-Based Metrics .....	65
Appendix A — Compliance Test Results .....	69
Appendix B — Clinical Data .....	83
Appendix C — Compliance Sampling Methodology .....	85
California Correctional Health Care Services’ Response .....	91

## LIST OF TABLES AND FIGURES

---

Health Care Quality Indicators .....	ii
ISP Executive Summary Table .....	ix
ISP Health Care Staffing Resources as of December 2015 .....	2
ISP Master Registry Data as of December 7, 2015 .....	3
Commonly Used Abbreviations .....	4
ISP Results Compared to State and National HEDIS Scores .....	68

---

## EXECUTIVE SUMMARY

---

Under the authority of California Penal Code Section 6126, which assigns the Office of the Inspector General (OIG) responsibility for oversight of the California Department of Corrections and Rehabilitation (CDCR), the OIG conducts a comprehensive inspection program to evaluate the delivery of medical care at each of CDCR's 35 adult prisons. The OIG **explicitly** makes no determination regarding the constitutionality of care in the prison setting. That determination is left to the Receiver and the federal court. The assessment of care by the OIG is just one factor in the court's determination whether care in the prisons meets constitutional standards. The court may find that an institution the OIG found to be providing adequate care still did not meet constitutional standards, depending on the analysis of the underlying data provided by the OIG. Likewise, an institution that has been rated *inadequate* by the OIG could still be found to pass constitutional muster with the implementation of remedial measures if the underlying data were to reveal easily mitigated deficiencies.

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

For this fourth cycle of inspections, the OIG added a clinical case review component and significantly enhanced the compliance portion of the inspection process from that used in prior cycles. In addition, the OIG added a population-based metric comparison of selected Healthcare Effectiveness Data Information Set (HEDIS) measures from other State and national health care organizations and compared that data to similar results for Ironwood State Prison (ISP).

The OIG performed its Cycle 4 medical inspection at ISP from January to March 2016. The inspection included in-depth reviews of 70 inmate-patient files conducted by clinicians, as well as reviews of documents from 426 inmate-patient files, covering 92 objectively scored tests of compliance with policies and procedures applicable to the delivery of medical care. The OIG assessed the case review and compliance results at ISP using 14 health care quality indicators applicable to the institution, made up of 12 primary clinical indicators and two secondary administrative indicators. To conduct clinical case reviews, the OIG employs a clinician team consisting of a physician and a registered nurse consultant, while compliance testing is done by a team of deputy inspectors general and registered nurses trained in monitoring medical compliance. Of the 12 primary indicators, seven were rated by both case review clinicians and compliance inspectors, three were rated by case review clinicians only, and two were rated by compliance inspectors only; both secondary indicators were rated by compliance inspectors only. See the *Health Care Quality Indicators* table on page ii. Based on that analysis, OIG experts made a considered and measured overall opinion that the quality of health care at ISP was *inadequate*.

## Health Care Quality Indicators

<b>Fourteen Primary Indicators (Clinical)</b>	<b>All Institutions– Applicability</b>	<b>ISP Applicability</b>
<i>1–Access to Care</i>	All institutions	Both case review and compliance
<i>2–Diagnostic Services</i>	All institutions	Both case review and compliance
<i>3–Emergency Services</i>	All institutions	Case review only
<i>4–Health Information Management (Medical Records)</i>	All institutions	Both case review and compliance
<i>5–Health Care Environment</i>	All institutions	Compliance only
<i>6–Inter- and Intra-System Transfers</i>	All institutions	Both case review and compliance
<i>7–Pharmacy and Medication Management</i>	All institutions	Both case review and compliance
<i>8–Prenatal and Post-Delivery Services</i>	Female institutions only	Not Applicable
<i>9–Preventive Services</i>	All institutions	Compliance only
<i>10–Quality of Nursing Performance</i>	All institutions	Case review only
<i>11–Quality of Provider Performance</i>	All institutions	Case review only
<i>12–Reception Center Arrivals</i>	Institutions with reception centers	Not Applicable
<i>13–Specialized Medical Housing (OHU, CTC, SNF, Hospice)</i>	All institutions with an OHU, CTC, SNF, or Hospice	Both case review and compliance
<i>14–Specialty Services</i>	All institutions	Both case review and compliance
<b>Two Secondary Indicators (Administrative)</b>	<b>All Institutions– Applicability</b>	<b>ISP Applicability</b>
<i>15–Internal Monitoring, Quality Improvement, and Administrative Operations</i>	All institutions	Compliance only
<i>16–Job Performance, Training, Licensing, and Certifications</i>	All institutions	Compliance only

## ***Overall Assessment: Inadequate***

Based on the clinical case reviews and compliance testing, the OIG’s overall assessment rating for ISP was *inadequate*. Of the 12 primary (clinical) quality indicators applicable to ISP, the OIG found none *proficient*, nine *adequate*, and three *inadequate*. Of the two secondary (administrative) quality indicators, the OIG found one *adequate* and one *inadequate*. To determine the overall assessment for ISP, the OIG considered individual clinical ratings and individual compliance question scores within each of the indicator categories, putting emphasis on the primary indicators. Based on that analysis, OIG experts made a considered and measured overall opinion about the quality of health care observed at ISP.

**Overall Assessment  
Rating:**

***Inadequate***

## ***Clinical Case Review and OIG Clinician Inspection Results***

The clinicians’ case reviews sampled patients with high medical needs and included a review of more than 1,396 patient care events.<sup>1</sup> Of the 12 primary indicators applicable to ISP, ten were evaluated by clinician case review; eight were *adequate*, and two were *inadequate*. When determining the overall adequacy of care, the OIG paid particular attention to the clinical nursing and provider quality indicators, as adequate health care staff can sometimes overcome suboptimal processes and programs. However, the opposite is not true; inadequate health care staff cannot provide adequate care, even though the established processes and programs onsite may be adequate. The OIG clinicians identify inadequate medical care based on the risk of significant harm to the patient, not the actual outcome.

### **Program Strengths — Clinical**

- Access to care and health care staff’s performance during emergency situations were excellent. Patients requiring urgent care were appropriately triaged. Patients were timely seen and appropriately transferred to higher levels of care.
- Health care staff saw patients timely, and specialty services for patients were readily available.
- Diagnostic services were performed timely, reviewed by providers, and communicated to patients.

---

<sup>1</sup> Each OIG clinician team includes a board-certified physician and registered nurse consultant with experience in correctional and community medical settings.



## Program Weaknesses — Clinical

- Provider assessment, decision-making, and review of records were inadequate. Superficial management of complex medical illnesses delayed treatment and monitoring.
- Primary care providers failed to manage patients returning from offsite specialty or hospital consultations. Instead, the ISP’s workflow process substituted an urgent care provider for the primary care provider for these tasks. While access to care was improved, patient care was compromised by poor provider continuity. Many medical errors relating to the quality of care occurred during transfers of care. This case review finding contrasted the compliance testing results, discussed below, which concluded that ISP was generally compliant with technical policy requirements related to transfers, such as timely issuance of transfer medications and timely completion of health transfer forms. Unlike the case review portion of the OIG’s medical inspection, the compliance review did not focus on the quality of care delivered to patients.
- Providers also demonstrated poor performance by over-utilizing specialists, which placed patients at risk of undergoing unnecessary procedures. In addition, the providers failed to safely prepare patients prior to elective surgery and the providers did not always have direct involvement in patient’s post specialty service care plans.

## Compliance Testing Results

Of the 14 total health care indicators applicable to ISP, 11 were evaluated by compliance inspectors.<sup>2</sup> There were 92 individual compliance questions within those 11 indicators, generating 1,191 data points, testing ISP’s compliance with California Correctional Health Care Services (CCHCS) policies and procedures.<sup>3</sup> Those 92 questions are detailed in *Appendix A — Compliance Test Results*. The institution’s inspection scores in the 11 applicable indicators ranged from 53.9 percent to 96.7 percent, with the secondary (administrative) indicator *Internal Monitoring, Quality Improvement, and Administrative Operations* receiving the lowest score, and the primary indicator *Inter-Intra-System Transfers* receiving the highest. Of the nine primary indicators applicable to compliance testing, the OIG rated three *proficient*, four *adequate*, and two *inadequate*. Of the two secondary indicators, which involve administrative health care functions, one was rated *adequate* and the other *inadequate*.

## Program Strengths — Compliance

As the *ISP Executive Summary Table* on page ix indicates, the institution’s compliance ratings were *proficient* in the following three indicators: *Diagnostic Services* (85.6 percent), *Inter- and*

---

<sup>2</sup> The OIG’s compliance inspectors are trained deputy inspectors general and registered nurses with expertise in CDCR policies regarding medical staff and processes.

<sup>3</sup> 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.

*Intra-System Transfers* (96.7 percent), and *Specialty Services* (87.2 percent). The following are some of ISP's strengths based on its compliance scores on individual questions in all the primary health care indicators:

- Patients had a standardized process to obtain and submit health care service request forms, and nursing staff timely reviewed patients' health care requests and timely conducted face-to-face visits with patients.
- Nearly all patients sampled received their radiology, laboratory, and pathology services timely. In addition, providers reviewed the diagnostic reports related to laboratory and pathology services timely, and they communicated the radiology and laboratory test results to patients timely.
- Non-dictated progress notes, initial health screening forms, health care service request forms, and specialty service documents were routinely scanned into the eUHR within the required time frame.
- All clinics were appropriately disinfected, cleaned, and sanitary; clinical staff properly controlled exposure to blood-borne pathogens and contaminated waste in health care areas; clinical staff properly sterilized or disinfected reusable invasive and non-invasive medical equipment and properly managed and stored bulk medical supplies; and clinic common areas had an adequate environment for providing medical services.
- When patients transferred into ISP from other institutions, nurses timely completed their assessments on the Initial Health Screening forms (CDCR Form 7277).
- When patients transferred out of ISP into other institutions, nursing staff was proficient at documenting scheduled specialty service appointments on patients' Health Care Transfer Information forms (CDCR Form 7371). In addition, health care staff properly prepared medication transfer packages, including required medications along with the corresponding medical administration records and medication reconciliations.
- Nursing staff timely administered or delivered newly ordered medications to patients and employed appropriate administrative controls and protocols when preparing medications.
- In its main pharmacy, ISP followed general security, organization, and cleanliness management protocols; properly stored and monitored refrigerated, frozen, and non-refrigerated medications; and properly accounted for narcotic medications.
- ISP timely provided or offered patients seasonal influenza vaccinations and routine colorectal cancer screenings, when required.

- All of the sampled patients in ISP’s outpatient housing unit received an initial assessment by nursing staff on the day of admission.
- When the OIG observed the working order of a sample of call buttons in outpatient housing unit patient rooms, the call buttons were working properly and health care staff had timely access to those rooms when emergent events occurred.
- Patients timely received their approved high-priority and routine specialty services, and providers timely reviewed those specialty service consultant reports.
- When providers’ requests for health care services were denied, the denials occurred within the required time frame.

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

- The institution promptly processed inmate medical appeals during the most recent 12 months, and ISP addressed all of the patients’ appealed issues for sampled second-level medical appeals.
- All providers, nurses, and the pharmacist-in-charge were current with their professional licenses and certifications, and the pharmacy and authorized providers maintained current Drug Enforcement Agency registrations.
- All providers timely received structured clinical performance appraisals, nurse supervisors completed required reviews of sampled nursing staff, and sampled nursing staff received annual clinical competency validations.

### **Program Weaknesses — Compliance**

The institution received ratings of *inadequate* in the following primary indicators: *Health Information Management* (64.6 percent) and *Pharmacy and Medication Management* (70.9 percent). The institution also received an *inadequate* score in the secondary indicator *Internal Monitoring, Quality Improvement, and Administrative Operations* (53.9 percent). The following are some of the weaknesses identified by ISP’s compliance scores on individual questions in all the primary health care indicators:

- Patients who arrived from other institutions and were then referred by a nurse to see a provider did not always receive timely medical appointments.
- Providers did not routinely communicate pathology results to their patients within the required time frame.

- Health information management staff did not always properly label documents scanned into patients' electronic health records; dictated or transcribed documents were not always scanned into the eUHR timely; and for inmate-patients discharged from a community hospital, the hospital discharge reports periodically lacked key elements or were not timely reviewed by a PCP.
- Clinical nursing staff failed to routinely adhere to universal hand hygiene practices.
- Clinical exam rooms did not have an adequate environment for providing medical services due to insufficient space, hindered access to exam tables, or tables in disrepair.
- Either emergency response bags did not contain required items, or else staff did not always complete required daily bag inspections to ensure the bags were response ready.
- Nursing staff did not timely administer prescribed medications to patients returning from a community hospital, and did not always properly employ and follow hand hygiene contamination control protocols when preparing patients' medications.
- The institution's clinic and medication line locations did not employ strong medication security controls over narcotic medications, nor properly store non-narcotic refrigerated or non-refrigerated medications, nor always employ appropriate administrative controls and protocols when distributing medications to inmate-patients.
- Nursing staff did not properly conduct annual tuberculosis screenings.
- Providers in ISP's outpatient housing unit did not always complete subjective, objective, assessment, plan, and education (SOAPE) notes on patients at the required intervals.
- Providers did not always timely inform patients of denied requests for specialty services.

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

- ISP's Quality Management Committee did not routinely discuss or evaluate program performance or identify improvement opportunities during meetings.
- The institution's Emergency Medical Response Review Committee meeting minutes did not always include all required documentation for discussed incidents, or the ISP's chief executive officer never approved the meeting minutes.
- During the most recent quarter, ISP did not complete required emergency response training drills for the two of three watches. For a third watch, a drill was completed; however, staff did not complete all required event documentation.

- The institution did not ensure that all recently hired nurses completed new employee orientation training within the required time frame.

The *ISP Executive Summary Table* on the following page lists the quality indicators the OIG inspected and assessed during the clinical case reviews and objective compliance tests, and provides the institution's rating in each area. The overall indicator ratings were based on a consensus decision by the OIG's clinicians and non-clinical inspectors.

## ISP Executive Summary Table

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

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

### Secondary Indicators (Administrative)

<i>Internal Monitoring, Quality Improvement, and Administrative Operations</i>	Not Applicable	Inadequate	Inadequate
<i>Job Performance, Training, Licensing, and Certifications</i>	Not Applicable	Adequate	Adequate

Compliance results for quality indicators are *proficient* (greater than 85.0 percent), *adequate* (75.0 percent to 85.0 percent), or *inadequate* (below 75.0 percent).

## ***Population-Based Metrics***

Overall, population-based metrics showed that ISP's performance had mixed results. While the institution performed comparatively well in the area of diabetic care and administering influenza shots to older adults, it performed only marginally well in the area of providing pneumococcal vaccinations, and poorly in providing influenza shots to younger adults (under age 65) and colorectal cancer screenings to older adults (aged 50 to 75).

In comprehensive diabetes care, ISP outperformed all other State and national organizations in three out of five comparable measures. In blood pressure control for diabetics, ISP scored in the mid to high comparative range, with a higher score than all other organizations except Kaiser Permanente, which had a slightly higher score. In eye exams, ISP outsourced all other comparable organizations except the U.S. Department of Veterans Affairs (VA), which also had a slightly higher score.

With regard to immunization measures for younger adults, ISP performed more poorly than all entities with comparable data; however, the institution's score was significantly and adversely affected by patient refusals. With regard to immunizations for older adults (age 65 and over), ISP scored better than both Medicare and the VA, and with regard to administering pneumococcal vaccinations, ISP had mixed results, scoring better than Medicare but worse than the VA. For this comparative measure, ISP's score was negatively affected by patients who ISP did not ensure were offered the vaccine.

In the area of colorectal cancer screening, ISP's scores were poorer than all other entities, but the low score was, again, directly attributable to a high percentage of patients who refused the screening. Combining those patients who received or refused the colorectal cancer screening within the required time frame, ISP would have had the highest comparable score and outperformed all other applicable entities.

Overall, ISP's performance reflects only a marginally acceptable chronic care program, corroborated by the institution's *adequate* ratings in the *Access to Care*, *Preventive Services*, and *Diagnostic Services* indicators. With regard to the institution's low scores in providing influenza shots to younger adults and colorectal cancer screenings to older adults, the institution has an opportunity to significantly improve its low comparative scores by initiating more patient education to help lower patient refusal rates. With regard to pneumococcal vaccinations, the institution could better ensure that all applicable patients are offered the vaccine when required.

## **INTRODUCTION**

---

Under the authority of California Penal Code Section 6126, which assigns the Office of the Inspector General (OIG) responsibility for oversight of the California Department of Corrections and Rehabilitation (CDCR), and at the request of the federal Receiver, the OIG developed a comprehensive medical inspection program to evaluate the delivery of medical care at each of CDCR's 35 adult prisons. For this fourth cycle of inspections, the OIG augmented the breadth and quality of its inspection program used in prior cycles, adding a clinical case review component and significantly enhancing the compliance component of the program.

Ironwood State Prison (ISP) was the 17th medical inspection of Cycle 4. During the inspection process, the OIG assessed the delivery of medical care to patients for 12 primary clinical health care indicators and two secondary administrative health care indicators applicable to the institution. It is important to note that while the primary quality indicators represent the clinical care being provided by the institution at the time of the inspection, the secondary quality indicators are purely administrative and are not reflective of the actual clinical care provided.

The OIG is committed to reporting on each institution's delivery of medical care to assist in identifying areas for improvement, but the federal court will ultimately determine whether any institution's medical care meets constitutional standards.

## **ABOUT THE INSTITUTION**

---

Ironwood State Prison (ISP) primarily houses general population, minimum and medium custody male offenders. Consisting of four main housing facilities and a separate minimum yard facility, the institution operates six medical clinics where staff handles non-urgent requests for medical services. ISP also treats inmates needing urgent or emergency care in its triage and treatment area (TTA), treats inmate-patients requiring outpatient health services in its outpatient housing unit (OHU) and provides specialty services in its specialty clinic. Located in Blythe, ISP 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 inmate-patient population.

On August 17, 2014, 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.



According to unaudited information provided by the institution, ISP’s overall vacancy rate among medical managers, primary care providers, nursing supervisors, and non-supervisory nurses was 4.5 percent in December 2015, with the most vacancies among nursing supervisors at 14 percent. In addition, there was one nursing supervisor who was on long-term medical leave. As a result, approximately 25 percent of ISP’s supervisory nursing positions were either vacant or otherwise not contributing to nursing oversight. In a related area, ISP had 55.2 filled line-nurse positions, of which six were on long-term medical leave. This accounted for 11 percent of the total non-supervisory nursing workforce. To help offset the staffing void, the institution employed 12 registry nurses. Lastly, ISP’s CEO reported that in December 2015, there were no redirected medical staff.

### ISP Health Care Staffing Resources as of December 2015

Description	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff		Totals	
	Number	%	Number	%	Number	%	Number	%	Number	%
Authorized Positions	4	5%	6	8%	10.5	14%	57.2	74%	77.7	100%*
Filled Positions	4	100%	6	100%	9	86%	55.2	97%	74.2	95%
Vacancies	0	0%	0	0%	1.5	14%	2	3%	3.5	4.5%
Recent Hires (within 12 months)	2	50%	0	50%	0	0%	12	22%	14	19%
Staff Utilized from Registry	0	0%	0	17%	0	0%	12	22%	12	16%
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%	1	11%	6	11%	7	9%

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

\*Due to rounding, individual percentages for Authorized Positions do not add to exactly 100 percent.

The Master Registry for ISP showed that as of December 7, 2015, the institution had 3,591 inmate-patients. Within that total population, 0.4 percent were designated High-Risk, Priority 1 (High 1), and 2.2 percent were designated High-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 labs and procedures. High 1 has at least two high-risk conditions; High 2 has only one. High-risk patients are more susceptible to poor health outcomes than medium- or low-risk patients. High-risk patients 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.

**ISP Master Registry Data as of December 7, 2015**

Medical Risk Level	# of Inmate-Patients	Percentage
High 1	14	0.4%
High 2	80	2.2%
Medium	689	19.2%
Low	2,808	78.2%
<b>Total</b>	<b>3,591</b>	<b>100.0%</b>

## Commonly Used Abbreviations

<b>ACLS</b>	Advanced Cardiovascular Life Support	<b>HIV</b>	Human Immunodeficiency Virus
<b>AHA</b>	American Heart Association	<b>HTN</b>	Hypertension
<b>ASU</b>	Administrative Segregation Unit	<b>INH</b>	Isoniazid (anti-tuberculosis medication)
<b>BLS</b>	Basic Life Support	<b>IV</b>	Intravenous
<b>CBC</b>	Complete Blood Count	<b>KOP</b>	Keep-on-Person (in taking medications)
<b>CC</b>	Chief Complaint	<b>LPT</b>	Licensed Psychiatric Technician
<b>CCHCS</b>	California Correctional Health Care Services	<b>LVN</b>	Licensed Vocational Nurse
<b>CCP</b>	Chronic Care Program	<b>MAR</b>	Medication Administration Record
<b>CDCR</b>	California Department of Corrections and Rehabilitation	<b>MRI</b>	Magnetic Resonance Imaging
<b>CEO</b>	Chief Executive Officer	<b>MD</b>	Medical Doctor
<b>CHF</b>	Congestive Heart Failure	<b>NA</b>	Nurse Administered (in taking medications)
<b>CME</b>	Chief Medical Executive	<b>N/A</b>	Not Applicable
<b>CMP</b>	Comprehensive Metabolic (Chemistry) Panel	<b>NP</b>	Nurse Practitioner
<b>CNA</b>	Certified Nursing Assistant	<b>OB</b>	Obstetrician
<b>CNE</b>	Chief Nurse Executive	<b>OHU</b>	Outpatient Housing Unit
<b>C/O</b>	Complains of	<b>OIG</b>	Office of the Inspector General
<b>COPD</b>	Chronic Obstructive Pulmonary Disease	<b>P&amp;P</b>	Policies and Procedures (CCHCS)
<b>CP&amp;S</b>	Chief Physician and Surgeon	<b>PA</b>	Physician Assistant
<b>CPR</b>	Cardio-Pulmonary Resuscitation	<b>PCP</b>	Primary Care Provider
<b>CSE</b>	Chief Support Executive	<b>POC</b>	Point of Contact
<b>CT</b>	Computerized Tomography	<b>PPD</b>	Purified Protein Derivative
<b>CTC</b>	Correctional Treatment Center	<b>PRN</b>	As Needed (in taking medications)
<b>DM</b>	Diabetes Mellitus	<b>RN</b>	Registered Nurse
<b>DOT</b>	Directly Observed Therapy (in taking medications)	<b>Rx</b>	Prescription
<b>Dx</b>	Diagnosis	<b>SNF</b>	Skilled Nursing Facility
<b>EKG</b>	Electrocardiogram	<b>SOAPE</b>	Subjective, Objective, Assessment, Plan, Education
<b>ENT</b>	Ear, Nose and Throat	<b>SOMS</b>	Strategic Offender Management System
<b>ER</b>	Emergency Room	<b>S/P</b>	Status Post
<b>eUHR</b>	electronic Unit Health Record	<b>TB</b>	Tuberculosis
<b>FTF</b>	Face-to-Face	<b>TTA</b>	Triage and Treatment Area
<b>H&amp;P</b>	History and Physical (reception center examination)	<b>UA</b>	Urinalysis
<b>HIM</b>	Health Information Management	<b>UM</b>	Utilization Management

## OBJECTIVES, SCOPE, AND METHODOLOGY

---

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

To maintain a metric-oriented inspection program that evaluates medical care delivery consistently at each State prison, the OIG identified 14 primary (clinical) and two secondary (administrative) quality indicators of health care to measure. The primary quality indicators cover clinical categories directly relating to the health care provided to patients, whereas the secondary quality indicators address the administrative functions that support a health care delivery system. The 14 primary quality indicators are *Access to Care*, *Diagnostic Services*, *Emergency Services*, *Health Information Management (Medical Records)*, *Health Care Environment*, *Inter- and Intra-System Transfers*, *Pharmacy and Medication Management*, *Prenatal and Post-Delivery Services*, *Preventive Services*, *Quality of Nursing Performance*, *Quality of Provider Performance*, *Reception Center Arrivals*, *Specialized Medical Housing (OHU, CTC, SNF, Hospice)*, and *Specialty Services*. The two secondary quality indicators are *Internal Monitoring*, *Quality Improvement*, and *Administrative Operations*; and *Job Performance*, *Training*, *Licensing*, and *Certifications*.

The OIG rates each of the quality indicators applicable to the institution under inspection based on case reviews conducted by OIG clinicians and compliance tests conducted by OIG deputy inspectors general and registered nurses. The ratings 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 results, while the ratings for the primary quality indicators *Health Care Environment* and *Preventive Services* are derived entirely from compliance test results. As another example, primary quality indicators such as *Diagnostic Services* and *Specialty Services* receive ratings derived from both sources. At ISP, 14 of the quality indicators were applicable, consisting of 12 primary clinical indicators and two secondary administrative indicators. Of the 12 primary indicators, seven were rated by both case review clinicians and compliance inspectors, two were rated by case review clinicians only, and three were rated by compliance inspectors only; both secondary indicators were rated by compliance inspectors only.

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

In all areas, the OIG is alert for opportunities to make appropriate recommendations for improvement. Such opportunities may be present regardless of the score awarded to any particular quality indicator; therefore, recommendations for improvement should not necessarily be interpreted as indicative of deficient medical care delivery.

---

## **CASE REVIEWS**

The OIG has added case reviews to the Cycle 4 medical inspections at the recommendation of its stakeholders. At the conclusion of Cycle 3, the federal Receiver and the Inspector General determined that the health care provided at the institutions was not fully evaluated by the compliance tool alone, and that the compliance tool was not designed to provide comprehensive qualitative assessments. Accordingly, the OIG added case reviews in which OIG physicians and nurses evaluate selected cases in detail to determine the overall quality of health care provided to the inmate-patients. 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, ISP Sample Sets*, the OIG clinicians evaluated medical charts for 70 unique inmate-patients. *Appendix B, Table B-4, ISP Case Review Sample Summary*, clarifies that both nurses and physicians reviewed charts for 14 of those patients, for 84 reviews in total. Physicians performed detailed reviews of 30 charts, and nurses performed detailed reviews of 19 charts, totaling 49 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 34 inmate-patients. These generated 1,396 clinical events for review (*Appendix B, Table B-3, ISP Event-Program*). The reporting format 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 seven chronic care patient records, i.e., seven diabetes patients (*Appendix B, Table B-1, ISP Sample Sets*), the 70 unique inmate-patients sampled included patients with 146 chronic care diagnoses, including seven additional patients with diabetes (for a total of 14) (*Appendix B, Table B-2, ISP Chronic Care Diagnoses*). The OIG's sample selection tool evaluated 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 asserts that the physician sample size of over 30 detailed reviews certainly far exceeds the saturation point necessary for an adequate qualitative review. With regard to reviewing charts from different providers, the case review is not intended to be a focused search for poorly performing providers; rather, it is focused on how the system cares for those patients who need care the most. Nonetheless, while not sampling cases by each provider at the institution, the OIG inspections adequately review

most providers. Providers would only escape OIG case review if institutional management successfully mitigated patient risk by having the more poorly performing providers care for the less complicated, low-utilizing, and lower-risk patients. The OIG’s clinicians concluded that the case review sample size was more than adequate to assess the quality of services provided.

Based on the collective results of clinicians’ case reviews, the OIG rated each quality indicator as either *proficient* (excellent), *adequate* (passing), *inadequate* (failing), or *not applicable*. A separate confidential *ISP 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 January to March 2016, deputy inspectors general and registered nurses attained answers to 92 objective medical inspection test (MIT) questions designed to assess the institution’s compliance with critical policies and procedures applicable to the delivery of medical care. To conduct most tests, inspectors randomly selected samples of inmate-patients for whom the testing objectives were applicable and reviewed their electronic unit health records. In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed health records for 426 individual inmate-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 January 4, 2016, field inspectors conducted a detailed onsite inspection of ISP’s medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,191 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 ISP’s plant infrastructure, protocols for tracking medical appeals and local operating procedures, and staffing resources.

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



## ***SCORING OF COMPLIANCE TESTING RESULTS***

The OIG rated the institution in the following nine primary (clinical) and two secondary (administrative) quality indicators applicable to the institution for compliance testing:

- Primary indicators: *Access to Care, Diagnostic Services, Health Information Management (Medical Records), Health Care Environment, Inter- and Intra-System Transfers, Pharmacy and Medication Management, Preventive Services, Specialized Medical Housing (OHU, CTC, SNF, Hospice), and Specialty Services.*
- Secondary indicators: *Internal Monitoring, Quality Improvement, and Administrative Operations; and Job Performance, Training, Licensing, and Certifications.*

After compiling the answers to the 92 questions, the OIG derived a score for each primary and secondary quality indicator identified above by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Based on those results, the OIG assigned a rating to each quality indicator of *proficient* (greater than 85 percent), *adequate* (between 75 percent and 85 percent), or *inadequate* (less than 75 percent).

---

## ***CCHCS DASHBOARD COMPARISONS***

In the first ten medical inspection reports of Cycle 4, the OIG identified where similar metrics for some of the individual compliance questions were available within the CCHCS Dashboard, which is a monthly report that consolidates key health care performance measures statewide and by institution. However, there was not complete parity between the metrics due to differing time frames for data collecting and differences in sampling methods, rendering the metrics non-comparable. In addition, the OIG specifically identified where the SCC's local process erroneously increased its Dashboard results for one of reported measure. This is further described in the *Access to Care* indicator in this report. The Dashboard information will not be provided in future reports to eliminate confusion. Dashboard data is available on CCHCS's website, [www.cphcs.ca.gov](http://www.cphcs.ca.gov).

## **OVERALL QUALITY INDICATOR RATING FOR CASE REVIEWS AND COMPLIANCE TESTING**

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

To derive an overall assessment rating for 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 for the primary quality indicators, which directly relate to the health care provided to inmate-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 inmate-patient population. To identify outcomes for ISP, the OIG reviewed some of the compliance testing results, randomly sampled additional inmate-patients' records, and obtained ISP data from the CCHCS Master Registry. The OIG compared those results to HEDIS metrics reported by other statewide and national health care organizations.

# MEDICAL INSPECTION RESULTS

---

## PRIMARY (CLINICAL) QUALITY INDICATORS OF HEALTH CARE

The primary quality indicators assess the clinical aspects of health care. As shown on the *Health Care Quality Indicators* table on page ii of this report, 12 of the OIG's primary indicators were applicable to ISP. Of those 12 indicators, seven were rated by both the case review and compliance components of the inspection, three were rated by the case review component alone, and two were rated by the compliance component alone.

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

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

The OIG physicians rated the overall adequacy of care for each of the 30 detailed case reviews they conducted. Of these 30 cases, 20 were *adequate*, and 10 were *inadequate*. Among the 1,396 events reviewed, there were 390 deficiencies (28 percent), of which 89 (6 percent) were considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

**Adverse Events Identified During Case Review:** Medical care is a complex dynamic process with many moving parts, subject to human error even within the best health care organizations. Adverse events are typically identified and tracked by all major health care organizations for the purpose of quality improvement. They are not generally representative of medical care delivered by the organization. The OIG identified adverse events for the dual purposes of quality improvement and the illustration of problematic patterns of practice found during the inspection. Because of the anecdotal description of these events, the OIG cautions against drawing inappropriate conclusions regarding the institution based solely on adverse events.

There were two adverse events identified in the case reviews at ISP.

- On February 26, 2015, the radiologist at a community hospital performed a lung biopsy. A 5 to 10 percent pneumothorax (partial lung collapse) occurred during the needle biopsy. The radiologist recommended a chest x-ray on February 27, 2015, as a follow-up to determine if surgical treatment was needed. The x-ray was not performed. Fortunately, no harm resulted to the patient.
- A patient went six days without his asthma rescue medications when he transferred to administrative segregation housing. Fortunately, no harm resulted to the patient.

**Summary of Compliance Results:** The compliance component assessed 9 of the 12 primary (clinical) indicators applicable to ISP. Of these nine indicators, OIG inspectors rated three *proficient*, four *adequate*, and two *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*.

---

## ***ACCESS TO CARE***

This indicator evaluates the institution's ability to provide inmate-patients with timely clinical appointments. Areas specific to inmate-patients' access to care are reviewed, such as initial assessments of newly arriving inmates, acute and chronic care follow-ups, face-to-face nurse appointments when an inmate-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 inmate-patients have Health Care Services Request forms (CDCR Form 7362) available in their housing units.

***Case Review Rating:***

*Adequate*

***Compliance Score:***

*Adequate  
(78.0%)*

***Overall Rating:***

*Adequate*

### ***Case Review Results***

The OIG clinicians rated the *Access to Care* indicator *adequate*. Out of 817 provider and nurse encounters reviewed, there were only 30 deficiencies related to health care access. The clinicians considered six of the deficiencies serious; two of the serious deficiencies occurred upon transitions of care.

- In case 7, a specialist who performed a surgical procedure on a patient recommended that the patient return in two weeks for a follow-up visit. The ISP provider did not order a timely follow-up visit with the specialist. As a result, the specialist saw the patient two weeks late.
- In addition, in case 7, the provider failed to see the patient within three days after an urgent cardiology consultation.
- In case 8, the patient was not scheduled for an RN face-to-face visit within one business day of his sick call request that related to facial swelling and burning.
- In case 56, a provider saw a recently received transfer patient in eight weeks, instead of in two weeks as previously ordered.
- In case 59, the primary care provider untimely saw the patient 15 days after surgery.
- In case 60, the patient was not seen timely after a prolonged outpatient housing unit (OHU) admission.

### ***Clinician Onsite Inspection***

The OIG clinicians interviewed ISP staff regarding the absence of patient backlogs related to both provider caseloads for patients' chronic care needs and federal court compliance mandates. The OIG learned that ISP health care management openly emphasized access to care expectations within the institution. The providers and ancillary staff worked diligently to provide timely care. However,

ISP providers and executive staff had an increasing concern about maintaining those standards due to the recent loss of providers. At the time of the OIG's inspection, ISP had only four of six line providers actively conducting patient encounters.

### ***Compliance Testing Results***

The institution received an *adequate* compliance score of 78.0 percent in the *Access to Care* indicator, but scored in the *proficient* range for the following test areas:

- Inmates had access to Health Care Services Request forms (CDCR Form 7362) at all six housing unit locations inspected (MIT 1.101).
- Inspectors sampled 30 Health Care Services Request forms (CDCR Form 7362) submitted by inmate-patients across all facility clinics. For 29 patients (97 percent), nursing staff reviewed the request form on the same day it was received, and then nursing staff subsequently also completed a face-to-face triage encounter in a timely manner. For one patient, the nurse failed to document the review date on the form, and for another patient, nursing staff completed the triage encounter one day late (MIT 1.003, 1.004).
- Inspectors initially sampled 30 patients who submitted health service request forms. Of these, nine ultimately resulted in a PCP ordering a second provider visit to monitor or treat the patients' conditions. Seven of the nine patients (78 percent) received their subsequent follow-up appointments timely; two patients received their follow-up appointments four days late and 13 days late (MIT 1.006).

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

- Among 28 sampled patients who received a specialty service, 21 (75 percent) received a timely follow-up appointment with a PCP. Seven patients received their appointments from one to 21 days late (MIT 1.008).

The institution scored in the *inadequate* range and has room for improvement in the following areas:

- Among sampled patients who transferred into ISP from other institutions and were referred to a PCP based on nursing staff's initial health care screening, only 8 of 21 (38 percent) were seen timely. Nine inmate-patients were seen from one to 18 days late, and four other patients' appointments were held between 43 and 153 days late (MIT 1.002).
- Among 17 health care service requests sampled from which nursing staff referred the patient for a PCP appointment, 12 of the patients (71 percent) received a timely appointment. Four patients received a PCP follow-up appointment from one to eight days late. One patient received an appointment timely, but the PCP did not document evidence that the patient's

primary concern identified on the health care service request form was addressed (MIT 1.005).

- The OIG reviewed recent appointments for 30 patients who suffered from one or more chronic care conditions and found that 22 (73 percent) had received timely follow-up appointments. Six patients received their follow-up appointments from one to 149 days late. Two other patients never received a following up visit at all. More specifically, the two additional patients had chronic asthma conditions and, at the time of the OIG's review, were overdue for a PCP routine follow-up visit by five to six months. Prior to the conclusion of the OIG's review, ISP was notified of these patients who were lost to follow-up, and the institution's providers performed patient wellness checks (MIT 1.001).
- The OIG tested 23 patients discharged from a community hospital to determine if they received a PCP follow-up appointment within five calendar days of their return to ISP. Seventeen of the patients (74 percent) received a timely PCP follow-up appointment; four patients received their appointments from two to six days late. Two other patients did not receive a PCP follow-up appointment at all (MIT 1.007).

### ***Recommendations***

**No specific recommendations.**

---

## ***DIAGNOSTIC SERVICES***

This indicator addresses several types of diagnostic services. Specifically, it addresses whether radiology and laboratory services were timely provided to inmate-patients, whether the primary care provider (PCP) timely reviewed the results, and whether the results were communicated to the inmate-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 PCP timely reviewed and communicated the pathology results to the patient. The case reviews also factor in the appropriateness, accuracy, and quality of the diagnostic test(s) ordered and the clinical response to the results.

***Case Review Rating:***  
*Adequate*  
***Compliance Score:***  
*Proficient*  
*(85.6%)*  
***Overall Rating:***  
*Adequate*

In this indicator, the OIG’s case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance testing resulting in a *proficient* score. The OIG’s internal review process considered those factors that led to both results and ultimately rated this indicator *adequate*. The key factor was that the compliance score of 85.6 percent was within 1 percentage point of the upper end of the compliance review’s range limit to receive an *adequate* score. As a result, the OIG inspection team could not justify elevating the case review’s rating to a *proficient* level based on the compliance score.

### ***Case Review Results***

The OIG clinicians reviewed 135 diagnostic events and found 15 deficiencies, four of which were serious. All of the serious deficiencies were related to poor provider diabetic care. Often, significant lab abnormalities were reviewed and ordered to be followed up upon at the next chronic care appointment. These examples are discussed further in the *Quality of Provider Performance* indicator. Otherwise, ISP successfully performed and completed timely diagnostic services, PCPs reviewed reports timely, and patients were notified of the test results quickly. Action time lines were usually met, but the clinical response to the diagnostic data was occasionally poor, negatively affecting management of the patient. Still, the OIG case review rated diagnostic services *adequate*.

- In case 54, the provider should have arranged for an immediate clinic visit to address a patient’s very high HbA1c level (lab test for diabetes) that corresponded with an average blood glucose greater than 500 mg/dL. The patient was not seen until nearly three weeks later.
- In case 51, after lab tests indicated a patient had poor diabetic control and without a patient evaluation, the provider still extended the due date for the patient’s next diabetic appointment from four months to five months. Based on the test results, the provider should have expedited the next visit to occur within one month.



- In case 57, even though a laboratory test showed a patient had a glucose level greater than 230 mg/dl, the patient was still scheduled to be seen in four months. Based on the test results, the provider should have arranged an earlier appointment.
- In case 58, the provider failed to consider modifying the patient's diabetic management when lab testing showed an average glucose level greater than 215 mg/dL in a patient awaiting elective surgery.

### **Scanning of Radiology Imaging Results**

During the case review process, OIG clinicians were able to consistently locate radiology reports in patients' eUHR files due to the ISP practice of scanning radiology results despite the prohibition on this practice enacted by separate memoranda issued in August 2014 and February 2016 by CCHCS' Deputy Director of Medical Services. CCHCS' directive designated the Radiology Information System (RIS), a separate non-eUHR system, as the sole repository of all radiology studies because RIS preserves images of higher quality than the eUHR does. The OIG disagrees with CCHCS' directive and concurs with the institution's practice of scanning the written radiology reports into the eUHR because providers routinely access the eUHR during record reviews. Providers are able to see the written reports, but they are still able to access RIS to view the radiology images if needed.

### ***Compliance Testing Results***

The institution received a *proficient* compliance score of 85.6 percent in the *Diagnostic Services* indicator, which encompasses radiology, laboratory, and pathology services. For clarity, each diagnostic service type is discussed separately below:

#### **Radiology Services**

- All ten radiology services sampled were timely performed. However, when reviewing radiology reports, providers initialed and dated only six of them (60 percent) to evidence that they reviewed the report within two business days of receipt. Four reports did not have adequate evidence of timely review. More specifically, providers reviewed two report results three and ten days late. Two additional patients' reports included evidence of provider review but lacked the date reviewed, so inspectors could not determine their timeliness. Finally, providers communicated the radiology results timely to nine of the patients (90 percent). For one patient, the provider communicated the results three days late (MIT 2.001, 2.002, 2.003).

#### **Laboratory Services**

- ISP performed well in laboratory services. Nine out of ten laboratory services sampled were timely performed (90 percent) with only one lab service performed eight days late. In addition, ordering providers timely reviewed the diagnostic report results for all ten sampled

patients, and the test results were also timely communicated to all ten of them (MIT 2.004, 2.005, 2.006).

### **Pathology Services**

- The institution documented eUHR evidence that it timely received a final pathology report for all ten patients sampled . Further, for all ten samples for which the institution received a final report, providers timely reviewed the results. In a related area, providers timely communicated the final pathology results to only three of the ten applicable patients (30 percent). Seven other patients did receive their pathology results from the provider, but they were received from one to 17 days late (MIT 2.007, 2.008, 2.009).

### ***Recommendation for CCHCS***

The OIG recommends that CCHCS revise its radiological report storage policy to mandate that written radiology reports be stored in the patient’s eUHR medical record as well as RIS.

### ***Recommendations for ISP***

**No specific recommendations.**

---

## ***EMERGENCY SERVICES***

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

***Case Review Rating:***

*Adequate*

***Compliance Score:***

*Not Applicable*

***Overall Rating:***

*Adequate*

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

### ***Case Review Results***

The OIG clinicians reviewed 74 urgent/emergent events and found 26 deficiencies, most of which were related to nursing, and most of which were minor and did not place the patient at significant risk of harm. Notable exceptions are discussed below. In general, ISP performed well in emergency response times, BLS, ACLS, and 9-1-1 call activation times. Despite the deficiencies noted, case review showed that most patients requiring urgent or emergent services received timely and adequate care.

### **Provider Performance**

While providers covering the triage and treatment areas (TTA) generally made appropriate triage decisions and patients were sent to the appropriate levels of care, one exception was noted:

- In case 1, the provider failed to consider opiate intoxication in a patient with altered mental status, pinpoint pupils, and a recent increase in prescribed narcotics prior to sending the patient out to the hospital.

### **Nursing Performance**

Nursing care was generally adequate during emergency responses; however, there were some deficiencies, as noted below, relating to failures to document thorough and complete nursing actions and care:

- In case 15, during an encounter with a patient who had chest pains, the RN delayed giving aspirin and nitroglycerin for almost one hour.

- In case 16, a patient who experienced a seizure and fall received multiple injuries. There was a 40-minute delay between the initial notification to the TTA and the patient's arrival in the TTA. In addition, the nursing first responder's notes were illegible and incomplete.

### **Emergency Medical Response Review Committee**

The ISP's Emergency Medical Response Review Committee (EMRRC) reviewed only unscheduled transported patients who required a higher level of care and who were transported by air ambulance services. The committee's review focus was too limited and not within the intent of current statewide policy. In addition, the limited scope of review was insufficient to adequately monitor and evaluate the institution's typical emergency responses, which were more likely to involve a ground response only, without the need for air ambulance transportation.

### **Conclusion**

ISP staff provided adequate emergency services to their patients. TTA providers usually made appropriate assessments and triage decisions. Nursing staff at ISP generally provided appropriate assessment, intervention, and monitoring during emergency medical responses; however, there were some identified failures to follow established protocols and to complete required documentation. Finally, in discordance with current CCHCS policy, only patients who required air ambulance transportation out of the institution were reviewed for care and treatment by ISP's EMRRC.

### ***Recommendation***

The OIG recommends that nursing staff who typically act as first responders receive refresher training on emergency response protocols and requirements of complete documentation.

---

## ***HEALTH INFORMATION MANAGEMENT (MEDICAL RECORDS)***

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 unit health record (eUHR); whether the various medical records (internal and external, e.g., hospital and specialty reports and progress notes) are obtained and scanned timely into the inmate-patient's eUHR; whether records routed to clinicians include legible signatures or stamps; and whether hospital discharge reports include key elements and are timely reviewed by providers.

***Case Review Rating:***

*Adequate*

***Compliance Score:***

*Inadequate*

(64.6%)

***Overall Rating:***

*Inadequate*

In this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance testing resulting in an *inadequate* score. The OIG's internal review process considered those factors that led to both results. The compliance testing for this indicator is more robust and specifically focuses on the accuracy of the institution's medical records unit, so the *inadequate* compliance score outweighed the case review finding for the overall rating.

### ***Case Review Results***

The OIG clinicians found minor deficiencies during case review of ISP's health information management. Out of the 387 (total) deficiencies identified in case reviews, 35 were related to health information management processes, five of which were serious enough to likely contribute to patient harm. Despite those five deficiencies, described below, the overall case review rating was *adequate*.

#### **Inter and Intra-System transfers**

- In case 4, an intra-system transfer patient's initial health screening form and the second page of an OHU nursing admission assessment form were missing from the eUHR.

#### **Hospital Records / Specialty Services**

- In case 53, hospital emergency records for a patient with chest pain were not scanned into the eUHR.
- In case 59, hospital ER records for a patient with a traumatic skull fracture were not scanned into the eUHR.

- In case 13, after receiving surgery for a broken arm, the patient returned from the hospital without discharge records. The orthopedist consult report was not scanned into the eUHR for two weeks.
- In case 58, the wrong patient's ophthalmology report was in the eUHR.

## **Diagnostic Reports**

The OIG found a small number of delays, from retrieval of laboratories to the scanning and sharing of the information with the patient.

## **Scanning Performance**

Scanning times for most documents were generally good, with only 9 of the 37 deficiencies relating to scanning delays. Once reviewed by a provider, all reports were generally scanned within an adequate time frame.

In a related area, see the Scanning of Radiology Imaging Results section of the *Diagnostic Services* indicator for discussion about ISP's practices regarding the scanning of radiological images.

## **Legibility of Provider Notes**

With dictation, illegibility in this institution was rare.

## ***Compliance Testing Results***

The institution received an *inadequate* compliance score of 64.6 percent in the *Health Information Management (Medical Records)* indicator and showed room for improvement in the following areas:

- The institution scored zero in its labeling and filing of documents scanned into inmate-patients' electronic unit health records; most documents were mislabeled, such as a Form 7362 Health Care Services (HCS) Request (used by patients to request health services) that was scanned and labeled as a Form 7243 HCS Physician Request for Services (used by doctors to order specialty services). Other documents were simply missing from the eUHR altogether. For this test, once the OIG identifies 12 mislabeled or misfiled documents, the maximum points are lost and the resulting score is zero. During the ISP medical inspection, inspectors identified a total of 19 documents with scanning or filing errors, seven more than the maximum allowable errors (MIT 4.006).
- Inspectors tested 20 PCP-dictated progress notes to determine if staff scanned the documents within five calendar days of the patient encounter date. Only six of the documents were scanned timely (30 percent). The other 14 documents were scanned from one to 16 days late (MIT 4.002).

- Among hospital discharge records for 23 sampled inmate-patients whom the institution sent to the hospital for a higher level of care, only 15 were complete, included key elements, and were reviewed timely by an ISP provider (65 percent). In the eight others, either the discharge report lacked one or more key elements, such as the discharge date; the provider initialed but did not date the discharge report to evidence a timely review; or a provider did initial and date the discharge report, but the review occurred one or two days late (MIT 4.008).
- Clinical staff legibly documented their names on only 23 of 32 sampled medical documents that included hospital discharge reports, initial health screening forms, certain medication administration records, and specialty service reports (72 percent) (MIT 4.007).

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

- ISP staff scanned all 20 sampled specialty service consultant reports into the eUHR within five days of the date the specialty service was performed (MIT 4.003).
- Staff timely scanned 19 of 20 miscellaneous non-dictated documents, including provider progress notes, nursing initial health screening forms, and patient requests for health care services (95 percent). Only one initial health screening form was scanned late and only by one day (MIT 4.001).

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

- Staff timely scanned 16 of 20 sampled community hospital discharge reports into the eUHR (80 percent). Four reports were scanned between two and nine days late (MIT 4.004).
- ISP staff timely scanned 15 of 20 sampled MARs into the eUHR (75 percent). Five MARs were scanned between one and three days late (MIT 4.005).

## ***Recommendations***

**No specific recommendations.**

## ***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 inmate-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:***

*Adequate*

*(80.6%)*

***Overall Rating:***

*Adequate*

### ***Compliance Testing Results***

The institution scored well in the *Health Care Environment* indicator, with an *adequate* compliance score of 80.6 percent.

The institution performed at a *proficient* level in the following areas:

- All nine clinics were appropriately disinfected, cleaned, and sanitary. Cleaning logs were present and completed indicating that cleaning crews cleaned the clinic as scheduled (MIT 5.101).
- Health care staff in all eight applicable clinics ensured that medical staff properly sterilized and disinfected reusable invasive and non-invasive medical equipment (MIT 5.102).
- ISP was compliant at all nine clinics regarding mitigation of exposure to blood-borne pathogens and contaminated waste (MIT 5.105).
- ISP's non-clinic medical storage areas generally met the supply management process and support needs of the medical health care program, earning a score of 100 percent on this test. During the OIG's inspection, however, the ISP warehouse manager reported that medical product shipments from the warehouse storage location to the various clinic end users could be better controlled (to help prevent theft) with a larger more secure transportation cart that ISP management had not yet approved (MIT 5.106).
- Eight out of nine clinics followed adequate protocols for managing and storing bulk medical supplies, scoring 89 percent. The one exception was the OHU that had a disorganized storage area with some medical supplies stored on the ground (MIT 5.107).



- Eight of the institution's nine clinic common areas had an environment conducive to providing medical services (89 percent), such as acceptable wheelchair access, adequate patient waiting areas, sufficient non-exam-room clinician work space, and reasonable patient privacy in common area triage stations. However, inspectors identified one exception related to a clinic's common area where patient vital signs were taken that did not allow for auditory privacy because it was within audible range of other patients who periodically waited nearby (MIT 5.109).

The institution performed at an *adequate* level in the following area:

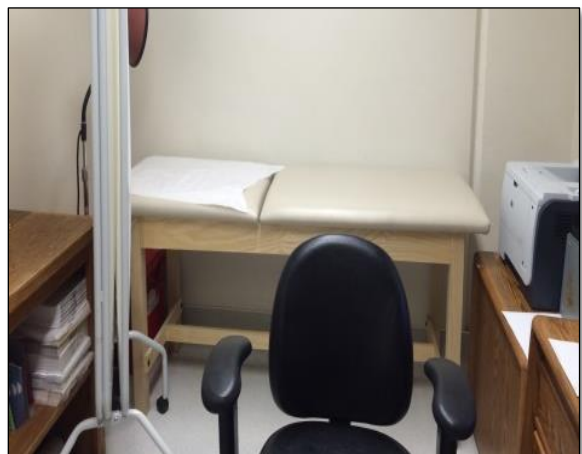
- Seven of nine clinics (78 percent) had adequate hygiene supplies and operable sinks; however, two clinics did not have adequate hand sanitation supplies. At one clinic's restroom, the soap dispenser was empty and there was no antiseptic soap. At another location that was undergoing construction activity, patients were redirected to utilize a nearby gym's restroom. However, the restroom had no antiseptic soap or disposable paper towel supplies (Figure 1) (MIT 5.103).



*Figure 1: Gym restroom, used as clinic's designated patient restroom, without supplies of antiseptic soap or disposable paper towels available for patient use*

While ISP generally performed adequately in the *Health Care Environment* indicator, the following specific areas scored in the *inadequate* range:

- Only four of eight applicable clinics (50 percent) had exam rooms with an adequate environment for providing medical services. More specifically, inspectors observed one or more of the following conditions: exam rooms did not have means to ensure patient privacy, such as a dedicated privacy screen; some exam tables had torn or ripped vinyl covers; or the exam table was situated in the exam room with insufficient space for a patient to extend his legs or lie down flat or for the provider to move freely within the room (Figure 2).



*Figure 2: Physician room with inadequate exam table patient space*

- In addition, confidential medical records either were not properly stored in designated shred containers or were inappropriately discarded in trashcans (Figure 3). In the specialty clinic, there were not enough computers accessible to health care staff (MIT 5.110).
- At only four of seven inspected emergency response bag staging locations (57 percent), emergency response bags were inspected daily and inventoried monthly, and contained all essential items. In one location, an oxygen tank was not full; in another location, a required blood pressure cuff was missing from a bag's contents; finally, in a third location, the response bag contained the required items, but staff did not always complete the required daily inspection log (MIT 5.111).
- Clinicians adhered to universal hand hygiene precautions at only four of seven applicable clinics observed, scoring 57 percent on this test. At three clinics, the treating clinicians either failed to sanitize their hands prior to applying gloves, or the clinicians did not timely remove the gloves after examining a patient and before completing other tasks, such as making a phone call (MIT 5.104).
- OIG inspectors visited all nine clinics where medical services were provided to ensure that clinic common areas and exam rooms had required medical equipment and supplies. Of the nine, only six were properly equipped and adequately stocked (67 percent). Three clinics were missing either necessary supplies or functional core equipment essential to conduct a comprehensive exam. Missing items included a medication refrigerator, a nebulization unit, an oto-ophthalmoscope and tips, tongue depressors, bio-hazard containers, and a clearly established permanent distance marker for the Snellen eye chart. In addition, the specialty clinic had specialized optometry equipment that had been in disrepair over two months. The institution's staff reported that a request to replace the optometry equipment had been made but had not yet occurred (MIT 5.108).



*Figure 3: Confidential medication record openly lying in trashcan*

### **Other Information Obtained from 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 adequate health care. This question was not scored. Overall, ISP's health care management did not have any significant concerns about the institution's existing infrastructure or its ability to provide adequate health care to the inmate population. However, as discussed below, there were several projects underway to improve the delivery of health care at ISP, and there was a system in place to

identify and report facility infrastructure problems when they occurred. At the time of the OIG's inspection, ISP had three ongoing projects:

- Project A: Statewide Medication Distribution Improvements Project using the Inmate/Ward Labor Program (IWL) for labor.

This project involved the renovation of Facilities A, B, C, and D existing space, specifically to allow for the safe, efficient, and effective distribution of medications, as well as to provide more space in the clinics. According to the institution, all four of the facility renovation projects were completed in February 2016.

- Project B: Health Care Facility Improvement Plan (HCFIP) using IWL.

According to the institution's health care management, this project will involve renovations and additions to primary care clinics at Facilities A, B, C, and D, and renovation to the central health services building. The facility renovations and addition will provide primary health care consultation and treatment areas, including lab draw stations. The central health services building renovation will provide additional shared specialty service exam room space, clinical support space, a relocated physical therapy room, optical services area, a mental health assessment room, and an expanded treatment and triage area. Drawings for this project are expected to be completed in June 2016, with construction starting soon after. The construction phase is scheduled to be completed in December 2017.

- Project C: Heating, Ventilation, and Air Conditioning using IWL.

This project will replace the institution's existing evaporative cooling system (currently shared with the neighboring Chuckawalla Valley State Prison) by building a new centralized chiller plant exclusively for ISP, located on the ISP site. The scope includes new piping for a chilled water distribution main loop, improvements to existing roofs, fire dampers, and smoke evacuation systems. The site will also receive a new electrical substation. According to the institution, a lawsuit by one of the losing contractors over the bidding process stalled this construction project. However, construction resumed in January 2016. The estimated completion time is July 2018.

## ***Recommendations***

The OIG recommends that ISP implement the following:

- Properly stock and maintain all clinic areas with a full complement of core equipment, including nebulization units, medication refrigerators, and Snellen eye chart with established distance marker. Also, ensure that each exam room has tongue depressors, a biohazard waste receptacle, an oto-ophthalmoscope and tips.

- Ensure that in all exam settings, the room is arranged so that a patient can lie fully extended on the exam table, and the provider and patient can move freely within the room.
  - Conduct periodic training and refresher courses on proper hand sanitation techniques and protocols that staff should follow when applying and removing protective gloves during patient encounters.
  - Train all medical staff on the proper protocols to be followed when temporarily storing or discarding confidential patient paper medical records. Require nursing supervisors to routinely monitor for patient confidential records compliance.
-

## ***INTER- AND INTRA-SYSTEM TRANSFERS***

This indicator focuses on the management of inmate-patients' medical needs and continuity of patient care during the inter- and intra-facility transfer process. The patients reviewed for *Inter- and Intra-System Transfers* include inmates received from other CDCR facilities and inmates transferring out of ISP to another CDCR facility. The OIG review includes evaluation of the institution's ability to provide and document health screening assessments, initiation of relevant referrals based on patient needs, and the continuity of medication delivery to patients arriving from another institution. For those patients, the OIG clinicians also review the timely completion of pending health appointments, tests, and requests for specialty services. For inmate-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 Rating:***

*Inadequate*

***Compliance Score:***

*Proficient*

(96.7%)

***Overall Rating:***

*Adequate*

In this indicator, the OIG's case review and compliance review processes yielded different results, with case reviews giving an *inadequate* rating and the compliance review resulting in a *proficient* score. Case reviews focused on qualitative measures, while the compliance review focused on quantitative ones. The OIG's internal review process considered those factors that led to both results and ultimately rated this indicator *adequate*. Case review revealed severe deficiencies in the quality of care for patients returning from outside community hospitals. Most of these deficiencies were from poor provider performance and decision-making. As these types of performance deficiencies contributed to the inadequate rating of the *Quality of Provider Performance* indicator, their influence on this rating's overall score was diminished to avoid penalizing twice for the same deficiencies. As a result, the overall indicator rating given was *adequate*.

### ***Case Review Results***

Clinicians reviewed 82 encounters relating to *Inter- and Intra-System Transfers*, including information from both the sending and receiving institutions. These included 63 hospitalization events, each of which resulted in a transfer back to the institution. There were eight serious deficiencies during hospitalization events. As noted in the *Specialty Services* and *Quality of Provider Performance* indicators, ISP utilized the urgent care physician, rather than the patient's regular PCP, to evaluate the patients who returned from the hospital or specialty services. This protocol resulted in the loss of the complete care model. This model is a patient-centered health care delivery system, approved by CCHCS, whereby one primary care provider actively follows a patient in all health care matters. ISP's divergence from this model was a major contributing factor

to several severe deficiencies. In addition, there were minor deficiencies regarding nursing assessment and documentation and completion of transfer forms.

### **Transfers In**

- In case 4, the patient's Initial Health Screening form (CDCR Form 7277), as well as the second page of an OHU nursing admission assessment form, were not in the eUHR.

### **Hospitalizations**

Patients returning from hospitalizations are some of the highest-risk encounters due to two factors. First, these patients are generally hospitalized for a severe illness or injury. Second, they are at risk due to potential lapses in care that can occur during any transfer. There were documentation deficiencies and hospital recommendations for several cases that were not addressed upon the patient's return to the institution. These serious deficiencies are described below:

- In case 4, the TTA RN did not complete a thorough abdominal and surgical wound assessment on a patient who had multiple chronic diseases and conditions. The RN failed to visualize, assess, or document the presence and condition of the dressings.
- In case 7, a patient was transferred to the hospital for a scheduled surgery without having undergone a cardiac stress test that was previously recommended by the cardiologist. This test was medically necessary to ensure the patient's chest pain symptoms were not caused by an unstable condition.
- In case 14, a 39-year-old patient with hypertension and obesity presented with chest pain. The electrocardiogram (EKG) and lab test for heart injury were normal. The ER physician discharged the patient with recommendations to have a stress test and an urgent cardiac evaluation. Several days later, the ISP provider evaluated the patient and diagnosed him with non-cardiac chest wall pain, but failed to address the ER physician's recommendations.
- In case 16, the ER physician found the patient had anemia and an abnormal computerized tomography (CT) scan of the abdomen with colon wall thickening. The ER physician recommended a gastroenterology consultation. The ISP provider failed to address these findings when the patient was seen for a follow-up visit.
- In case 16, the patient was sent to the ER for head trauma after a seizure and fall. The ER physician advised a neurology consultation based on an abnormal CT scan of the brain. The ISP provider failed to order the neurology consultation when the patient was seen for a follow-up visit.
- In case 50, the patient was sent to the ER for management of chest pain. The ER physician advised treatment with a nitroglycerin-type medication and a follow-up cardiac stress test for this patient with multiple risk factors for heart disease. These recommendations were not

implemented by either the covering urgent care provider or the patient's usual primary care provider. In addition, the patient's usual provider inappropriately advised the patient to follow up as needed, without scheduling a follow-up for the primary care provider.

- In case 53, the patient was sent to the ER due to complaints of chest pain. The corresponding medical records were not in the eUHR.
- In case 59, the ER medical records for a patient with traumatic skull fractures were not in the eUHR.

### **Onsite Visit**

The onsite visit provided valuable insight into the institution's workflow. Physicians were well versed in their roles as primary care providers. ISP also designated an urgent care physician of the day (POD); however, the practice was not always in the patient's best interest because the POD evaluated patients returning from community hospitals or specialists without being fully aware of their current health care status or historical chronic care problems. More specifically, vital medical information during the transfer process was delayed or missed when the urgent care provider, rather than the primary care physician, evaluated the patient. Ownership of the patient's health care was lost in many of the cases discussed above. Further discussion is provided in the *Quality of Provider Performance* indicator.

### **Compliance Testing Results**

The institution obtained a *proficient* compliance score of 96.7 percent in the *Inter- and Intra-System Transfers* indicator. ISP performed in the *proficient* range in four of the five tests, as described below:

- Inspectors sampled 20 inmate-patients who transferred out of ISP to other CDCR institutions to determine whether ISP listed their scheduled specialty service appointments on the Health Care Transfer Information form (CDCR form 7371). All 20 sampled patients had the service correctly listed on the form (MIT 6.004).
- OIG inspectors observed scheduled transfers of ten inmates being sent out of the institution to ensure that their transfer packages contained required medications and corresponding documentation; only six of them were inmate-patients with prescribed medications and thus subject to the test. Based on a review of all six applicable transfer packages, all required medications and support documentation were present (MIT 6.101).
- For all 26 inmate-patients sampled who transferred into the institution and required the assessment and disposition sections of the Initial Health Screening form (CDCR Form 7277) to be completed, nursing staff did so on the day of the patients' arrival (MIT 6.002).

- Out of 30 sampled inmate-patients who transferred into the institution, only four had an existing medication order that required nurses to issue or administer medications upon the patient's arrival. All four of those patients received their medications timely and without interruption (MIT 6.003).

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

- For 25 of 30 sampled inmate-patients who transferred into the institution (83 percent), nursing staff properly completed an initial health screening assessment form on the same day the patient arrived. For five of the sampled patients, nurses completed the screening forms timely, but they did not ensure that all applicable form questions were answered, or else they failed to document other required supplemental information (MIT 6.001).

### ***Recommendations***

**No specific recommendations.**

---



## ***PHARMACY AND MEDICATION MANAGEMENT***

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

***Case Review Rating:***

*Adequate*

***Compliance Score:***

*Inadequate*  
(70.9%)

***Overall Rating:***

*Inadequate*

In this indicator, the OIG's case review and compliance review processes yielded different results, with case review yielding an *adequate* rating and the compliance review giving an *inadequate* score. The case reviews focused on qualitative measures, while the compliance review focused on quantitative ones. Because the compliance testing for this indicator has more robust sampling and testing, the compliance score outweighed the case review rating. As a result, the inspection team considered this indicator *inadequate* overall.

### ***Case Review Results***

In the majority of cases, patients received their medications timely and as prescribed. ISP also adequately maintained medication continuity for most patients returning from the hospital. However, deficiencies of a more serious nature were found in several cases. These include the following:

- In case 9, a patient's dose of Nexavar (anticancer medication) was not given, and the reason for the missed dose was not documented on the medication administration record (MAR). Additionally, multiple days' doses of propranolol (to decrease high blood pressure) were not administered, and the nurse did not document a justification for the missed doses.
- In case 45, the patient was transferred to the administrative segregation unit from another yard. The patient did not receive his KOP asthma inhalers until six days later. Additionally, one dose of the patient's anti-seizure medication was not given, and the missed dose was not explained on the MAR.
- In case 51, the PCP ordered ciprofloxacin and metronidazole (antibiotics) to be started on the day of the patient's discharge from a community hospital after an appendectomy. Neither medication was started until the following day.

- In case 52, the PCP ordered doxycycline (antibiotic) to be given “stat” (immediately) for treatment of possible pneumonia. The first dose was not administered until the following day.
- In case 58, the patient’s medication reconciliation form reflected that two insulin regimens were prescribed, although one of the insulin regimens had been previously discontinued by the primary care provider. The patient’s pharmacy record was not correctly changed to reflect the provider’s order.

## **Conclusion**

Although OIG case review clinicians did identify some serious issues within the *Pharmacy and Medication Management* indicator, ISP generally maintained adequate medication continuity for most patients. As a result, case review clinicians rated pharmacy and medication administration performance *adequate*.

## ***Compliance Testing Results***

The institution received an *inadequate* compliance score of 70.9 percent in the *Pharmacy and Medication Management* indicator. For discussion purposes below, this indicator is divided into three sub-indicators: Medication Administration, Observed Medication Practices and Storage Controls, and Pharmacy Protocols.

### **Medication Administration**

In this sub-indicator, the institution received an *adequate* average score of 77 percent, performing well in the following three areas:

- The institution timely administered or delivered new medication orders to 28 of the 30 patients sampled (93 percent). The other two inmate-patients received their new medication orders 8 and 14 days late (MIT 7.002).
- Of 30 sampled ISP patients who had transferred from one housing unit to another, 25 of them (83 percent) received their prescribed medications without interruption. Five patients did not receive their medications by the next dosing interval after the transfer (MIT 7.005).
- The institution properly administered chronic care medications to 17 of 22 inmate-patients sampled (77 percent). However, five of the 22 patients had one or more identified deficiencies related to the proper and timely receipt of their medications. More specifically, four patients received a refill of their KOP medications from 5 days to 15 days late. A provider changed a fifth patient’s medication from simvastatin to atorvastatin, but the patient received both medications on one day. One of the patients discussed above had a critical insulin medication dose missed with no nurse referral or provider counseling , and another

patient had each of two different medications incurring a two-month lapse between pharmacy refills (MIT 7.001).

The institution could improve in the following medication administration areas:

- Only 14 of 23 sampled patients who were discharged from a community hospital had their needed medications timely provided (61 percent). Of the other nine patients, six received their medications late, one patient never received his medication, and two patients who were on multiple medications experienced both deficiencies (some medication was issued late, and some not at all). Of those patients who received medications late, the delays ranged from one to 16 days (MIT 7.003).
- Nursing staff administered medications without interruption to five out of seven patients who were en route from one institution to another and had a temporary layover at ISP (71 percent). For two patients, there was no documented eUHR evidence that they received their medications while temporarily housed at ISP (MIT 7.006).

### **Observed Medication Practices and Storage Controls**

In this sub-indicator, the institution received an *inadequate* average score of 45 percent, scoring poorly in the following five tests:

- The OIG interviewed nursing staff and inspected storage areas specifically for the storage of narcotics at seven applicable locations to assess whether strong narcotics security controls existed. Only one of the seven areas (14 percent) was adequately controlled. All six exceptions related to missing signatures in the narcotics log book, indicating a habitual lack of physical shift inventories performed by nursing staff who safeguard the narcotics storage areas (MIT 7.101).
- Non-narcotic medications not requiring refrigeration were properly stored at only 3 of 12 applicable clinic and medication line storage locations (25 percent). At eight clinics, there was no system in place to temporarily store medications pending return to the pharmacy, and at another clinic, internal and external medications were not stored separately (MIT 7.102).
- Narcotic medications requiring refrigeration were properly stored at only two of seven locations inspected (29 percent). At five other clinic locations, there was no established process to separate refrigerated medication awaiting return to the pharmacy from other medications intended for patient use. Further, at two of these five clinics, refrigeration temperature logs were missing required daily entries evidencing that the units were operating within required temperature ranges. Finally, one of the five locations also had expired medication in stock (MIT 7.103).
- Only two of five applicable medication preparation and administration locations (40 percent) employed appropriate administrative controls and protocols when distributing medications

to inmate-patients. At three inspected locations, the institution was not equipped with appropriate physical structures to protect patients waiting outside to receive their medications during periods of extreme heat or inclement weather (MIT 7.106).

- Nursing staff at three of five sampled medication preparation and administration locations (60 percent) followed proper hand hygiene contamination control protocols during the medication preparation and administration processes. Nurses at two locations did not sanitize their hands when required, such as prior to initially putting on gloves and before each subsequent re-gloving (MIT 7.104).

ISP scored well on the following test:

- ISP nursing staff at all five sampled locations employed appropriate administrative controls and protocols when preparing inmate-patients' medications (MIT 7.105).

### **Pharmacy Protocols**

In this sub-indicator, the institution received a *proficient* average score of 96 percent in the following tests:

- The institution's main pharmacy followed general security, organization, and cleanliness management protocols; properly stored non-refrigerated medications; and properly stored and monitored non-narcotic medications that require refrigeration (MIT 7.107, 7.108, 7.109).
- The ISP pharmacist-in-charge (PIC) documented and retained evidence that he reviewed the monthly narcotics inventory results for the institution's clinic and medication line storage locations (MIT 7.110).
- The institution's PIC properly processed only 24 of 30 sampled medication error reports (80 percent). For six medication error reports, the PIC completed the corresponding medication error follow-up reports between 6 and 43 days late (MIT 7.111).

### **Non-Scored Tests**

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

During the OIG's site visit, the OIG visited inmate-patients in isolation units to determine if they had immediate access to their prescribed KOP rescue inhalers and nitroglycerin medications. All four applicable patients identified had possession of rescue medications (MIT 7.999).

## ***Recommendations***

The OIG recommends that ISP implement the following:

- As part of staff's performance evaluation, management evaluate clinicians' compliance and understanding of good hand sanitation practices.
  - Develop a local operating policy that establishes the protocols clinics and medication lines should follow when temporarily storing medications designated for pharmacy return.
-

## ***PREVENTIVE SERVICES***

This indicator assesses whether various preventive medical services are offered or provided to inmate-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 inmate-patients identified as being at higher risk for contracting coccidioidomycosis (valley fever).

***Case Review Rating:***

*Not Applicable*

***Compliance Score:***

*Adequate  
(76.7%)*

***Overall Rating:***

*Adequate*

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

### ***Compliance Testing Results***

The institution performed in the *adequate* range in the *Preventive Services* indicator, with a compliance score of 76.7 percent. The institution scored in the *proficient* range in the following two tests:

- The institution timely offered all 30 sampled inmate-patients an influenza vaccination for the most recent influenza season (MIT 9.004).
- Of 30 patients aged 50 through 75 whom the OIG sampled for colorectal cancer screening (90 percent), 27 either had a normal colonoscopy within the last ten years or had been offered a colon cancer screening in the last year (MIT 9.005).

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

- The institution scored 85 percent for administering timely anti-tuberculosis medications to inmate-patients with tuberculosis. Seventeen of 20 sampled patients received their medication timely, while three inmate-patients did not receive their medications in accordance with providers' orders. More specifically, one patient missed a required medication dose and did not receive the required provider counseling for the missed dosage, a second patient received an extra dose of the medication on a prescribed non-dosing day, and a third patient had two additional weeks of medication ordered but never administered (MIT 9.001).
- The OIG initially selected 30 patients with various chronic medical conditions, 14 of whom required one or more routine vaccinations based on the particular condition. Of the 14 patients, 11 were timely offered vaccinations for influenza, pneumonia, and hepatitis (79 percent). Three patients had no eUHR record that indicated they received, or that the institution offered, the recommended influenza, hepatitis A, and pneumococcal immunizations within the required time frame (MIT 9.008).

The institution scored poorly and displayed room for improvement in the following two tests:

- OIG inspectors tested 30 inmate-patients for evidence of a properly completed annual tuberculosis (TB) screening within the last year. Fifteen of the sampled patients were classified as code 34 (subject only to an annual signs and symptoms check), and 15 sampled patients were classified as a code 22 (requiring a skin test in addition to a signs and symptoms check). In total, 14 of the 30 sampled patients (47 percent) timely received these annual tuberculosis screenings. While the remaining 16 sampled patients also received a screening evaluation, it was either not properly completed or not properly documented. Thirteen code 22 samples had deficiencies, while only three of the code 34 samples had deficiencies. The inadequate screenings involved one or more of the following deficiencies: ISP nurses who performed the TB screening did not fully complete the history evaluation section of the TB report (seven samples); the administration and reading time of the TB skin test was not completed within a 72-hour period (two samples); or the nurse did not document the time the TB test was administered or read, making it undeterminable if both were done within a 72-hour period (two samples). Lastly, for ten samples, LVNs, instead of RNs, PCPs, or public health nurses as CCHCS policy requires, read the TB test results (MIT 9.003).
- Only 12 of 20 sampled patients who received anti-tuberculosis medications received required weekly or monthly monitoring (60 percent). For 8 of the 20 samples, either the patients missed one of their weekly or monthly TB monitoring events, staff failed to scan the monitoring results into the eUHR after each clinical encounter, or a combination of both deficiencies occurred (MIT 9.002).

### ***Recommendations***

**No specific recommendations.**

---

## ***QUALITY OF NURSING PERFORMANCE***

The *Quality of Nursing Performance* indicator is a qualitative evaluation of the institution's nursing services. The evaluation is completed entirely by OIG nursing clinicians within the case review process, and, therefore, does not have a score under the compliance testing component. The OIG nurses conduct case reviews that include reviewing face-to-face encounters related to nursing sick call requests identified on the Health Care Services Request form (CDCR Form 7362), urgent walk-in visits, referrals for medical services by custody staff, RN case management, RN utilization management, clinical encounters by licensed vocational nurses (LVNs) and licensed psychiatric technicians (LPTs), and any other nursing service performed on an outpatient basis. The OIG case review also includes activities and processes performed by nursing staff that are not considered direct patient encounters, such as the initial receipt and review of CDCR Form 7362 service requests and follow-up with primary care providers and other staff on behalf of the patient. Key focus areas for evaluation of outpatient nursing care include appropriateness and timeliness of patient triage and assessment, identification and prioritization of health care needs, use of the nursing process to implement interventions including patient education and referrals, and documentation that is accurate, thorough, and legible. Nursing services provided in the outpatient housing unit (OHU), correctional treatment center (CTC), or other inpatient units are reported under the *Specialized Medical Housing* indicator. Nursing services provided in the triage and treatment area (TTA) or related to emergency medical responses are reported under *Emergency Services*.

***Case Review Rating:***

*Adequate*

***Compliance Score:***

*Not Applicable*

***Overall Rating:***

*Adequate*

### ***Case Review Results***

The OIG clinicians reviewed 343 outpatient nursing encounters and identified 61 deficiencies in the quality of nursing care, six of which were serious (cases 1, 9, 23, and 28). Of particular note, case 9 had three of the serious deficiencies. However, nursing care was generally acceptable, and case review showed that the institution's outpatient nursing performance was *adequate*.

Nurses generally evaluated patients timely and made appropriate assessments and interventions; however, several significant patterns of deficiencies emerged. Some outpatient nurses at ISP failed to notify primary care providers of significant changes in patients' conditions, were inconsistent with implementing providers' orders, or failed to adequately assess patients. Occasionally, patients were not seen in the RN clinic due to triage nurses' failure to thoroughly read the patients' requests to be seen. For example, in case 45, the patient requested to be seen for trouble breathing and pain, but the request was managed only as a medication refill request. Also, some care plans were inappropriate because of inadequate nursing assessments. The OIG's review of medication administration records showed that some medications were not given or were missed without written explanations on the records. In addition, some providers' discontinuation orders were not followed.



### **Failure to Refer to the Provider**

- In case 1, the RN failed to immediately consult with the provider regarding a patient with a severe headache and seizures. Instead, the RN made a routine provider referral.
- In case 9, the RN failed to notify a provider that a patient had slow heart rate readings of 36 and 48 beats per minute.
- In case 23, the RN failed to report to the provider a postoperative patient who had a temperature of 101.1° F.

### **Inadequate Nursing Assessment**

- Also in case 23, the RN failed to adequately assess a postoperative patient with an elevated temperature of 101.1° F.
- In case 28, the RN failed to address the patient's medication issues or broken leg brace.

### **Failure to Follow Provider Orders**

- In case 9, there was no documentation that nurses followed a provider's order and performed wound care on a patient.
- In case 51, a provider's ordered RN follow-up visit did not occur for a patient who recently returned from the hospital after an appendectomy.

### **Nursing Sick Call**

- Again in case 23, the RN made inconsistent provider referrals by documented both "no referral" and "urgent referral" on the patient's health care services request form.
- In case 45, the patient reported pain and that his asthma was "acting up." An RN failed to see the patient. Instead, his request was forwarded for a medication refill.

### **Inter and Intra-System Transfers**

- In case 4, the Initial Health Screening form (CDCR Form 7277) was not in the eUHR. In addition, the second page of an OHU nursing admission assessment form was not in the eUHR.

### **Medication Administration**

See the *Pharmacy and Medication Management* indicator.

## **Onsite Visit**

During the onsite visit, the OIG clinicians visited various outpatient medical clinics and attended a combined daily morning huddle for the OHU, the TTA, and the central health building. Participants included the OHU RN, utilization management RN, offsite RN, TTA RN and LVN, supervising RNs, custody staff, and office technicians. The yard clinic providers participated by telephone. The OHU RN led the discussion and discussed each patient in the OHU, including status, results of new diagnostic reports, and medications ready to expire. The TTA, utilization management, and offsite RNs informed the provider about emergency send-outs and patients sent to specialty appointments. Others participated as needed. The process was well done, thorough, and concise.

## **Conclusion**

Overall, the OIG case review clinicians determined that the ISP's quality of nursing performance was *adequate*.

## ***Recommendation***

The OIG recommends the following that nursing supervisors at ISP work with nursing staff to develop performance improvement strategies related to provider notification, focused assessments, and complete documentation. This would include training, ongoing monitoring, and evaluation of implemented strategies related to the sick call process.

---

## ***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 391 medical provider encounters at ISP and identified 144 deficiencies related to provider performance. Of those 144, 38 were serious enough to place patients at an increased risk of harm. In addition, of the 30 detailed physician case reviews, ten were inadequate because of the quality of provider performance.

### **Assessment and Decision-Making**

Twenty-one of the 38 provider deficiencies were from incomplete assessment documentation and inappropriate plans. While more than one-third of the total deficiencies in this indicator were due to one provider, the other providers also displayed many serious deficiencies:

- In case 1, a provider ordered a fentanyl patch (narcotic pain medication) to be started without a patient visit. The provider should have explained the side effects to the patient. There was also no reason for the fentanyl since the patient was tolerating a low dose of oral morphine.
- In case 8, a five-day follow-up with the primary provider occurred after a surgical removal of the parathyroid gland (a small endocrine gland in the neck). The provider failed to perform a proper history and physical exam, and to examine the surgical site for signs of infection or wound breakdown.
- In case 9, a provider inappropriately ordered the patient receive a groin hernia surgery. The patient had no significant pain and was able to perform all daily activities. The patient was a very high-risk surgical candidate because he had liver cirrhosis, liver cancer, and a low blood platelet count with an elevated risk of bleeding.
- In case 53, the provider's progress notes indicated that the patient walked a mile a day, and the provider further encouraged the patient to increase his physical activity. In the same progress notes, the provider inappropriately referred the patient with poorly controlled diabetes to orthopedics for surgery. Given the case factors, the surgery was unwarranted; the

patient was adequately performing daily walking activities, and the surgery would increase the risk of harm from complications of wound healing and stress on the body.

- In case 56, upon initial evaluation of a patient with two weeks of severe leg edema (swelling), the provider did not order laboratory tests to evaluate the cause, such as problems with the kidneys, liver, or nutrition. This patient had not had these laboratory tests previously completed in over 15 months.
- In case 61, the provider documented concern about a patient's rapidly growing liposarcoma (typically a large, bulky tumor that arises in fat cells). However, the provider improperly ordered a routine general surgery consult, instead of an urgent consult. The consult should have been expedited due to the provider's concerns about a rapidly growing tumorous cancer.
- Also in case 61, the provider ordered surgery without an examination of the patient's knee. The patient was actively playing sports with no acute injury documented. Even though multiple medical encounters were dictated, the physician decided to use a cloned note and did not examine the knee for months prior to knee surgery consideration.

In a related area to the finding above, the OIG clinicians had concerns that ISP providers had developed an unusually high dependence on specialty services. This dependence extended into common medical areas within the scope of practice for primary care providers. This pattern of specialty overuse suggested that some providers may have been uncomfortable in primary care practice, unwilling to perform services due to time constraints, incapable of treating some basic conditions (including chronic pain management), or unskilled at performing overall risk evaluation prior to ordering surgery. There was also underutilization of some specialty services, such as cardiology. Cardiology consultations were recommended in the cases below, which highlight the failure of the providers to seek specialty consultation in serious cardiac cases. The concerns varied from ischemia (lack of cardiac tissue blood flow) to unknown origin of bradycardia (slow heart rate):

- In case 7, the provider and specialty staff allowed a patient to undergo a non-emergency surgery before obtaining heart stress test results. The stress test had been ordered because the provider was concerned that the patient was at risk for a heart attack.
- In case 9, the provider failed to order a cardiology evaluation for a 59-year-old patient with a slow heart rate of 30 to 40 beats per minute over a five-month period.
- In case 14, a 39-year-old patient with hypertension and obesity presented with chest pain. The EKG and troponin levels were normal (high troponin levels indicate that a heart attack has occurred). The ER physician evaluated and discharged the patient from the ER with recommendations to have a stress test and an urgent cardiology evaluation. The provider saw the patient several days later and diagnosed the patient with non-cardiac chest wall pain.

In patients with significant risk factors for heart disease and chest pain, the goal of every physician should be to perform the necessary tests to rule out heart disease before coming to the conclusion that chest pain is non-cardiac in origin. This provider failed to perform this service and ignored the recommendations of the ER physician without providing a proper reason for refuting the recommendations.

- Similarly, in case 50, a 57-year-old patient with hyperlipidemia, a family history of heart disease, and an abnormal EKG was sent to the ER for evaluation of chest pain. The ER physician recommended a stress test. The provider saw the patient upon return, but diagnosed him with non-cardiac chest pain and failed to address the recommendations of the ER physician.

## **Review of Records**

Forty of the provider care deficiencies related to inadequate review of medical records. The providers sometimes demonstrated a superficial and cursory review of diagnostic, specialty, and hospital reports. ISP providers also frequently failed to review or provided only a cursory review of the eUHR during each patient encounter. This resulted in patients being sent unnecessarily to local hospitals, inappropriate orders, missed diagnoses, and inadequate patient treatment. This also led to inaccurate notifications of test results to patients. Specific examples are as follows:

- In case 1, the PCP failed to review a patient's positron emission tomography (PET) report in its entirety and did not discuss the potential of a lesser invasive targeted biopsy with the interventional radiologist. As a result, the patient received a lung biopsy instead of a superficial paraspinal lesion biopsy, which would have been safer and easier for the provider to perform with less mortality or morbidity risk to the patient.
- In case 8, on several encounters, the providers failed to evaluate a patient's liver laboratory and radiology tests (hepatitis C fibrosis score and ultrasound), which delayed the diagnosis of liver cirrhosis and consideration of hepatitis C treatment.
- In case 9, a failure to review the esophagogastroduodenoscopy (EGD, an upper digestive optical imaging test) resulted in inadequate treatment of stomach ulcers.
- Also in case 9, the provider failed to review the biopsy results from the same EGD (discussed above). This resulted in the patient not being treated for a bacterial infection of the stomach, the cause of the patient's stomach ulcers.
- In case 16, the patient went to the ER, where he was diagnosed with a new finding of anemia and radiology findings of abnormal colon wall thickening. The ER physician recommended a gastroenterology consultation upon the patient's discharge. The ISP provider failed to address these serious findings, which suggested inflammation or cancer of the colon.

- Also in case 16, the patient was sent to the ER for head trauma from a seizure and fall. The patient had a remote history of a seizure and an abnormal CT scan of the brain. A neurology consultation was recommended by the emergency room physician for this patient. Further, the emergency room physician did not prescribe anti-seizure medications but was concerned that there was brain pathology that needed further work-up. The ISP primary care providers did not prescribe anti-seizure medications despite their concern about breakthrough seizures, and failed to address the emergency room findings and recommendations of a neurology consultation.
- In case 50, the provider failed to address an abnormal kidney ultrasound report that was ordered during an evaluation of the patient's back pain. The radiologist advised a three-month follow-up ultrasound or CT scan to check on the abnormal kidney, but no follow-up occurred.
- In case 57, the provider reviewed an abnormal HgA1c (average blood sugar level over a three-month duration) prior to an encounter. The provider noted evaluating the lab result at a date earlier than the encounter. During the patient encounter, the provider did not remember the HgA1c result, so he used a prior HgA1c to make his assessment. The assessment, therefore, was flawed because the provider did not use real time data and thus did not react to the worsening glucose control with diabetic medication. OIG clinicians also noted that the HgA1c was 8.9 (showing suboptimal blood sugar control), which warranted medication management. Two weeks later, the provider canceled a patient visit but cited no new information or discovery of the newly evaluated HgA1c level. This led to further delay of medication modification.
- In case 58, the provider failed to review documentation from an ophthalmology consultation, which recommended stopping two eye drop prescriptions. In contradiction, the provider extended the ophthalmic ciprofloxacin (antibiotic) for several weeks, and the diclofenac (anti-inflammatory) drops were inappropriately ordered for a one-year extension. These serious errors placed the patient at risk of eye damage and vision loss.
- In case 60, the patient was leaving the OHU, but the provider failed to appropriately complete the patient's discharge summary. The discharge notes lacked detail on pending important laboratory and radiology results to assist the next primary care provider with continuity of follow-up care.

In a related area, see the Scanning of Radiology Imaging Results section of the *Diagnostic Services* indicator for discussion about ISP's practices regarding the scanning of radiological images.

## Emergency Care

Ten of the provider care deficiencies were in the emergency care setting. ISP providers generally made appropriate triage decisions when patients presented emergently to the TTA. Their care in the acute setting was generally well managed. However, there were three serious deficiencies, two of which related to the management of uncontrolled diabetes in the acute setting:

- In case 55, the urgent care provider reviewed a critically high average blood glucose result (HgA1c of 16.9). The provider failed to arrange an immediate clinic visit for this poorly controlled diabetic patient. The patient was not seen until nearly three weeks later.
- Also in case 55, the urgent care provider failed to schedule an appropriate chronic care provider evaluation for a patient started on a long-acting insulin and daily finger stick blood glucometer checks. Instead, the patient was ordered to see the primary care provider two months later.
- As discussed above under Review of Records, in case 50, the urgent care provider failed to address recommendations from the ER physician for cardiac risk stratification.

## Chronic Care

Thirty-nine of the provider deficiencies were due to inadequate chronic care delivery. Twelve of the deficiencies were serious, nine of which originated from one particular provider. Among the chronic care patients housed at ISP, most had mild and stable conditions and required no significant medical intervention. Further, no patients received anticoagulation therapy, and there were no HIV patients. Nevertheless, the OIG still reviewed cases in which chronic care interventions were needed and found performance lacking due to a combination of system deficiencies and questionable provider performance.

- Cases 10, 51, 53, 54, 55, 57, and 58 displayed inadequate management of diabetes. These deficiencies varied from inappropriately long ordered follow-up intervals of four to six months in a poorly controlled diabetic patient (HgA1c greater than 8), to not monitoring fasting blood sugar levels nor using the fasting blood sugar results to guide the management of insulin.
- In case 16, the provider failed to assess a 64-year-old patient with chronic anemia. The provider continued the patient on a non-steroidal anti-inflammatory medication (NSAID), and ordered a three-month follow-up. This placed the patient at risk for worsening anemia from gastrointestinal bleeding caused by the NSAID.
- In case 58, the provider reviewed the patient's diabetes laboratory result of 9.2 for HgA1c. No further diabetes treatment changes were ordered, and the patient was referred for surgery with this poorly controlled condition.

## **Specialty Services**

Seventeen of the provider deficiencies were in specialty services. Two of the deficiencies were serious. During the case review, a workflow pattern emerged that indicated a deviation from the CCHCS-approved complete care model. When patients returned from specialty service appointments, they were first seen for specialty services follow-up by the TTA provider (also known as the urgent care provider), who acted as the physician of the day (POD). The POD saw the patient, evaluated the specialist's report, and made orders based on the report recommendations. Subsequent patient follow-up visits with the primary care physician were ordered at the POD's discretion. This practice decreased the continuity of care between the patient and his regular yard provider. This particular model of health delivery is inferior to the approved CCHCS's complete care model. The approved model requires the primary care team to personally review reports from radiology, the laboratory, and specialty referrals.

- In case 72, the POD evaluated a diabetic patient returning from an endocrinology consult. The POD referred the patient to see the primary care provider in four to five months. The primary care provider thus did not see any of the recommendations of the specialist since they were addressed by the POD and then scanned into the patient's electronic health record without notification made to the primary care provider. Also, the next specialist appointment was scheduled sooner than the next primary care provider appointment. As a result, the subsequent care of the patient for the next several months was managed by the specialist and the POD, who saw the patient again after the next specialist appointment. With this model, the primary care provider unintentionally became a non-participant in the patient's care, which increased the risk of harm due to poor diabetic care.

## **Health Information Management**

ISP providers documented onsite and on-call encounters timely, and there were only six minor provider deficiencies relating to health information management. While the institution had appropriate computerized medical tracking information for nighttime or weekend medical occurrences, patient care would have benefitted from direct provider communication via morning handoffs to relief clinicians to provide context from the prior night or weekend medical events.

## **Pharmacy and Medication Management**

Ten of the provider deficiencies were due to pharmacy and medical management. None of the deficiencies was serious. Overall, pharmacy and medication management was appropriate.

## **Onsite Inspection**

Providers at ISP were generally content with their work, leadership, and ancillary services, including laboratory, pharmacy, radiology, and specialty services. They mostly felt the workload was appropriate and manageable. However, one provider had a much greater workload than other ISP physicians. For the previous six months, the provider saw 20 to 30 patients each eight-hour



workday. This was two to three times as many patients than the other providers saw. The patients were also more complex. These factors may have contributed to this one provider having a much higher number of deficiencies than other providers. Neither the provider nor management at the time were able to provide any explanation for the significant discrepancy among providers' workloads.

At the time of the OIG's onsite visit by case review clinicians, ISP providers were genuinely concerned over the future loss of two providers, and the historical recruitment problems for this remote Southern California location. Management was strained, with no chief physician and surgeon (CP&S) for at least six months and a chief medical executive who was responsible for the care at two institutions (ISP and the neighboring Chuckawalla Valley State Prison). Fortunately, a highly experienced CP&S had recently joined the team. This leadership guidance was necessary, as the institution was expecting to have one-third of its line-provider positions vacant for an unknown period of time due to the expected separation of two current providers in the near future. Nevertheless, the ISP providers indicated that they were a cohesive team who appreciated ISP leadership. They were optimistic that, with hard work, the future medical care at ISP would improve to the point of proficiency.

## **Conclusion**

Overall, the provider deficiencies were numerous and significantly contributed to the ten inadequate case review ratings. More specifically, the OIG's case review identified 38 serious provider deficiencies. These included a widespread pattern of inadequate assessment and decision-making, inadequate review of records, poor chronic care, and poor patient continuity. ISP providers did well, however, with respect to providing emergency services and documenting their clinical encounters on the same day. The OIG found during individual provider interviews that the provider staff were individually competent. Therefore, underperformance was most likely due to systemic factors, such as unfamiliarity with patients, insufficient provider staffing levels or vacancies, poor continuity of care, and a lack of dedication to a primary care provider as would occur under the CCHCS approved complete care model. The excessive number of patients allocated to one provider was also likely a contributing factor to the large number of identified deficiencies. As result of the above, the OIG rated ISP *Quality of Provider Performance* as *inadequate*.

## ***Recommendations***

- The OIG recommends that providers review the CCHCS guidelines for the management of diabetes, hepatitis C, and end-stage liver disease (ESLD), as well as cardiac risk stratification.
- The OIG recommends that, to improve continuity of care, management ensure that all patients returning from specialty consultations or community hospitals be evaluated by their primary care physicians upon return to the institution, instead of being solely seen by a TTA provider or other designated interim provider of the day.

- The OIG recommends holding daily morning meetings to encourage hand-offs of patient events from the night prior and to build a greater camaraderie between physicians.
  - The OIG recommends medical leadership encourage complex cases be brought to the provider meetings to create consensus regarding specialty consultations, including consensus opinions on chronic pain patients and the medical indications for elective surgery in this patient population.
-

## ***SPECIALIZED MEDICAL HOUSING (OHU, CTC, SNF, HOSPICE)***

This indicator addresses whether the institution follows appropriate policies and procedures when admitting inmate-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. ISP's only specialized medical housing unit is the outpatient housing unit (OHU).

***Case Review Rating:***

*Adequate*

***Compliance Score:***

*Adequate  
(82.5%)*

***Overall Rating:***

*Adequate*

### ***Case Review Results***

At the time of the OIG's inspection, ISP had an onsite 14-bed medical OHU. The OIG clinicians reviewed a total of 149 provider and nursing OHU encounters, including admissions to the OHU for medical conditions and overnight holds in the OHU for procedures scheduled at offsite community health care centers.

### **Provider Performance**

Provider performance in the OHU was adequate. Of the 40 OHU provider encounters reviewed, only three deficiencies were identified, and of those, only one was significant. The one significant deficiency was primarily due to the potential risk for missed or delayed follow-up after OHU discharge.

- In case 60, the patient with testicular cancer was admitted to the OHU after undergoing lymph node surgery. During his OHU stay, the patient underwent multiple laboratory studies and a CT scan. On the OHU discharge summary, the OHU provider documented that these studies had not been completed, even though reports for these studies were actually pending. It is important for the transitioning doctor to supply an appropriate hand-off of studies that were performed but are still pending review to avoid losing vital information of abnormal results.

### **Nursing Performance**

Nursing performance in the OHU was adequate. There were 29 nursing deficiencies, most of which were unlikely to contribute to serious patient harm. However, the following cases clearly demonstrate potentially serious issues that may have increased the risk of harm to patients:

- In case 17, a patient with end-stage lung disease was admitted to the OHU because of his need for constant oxygen. The RN incorrectly documented that the patient had a peripherally inserted central catheter (PICC line) and that an intravenous infusion was ordered. The patient did not have a PICC line, nor was there a provider order for an infusion.

- Also in case 17, the PCP ordered new medications to start the same day. They included a nitroglycerin-type medication (to prevent chest pain), prednisone (steroid to reduce inflammation), and levofloxacin (antibiotic). The patient did not receive these medications until the next day.
- Again in case 17, the RN took 50 minutes to update the provider on the patient's status following a breathing treatment. The patient's condition had not improved. In addition, the medication used for the breathing treatment was only albuterol, when the orders were for both albuterol and ipratropium (Atrovent) for shortness of breath.
- In case 67, the patient had a stroke and required assistance with normal activities of daily living. He had bedsores on his tailbone area. The RN failed to assess or provide basic skin care for this patient.

Other deficiencies in nursing care included inadequate documentation of assessments and reassessments, as well as failure to notify providers of changes in patient status.

### **Onsite Inspection**

At the time of the onsite inspection, the OHU housed 11 patients, who were monitored and cared for by one nurse per shift. The staffing model used in the OHU at ISP did not allow for assistance with patient care by an additional nurse. Of the 11 patients in the OHU, two were recovering from a stroke. One of these patients had severe weakness, and the other had total paralysis to one side of his body. Other patient conditions in the OHU included advanced dementia, recovery from open heart surgery, jaw fracture with jaw wired shut for healing, recovery from a lumbosacral fusion (spinal surgery), and recovery from left leg surgery. Having only one on-duty nurse who had full responsibility for all assessments, medications, treatments, and documentation of multiple patients at this level of care jeopardized patient care and safety due to an insufficient level of nursing resources during periods of peak activity.

### ***Compliance Testing Results***

The institution received an *adequate* compliance score of 82.5 percent in the *Specialized Medical Housing* indicator, which focused on the institution's outpatient housing unit (OHU). As discussed below, three of the five test areas scored in either the *proficient* or *adequate* range:

- For all ten inmate-patients sampled, nursing staff timely completed an initial assessment on the day a provider admitted the inmate-patient to the OHU (MIT 13.001).
- ISP utilized a working call-button system in the OHU, and OHU staff properly documented call-button tests in a daily log. Also, knowledgeable staff who regularly worked in the OHU collectively indicated that during an emergent event, responding staff could generally access a patient's room in two minutes, on average. Further, the institution's management believed

the average response time was reasonable. The institution received a score of 100 percent on this test (MIT 13.101).

- Providers completed a history and physical examination (H&P) within 72 hours of OHU admission for eight of ten inmate-patients sampled (80 percent). An H&P was not properly completed for two of the remaining sampled patients. In one exception, the H&P exam did not occur within 72 hours of admission and the provider completed it two days late. In the other exception, there was no evidence in the eUHR that the inmate-patient received an H&P exam at all (MIT 13.003).

The following two areas scored in the *inadequate* range:

- For seven of ten sampled inmate-patients (70 percent), providers performed a face-to-face evaluation within 24 hours of OHU admission. For three other patients, PCPs' physical examinations occurred between one and three days late (MIT 13.002).
- Providers completed their SOAPE notes at required 14-day intervals for only five of eight sampled patients, scoring 63 percent. Providers completed required SOAPE notes one, 12, and 26 days late for the three other sampled patients (MIT 13.004).

### ***Recommendations***

- The OIG recommends that the institution conduct an evaluation of the nursing care and staffing level provided in the OHU, and develop ways to ensure there is sufficient staffing for the level of care needed.
- The OIG recommends the institution's leadership address nursing documentation deficiencies and provide ongoing staff training and education sessions with ongoing monitoring by supervising nurses.

## ***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 inmate-patient is updated on the plan of care.

**Case Review Rating:**  
*Adequate*

**Compliance Score:**  
*Proficient*  
(87.2%)

**Overall Rating:**  
*Adequate*

In this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance review resulting in a *proficient* score. The OIG's internal review process considered those factors that led to both results and ultimately rated this indicator *adequate*. The key factor warranting the lower overall rating was that the case review identified a significant number of deficiencies (as detailed below) related to specialty services, which did not support an overall indicator rating higher than *adequate*.

### ***Case Review Results***

Overall, the OIG clinicians reviewed 256 events related to *Specialty Services* and identified 44 deficiencies, ten of which were serious.

#### **Access to Specialty Services**

Urgent and routine specialty services were generally provided timely; however, there were nine deficiencies regarding access to specialty services, three of which were serious:

- In case 59, the provider did not evaluate the patient for ten days after an inner ear surgery.
- In case 7, the patient's two-week follow-up visit with the surgeon after ankle surgery did not occur.
- Also in case 7, the PCP saw the patient nine days after an urgent cardiology consultation. The PCP visit should have occurred within three business days of this specialty encounter.

#### **Nursing Performance**

Nursing performance in *Specialty Services* was *adequate*. The OIG clinicians found only a few minor deficiencies relating to documentation legibility.

## **Provider Performance**

Providers reviewed specialists' reports timely but often failed to appropriately implement patient care plans. They often failed to thoroughly review and appropriately address abnormal pathology results. The OIG attributed this finding to both provider error and the workflow of the institution, which shuttled important laboratory, hospital, or consultation reports to the urgent care physician of the day, i.e., an intermediary provider, instead of to the patient's regular primary care provider. The attention to this detailed task may have been lost because that intermediary provider often had to contemporaneously handle more urgent medical matters that occurred in the TTA or OHU.

As discussed in the *Quality of Provider Performance* indicator, OIG clinicians had concerns regarding ISP providers' overutilization and underutilization of specialty services.

## **Health Information Management**

When specialty reports were available, providers generally reviewed them timely and had them scanned within an acceptable time frame. However, case review found that there were problems with the processing of specialty reports. Of the 46 specialty deficiencies, ten were for health information management, three of which were significant. Specialty reports were sometimes not retrieved or not found in the medical record, placing patients at high risk for delays or even lapses in care.

- In case 58, the medical record suggested that the patient had undergone several eye surgeries, each with ophthalmic drops prescribed. On numerous appointments, the provider received insufficient information to implement the specialist's recommendations. The patient was continued on ophthalmic drops that were to be discontinued. The provider documented that he did not have the medical records necessary for proper patient follow-up. As the provider struggled with this patient's lack of documentation, a different patient's ophthalmologic record was placed in this patient's medical file, further complicating patient management and putting the patient at increased risk of harm.
- In case 13, the surgical report was not scanned for two weeks, thus the provider was unable to fully evaluate the patient's arm surgery without the orthopedist's evaluation and recommendations.

## **Onsite Inspection**

During the onsite inspection, the OIG clinicians reviewed many of the provider deficiencies noted above with the chief medical executive (CME). The CME was made aware of some of the problems regarding provider management of specialty services. The specialty services department was easily accessible and willing to track down specialty reports. Interviews with the ISP utilization management nurse and the offsite specialty nurse confirmed established procedures to ensure clinical information was routed timely and accurately. All clinical staff had access to the computer SharePoint system (an interdepartmental electronic communication database tool for patients

requiring specialty care). Both the utilization management nurse and specialty nurse reported in-place procedures for handling computer system failures or interruptions, and that they had trained backup staff to fill in during absences. Further, in January 2016, the staffing level for the offsite specialty nurse position was elevated from an LVN to RN.

### **Clinician Summary**

The OIG noted several deficiencies related to untimely provider follow-up visits that occurred after patients received their specialty services. In addition, the information workflow process could be improved, especially for ophthalmology reports. Overall, the case review clinicians considered *Specialty Services* at ISP to be within the *adequate* range.

### ***Compliance Testing Results***

The institution received a *proficient* compliance score of 87.2 percent in the *Specialty Services* indicator, scoring in the *proficient* range in the following test areas:

- For all 15 patients sampled, their high-priority specialty service appointment occurred within 14 calendar days of the provider's order. In addition, 15 other patients sampled also received their routine specialty services appointment within 90 calendar days of the provider's order (MIT 14.001, 14.003).
- Providers timely received and reviewed the specialists' reports within the required time frame for 14 of 15 sampled patients who received a high-priority specialty service. In addition, ISP providers also timely received and reviewed the specialist's reports for 14 of 15 sampled patients who received a routine specialty service. Both tests resulted in proficient scores of 93 percent. For the high-priority test, one specialists' report was received 14 days late; and, for the routine priority test, the provider reviewed one report 35 days late (MIT 14.002, 14.004).
- When patients did not meet the minimum requirements for a specialty service, the institution timely denied providers' specialty service requests for all 16 sampled patients (MIT 14.006).

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

- Among 13 patients sampled who had a specialty service denied by the institution's health care management, only seven (54 percent) received timely notification of the denied service that included the provider meeting with the patient within 30 days to discuss alternate treatment strategies. For two patients sampled, this requirement was not met at all; four other patients received a follow-up visit from one to ten days late (MIT 14.007).
- When inmate-patients at one institution have an approved pending or scheduled specialty services appointment and then transfer to a different institution, policy requires that the receiving institution reschedule or provide the patient's appointment within the required



time frame. Of 20 sampled patients who transferred to ISP with an approved appointment, 14 timely received their specialty services (70 percent). Of those six patients who did not receive the services timely, one patient did not receive it at all. Five other sampled patients received their specialty services from 13 to 95 days late (MIT 14.005).

### ***Recommendations***

**No specific recommendations.**

---

## SECONDARY (ADMINISTRATIVE) QUALITY INDICATORS OF HEALTH CARE

The last two quality indicators (*Internal Monitoring, Quality Improvement, and Administrative Operations*; and *Job Performance, Training, Licensing, and Certifications*) involve health care administrative systems and processes. Testing in these areas applies only to the compliance component of the process. Therefore, there is no case review assessment associated with either of the two indicators. As part of the compliance component for the first of these two indicators, the OIG did not score several questions. Instead, the OIG presented the findings for informational purposes only. For example, the OIG described certain local processes in place at ISP.

To test both the scored and non-scored areas within these two secondary quality indicators, OIG inspectors interviewed key institutional employees and reviewed documents during their onsite visit to ISP in January 2016. They also reviewed documents obtained from the institution and from CCHCS prior to the start of the inspection. The test questions used to assess compliance for each indicator are detailed in *Appendix A*.

For comparative purposes, the *ISP Executive Summary Table* on page ix of this report shows the case review and compliance ratings for each applicable indicator.

---

## ***INTERNAL MONITORING, QUALITY IMPROVEMENT, AND ADMINISTRATIVE OPERATIONS***

This indicator focuses on the institution’s administrative health care oversight functions. The OIG evaluates whether the institution promptly processes inmate-patient medical appeals and addresses all appealed issues. Inspectors also verify that the institution follows reporting requirements for adverse/sentinel events and inmate deaths, and whether the institution is making progress toward its Performance Improvement Work Plan initiatives. In addition, the OIG verifies that the Emergency Medical Response Review Committee (EMRRC) performs required reviews and that staff perform required emergency response drills. Inspectors also assess whether the Quality Management Committee (QMC) meets regularly and adequately addresses program performance. For those institutions with licensed facilities, inspectors also verify that required committee meetings are held.

***Case Review Rating:***  
*Not Applicable*  
***Compliance Score:***  
*Inadequate*  
*(53.9%)*  
***Overall Rating:***  
*Inadequate*

### ***Compliance Testing Results***

The institution scored within the *inadequate* range in the *Internal Monitoring, Quality Improvement, and Administrative Operations* indicator, receiving a compliance score of 53.9 percent. The low score resulted primarily from the following five tests that each scored in the *inadequate* range:

- The institution did not meet the emergency response drill requirements for any of its first, second, or third watch drills during the most recent quarter. More specifically, the most recent quarter’s first and third watch emergency response drill packages submitted for OIG review were for actual emergencies and not drills as policy requires. In addition, the quarter’s second watch drill did not include several of the required forms, such as, among others, the CDCR Form 837 (Crime Incident Report), CDCR Form 7463 (First Medical Responder – Data Collection Tool), and the CDCR Form 7462 (Cardiopulmonary Resuscitation Record). Because of these deficiencies, ISP received a score of zero on this test (MIT 15.101).
- None of the ten sampled incident packages for emergency medical response incidents reviewed by the institution’s Emergency Medical Response Review Committee (EMRRC) during the prior 12-month period complied with policy. Specifically, none of the reviewed packages included the required Emergency Medical Event Response Checklist, and six of the packages also did not have their corresponding meeting minutes reviewed and approved by the ISP’s CEO (MIT 15.007).
- The ISP’s 2014 Performance Improvement Work Plan (PIWP) only included sufficient evidence demonstrating that the institution made progress in achieving targeted performance

objectives for one of its seven quality improvement initiatives. In general, the work plan for six other targeted performance objectives included insufficient progress information to demonstrate that the corresponding objectives either improved or reached the targeted level. As a result, ISP received a score of only 14 percent on this test (MIT 15.005).

- The institution's QMC regularly met during each of the most recent six months to evaluate program performance, and the committee took action when staff identified improvement opportunities. However, for three of the sampled months (July, August, and September 2015), the committee failed to evaluate or discuss program Dashboard performance data or Scoreboard performance data (quantitative health care performance metrics). As a result, ISP scored 50 percent on this test (MIT 15.003).
- Medical staff promptly submitted the Initial Inmate Death Report (CDCR Form 7229A) to CCHCS's Death Review Unit for only two of three applicable deaths that occurred at ISP in the prior 12-month period. The Death Review Unit was notified one day late about the death of one inmate. As a result, ISP received a score of 67 percent on this test (MIT 15.103).

The institution received a *proficient* 100 percent in the following test areas:

- The institution took adequate steps to ensure the accuracy of its Dashboard data reporting. Specifically, ISP's Quality Management Committee meetings discussed methodologies used to conduct periodic validation and testing of Dashboard data, and the committee discussed methodologies used to train staff who collect Dashboard data (MIT 15.004).
- During the most recent 12 months, ISP timely processed all inmate medical appeals. In addition, based on the OIG's review of ten second-level medical appeals, institutional staff's appeal responses addressed each of the inmates' initial complaints (MIT 15.001, 15.102).

#### **Other Information Obtained from Non-Scored Areas**

- The OIG gathered non-scored data regarding the completion of death review reports and determined if CCHCS's Death Review Committee sent the final report to the institution on a timely basis. Based on the OIG's review, CCHCS's Death Review Committee did not timely complete its death review summary for one of the three deaths that occurred during the testing period. The CCHCS Death Review Committee is required to complete a death review summary within 30 business days of the death and submit it to the institution's CEO within five additional business days. The OIG reviewed all three inmate deaths that occurred in the last 12 months, and only one death included both timely completion and timely CEO notification (33 percent). Two death reports were either untimely completed, had untimely CEO notification, or both. More specifically, the death review report for one inmate was completed nine days late (52 calendar days after the death) and the report completion notification to the CEO was made late for both reports. The notification occurred 20 and 23 days late, i.e., 70 and 73 days after the inmate's death, respectively (MIT 15.996).

- Inspectors met with the institution’s chief executive officer (CEO) to inquire about ISP’s protocols for tracking appeals. The CEO received a monthly appeals report from CCHCS headquarters. The CEO, CME, CP&S, and the medical appeals coordinator met monthly to discuss outstanding appeals and to review the monthly tracking appeals reports. These appeal reports showed a list of appeals categorized by nature of complaint, aging of appeal, and comparisons to other institutions. The monthly report ranked appeals based on activity, with the top two appealed issues being medications and disagreement with treatment plans. According to the CEO, ISP had a fairly small number of medical appeals and, therefore, medical appeals were addressed quickly. The low appeals volume also allowed the institution to spot any trends fairly easily, though no trends emerged at the time of the OIG’s inspection. When an appealed issue or problem area arose, management dealt with it individually, on a case-by-case basis. As a result, the CEO said that ISP was ranked number one in November 2015 on the statewide quality Dashboard for medical appeal processing (MIT 15.997).
- Informational data gathered regarding the institution’s practices for implementing local operating procedures (LOPs) indicated that the institution had a process in place for developing LOPs. Further, ISP created an LOP dated April 2015 for the implementation and review of CCHCS-issued policies and procedures. All LOP’s were formally commissioned by the institution’s Quality Management Committee (QMC) and were developed, written, and approved via ISP’s formal process for such matters, which is also memorialized in an LOP. At the time of the OIG inspection, the institution had implemented only 25 of the 45 applicable LOP’s (56 percent) related to the topical areas recommended by the clinical experts who helped develop the OIG’s medical inspection compliance program (MIT 15.998).
- The OIG discusses the institution’s health care staffing resources in the *About the Institution* section on page 2 of this report (MIT 15.999).

## ***Recommendations***

**No specific recommendations.**

---

## ***JOB PERFORMANCE, TRAINING, LICENSING, AND CERTIFICATIONS***

In this indicator, the OIG examines whether the institution adequately manages its health care staffing resources by evaluating whether job performance reviews are completed as required; specified staff possess current, valid credentials and professional licenses or certifications; nursing staff receive new employee orientation training and annual competency testing; and clinical and custody staff have current medical emergency response certifications.

***Case Review Rating:***  
*Not Applicable*  
***Compliance Score:***  
*Adequate*  
*(83.3%)*  
***Overall Rating:***  
*Adequate*

### ***Compliance Testing Results***

The institution received an *adequate* compliance score of 83.3 percent in the *Job Performance Training, Licensing, and Certifications* indicator.

On six of the indicator's eight tests, the institution scored 100 percent, as follows:

- All providers were current with their professional licenses (MIT 16.001).
- ISP's one applicable nursing supervisor sufficiently completed the required number of subordinate nurses' performance evaluation reviews (MIT 16.101).
- All ten nurses sampled were current with their clinical competency validations (MIT 16.102).
- All five ISP providers had an appropriate clinical performance appraisal within the required time frame (MIT 16.103).
- All nurses and the pharmacist-in-charge were current with their professional licenses and certification requirements (MIT 16.105).
- The pharmacy and providers who prescribed controlled substances had current Drug Enforcement Agency registrations (MIT 16.106).

While the institution scored well in areas above, the following areas showed room for improvement:

- One nursing employee hired within the past year did not timely complete new employee orientation (NEO) training within 60 days of hire. More specifically, in November 2015, a recently hired LVN completed a portion of NEO training and then failed to attend the remainder of the orientation. The employee was rescheduled to attend the course in February 2016, more than 60 days after the date the employee failed to complete the first training course. The employee's rescheduled orientation date was late because it was rescheduled for

a time period greater than when it should have been initially completed, i.e., 60 days. As a result, ISP scored zero on this test (MIT 16.107).

- OIG inspectors examined provider, nursing, and custody staff records to determine if the institution ensured that those staff members had current emergency response certifications. While the institution's provider and nursing staff were all compliant, custody staff did not always have current certifications. Specifically, two non-managerial custody officers and four custody managers did not have a current certification on file. Regarding the certification requirement for custody managers, the OIG recognizes that the California Penal Code exempts those custody managers who primarily perform managerial duties from medical emergency response certification training; however, CCHCS policy does not allow for such an exemption. From a medical perspective, the institution was out of compliance. As a result, ISP received a score of 67 percent in this area (MIT 16.104).

### ***Recommendations***

**No specific recommendations.**

---

## **POPULATION-BASED METRICS**

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

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

### ***Methodology***

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

### ***Comparison of Population-Based Metrics***

For Ironwood State Prison, nine HEDIS measures were selected and are listed in the following *ISP Results Compared to State and National HEDIS Scores* table. Multiple health plans publish their HEDIS performance measures at the State and national levels. The OIG has provided selected results for several health plans in both categories for comparative purposes.



## ***Results of Population-Based Metric Comparison***

### **Comprehensive Diabetes Care**

For chronic care management, the OIG chose measures related to the management of diabetes. Diabetes is the most complex common chronic disease requiring a high level of intervention on the part of the health care system in order to produce optimal results. ISP performed only marginally well with its management of diabetes in the available HEDIS measures when compared to other reporting entities.

On a state level, ISP significantly outperformed Medi-Cal in all five diabetic measures selected (diabetic monitoring, diabetics under poor control, diabetics under good control, diabetic blood pressure control, and diabetic eye examinations). ISP also outperformed Kaiser Permanente in four of the five diabetic measures; but did not perform, as well as Kaiser with respect to diabetic patient blood pressure control.

Compared nationally, ISP outperformed Medicaid, Medicare, and commercial health plans (based on data obtained from health maintenance organizations) in all five listed diabetic measures. ISP slightly outperformed the U.S. Department of Veterans Affairs (VA), in three of the four applicable diabetic care monitoring areas reported by the VA (diabetic monitoring, diabetics under poor control, and blood pressure control), but ISP trailed the VA by 2 percentage points in conducting dilated eye exams.

### **Immunizations**

Comparative data for immunizations was only fully available for the VA, and partially available for Kaiser Permanente, Medicare, and commercial plans. With regard to administering influenza shots to adults under the age of 65, ISP performed more poorly than all State and national health plans. However, ISP's score directly suffered from patient refusals, which significantly lowered the institution's comparative score by 51 percentage points. More specifically, while only 49 percent of ISP's sampled patients actually received the influenza immunization, 100 percent of the sampled patients were timely offered the service. Had the refusals not occurred, the ISP would have had a higher comparative score than all other State and national comparative figures. With regard to administering influenza shots to adults 65 and over, ISP significantly outperformed both Medicare and the VA.

Finally, with regard to pneumococcal vaccinations, ISP scored better than Medicare by 10 percentage points, but worse than the VA by 13 percentage points. ISP would have scored higher had it not been for the fact that 20 percent of the sampled patients had no record of being recently offered the vaccination.

## **Cancer Screening**

With respect to colorectal cancer screening for inmates aged 50 to 75, ISP's score of 58 percent was significantly lower than the only other statewide comparative figures, which were 80 percent and 82 percent for Kaiser, Northern and Southern California, respectively. Nationally, ISP also performed lower than commercial plans, Medicare, and the VA. Overall, patient refusals directly impacted the institution's performance in this cancer screening measure. Specifically, 13 of the 16 patients who did not receive the screening had timely refused it. The 13 refusals accounted for 34 percent of the total sample size. Combining those patients who received or refused colorectal cancer screening within the required time frame, the score would increase to 92 percent.

## **Summary**

Overall, based on the institution's comparative HEDIS results, ISP's performance reflects only an adequate chronic care program. While the institution scored comparatively well in the areas of comprehensive diabetes care and influenza shots to older adults, it did not perform as well in some other comparative measures. The institution has room to improve its scores related to influenza shots to younger adults and colorectal cancer screenings to older adults by increasing patient education to reduce refusals. Finally, ISP can potentially improve its comparative score for pneumococcal vaccinations by simply ensuring that patients receive offers for the vaccine when required.

---

## ISP Results Compared to State and National HEDIS Scores

Clinical Measures	California				National			
	ISP Cycle 4 Results <sup>1</sup>	HEDIS Medi-Cal 2014 <sup>2</sup>	HEDIS Kaiser (No. CA) 2015 <sup>3</sup>	HEDIS Kaiser (So.CA) 2015 <sup>3</sup>	HEDIS Medicaid 2015 <sup>4</sup>	HEDIS Com- mercial 2015 <sup>4</sup>	HEDIS Medicare 2015 <sup>4</sup>	VA Average 2012 <sup>5</sup>
<b>Comprehensive Diabetes Care</b>								
HbA1c Testing (Monitoring)	<b>100%</b>	83%	95%	94%	86%	91%	93%	99%
Poor HbA1c Control (>9.0%) <sup>6, 7</sup>	<b>10%</b>	44%	18%	24%	44%	31%	25%	19%
HbA1c Control (<8.0%) <sup>6</sup>	<b>73%</b>	47%	70%	62%	47%	58%	65%	-
Blood Pressure Control (<140/90) <sup>6</sup>	<b>82%</b>	60%	84%	85%	62%	65%	65%	80%
Eye Exams	<b>88%</b>	51%	69%	81%	54%	56%	69%	90%
<b>Immunizations</b>								
Influenza Shots - Adults (18–64) <sup>8</sup>	<b>49%</b>	-	54%	55%	-	50%	-	65%
Influenza Shots - Adults (65+)	<b>87%</b>	-	-	-	-	-	72%	76%
Immunizations: Pneumococcal	<b>80%</b>	-	-	-	-	-	70%	93%
<b>Cancer Screening</b>								
Colorectal Cancer Screening	<b>58%</b>	-	80%	82%	-	64%	67%	82%

1. Unless otherwise stated, data was collected in January 2016 by reviewing medical records from a sample of ISP'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 2014 *HEDIS Aggregate Report for the Medi-Cal Managed Care Program*.

3. Data was obtained from Kaiser Permanente November 2015 reports for the Northern and Southern California regions.

4. National HEDIS data for Medicaid, commercial plans, and Medicare was obtained from the 2015 *State of Health Care Quality Report*, available on the NCQA website: [www.ncqa.org](http://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 *VHA Facility Quality and Safety Report - Fiscal Year 2012 Data*.

6. For this indicator, the entire applicable 121 patient 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.

8. The VA data is for the age range 50–64.

## APPENDIX A — COMPLIANCE TEST RESULTS

<b>Ironwood State Prison</b> Range of Summary Scores: 53.9% - 96.7%	
<b>Indicator</b>	<b>Compliance Score (Yes %)</b>
<i>Access to Care</i>	78.00%
<i>Diagnostic Services</i>	85.56%
<i>Emergency Services</i>	Not Applicable
<i>Health Information Management (Medical Records)</i>	64.64%
<i>Health Care Environment</i>	80.59%
<i>Inter- and Intra-System Transfers</i>	96.70%
<i>Pharmacy and Medication Management</i>	70.88%
<i>Prenatal and Post-Delivery Services</i>	Not Applicable
<i>Preventive Services</i>	76.71%
<i>Quality of Nursing Performance</i>	Not Applicable
<i>Quality of Provider Performance</i>	Not Applicable
<i>Reception Center Arrivals</i>	Not Applicable
<i>Specialized Medical Housing (OHU, CTC, SNF, Hospice)</i>	82.50%
<i>Specialty Services</i>	87.22%
<i>Internal Monitoring, Quality Improvement, and Administrative Operations</i>	53.87%
<i>Job Performance, Training, Licensing, and Certifications</i>	83.33%

Reference Number	<i>Access to Care</i>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
1.001	<b>Chronic care follow-up appointments:</b> Was the inmate-patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter?	22	8	30	73.33%	0
1.002	<b>For endorsed inmate-patients received from another CDCR institution:</b> If the nurse referred the inmate-patient to a provider during the initial health screening, was the inmate-patient seen within the required time frame?	8	13	21	38.10%	9
1.003	<b>Clinical appointments:</b> Did a registered nurse review the inmate-patient's request for service the same day it was received?	29	1	30	96.67%	0
1.004	<b>Clinical appointments:</b> Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed?	29	1	30	96.67%	0
1.005	<b>Clinical appointments:</b> If the registered nurse determined a referral to a primary care provider was necessary, was the inmate-patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter?	12	5	17	70.59%	13
1.006	<b>Sick call follow-up appointments:</b> If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified?	7	2	9	77.78%	21
1.007	<b>Upon the inmate-patient's discharge from the community hospital:</b> Did the inmate-patient receive a follow-up appointment within the required time frame?	17	6	23	73.91%	0
1.008	<b>Specialty service follow-up appointments:</b> Do specialty service primary care physician follow-up visits occur within required time frames?	21	7	28	75.00%	2
1.101	<b>Clinical appointments:</b> Do inmate-patients have a standardized process to obtain and submit health care services request forms?	6	0	6	100.00%	0
<b>Percentage:</b>					<b>78.00%</b>	

Reference Number	<i>Diagnostic Services</i>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
2.001	<b>Radiology:</b> Was the radiology service provided within the time frame specified in the provider's order?	10	0	10	100.00%	0
2.002	<b>Radiology:</b> Did the primary care provider review and initial the diagnostic report within specified time frames?	6	4	10	60.00%	0
2.003	<b>Radiology:</b> Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	9	1	10	90.00%	0
2.004	<b>Laboratory:</b> Was the laboratory service provided within the time frame specified in the provider's order?	9	1	10	90.00%	0
2.005	<b>Laboratory:</b> Did the primary care provider review and initial the diagnostic report within specified time frames?	10	0	10	100.00%	0
2.006	<b>Laboratory:</b> Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	10	0	10	100.00%	0
2.007	<b>Pathology:</b> Did the institution receive the final diagnostic report within the required time frames?	10	0	10	100.00%	0
2.008	<b>Pathology:</b> Did the primary care provider review and initial the diagnostic report within specified time frames?	10	0	10	100.00%	0
2.009	<b>Pathology:</b> Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	3	7	10	30.00%	0
<b>Percentage:</b>					<b>85.56%</b>	

<i>Emergency Services</i>	Scored Answers
Assesses reaction times and responses to emergency situations. The OIG RN clinicians will use detailed information obtained from the institution's incident packages to perform focused case reviews.	<b>Not Applicable</b>

Reference Number	<i>Health Information Management (Medical Records)</i>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated progress notes, initial health screening forms, and health care service request forms scanned into the eUHR within three calendar days of the inmate-patient encounter date?	19	1	20	95.00%	0
4.002	Are dictated / transcribed documents scanned into the eUHR within five calendar days of the inmate-patient encounter date?	6	14	20	30.00%	0
4.003	Are specialty documents scanned into the eUHR within the required time frame?	20	0	20	100.00%	0
4.004	Are community hospital discharge documents scanned into the eUHR within three calendar days of the inmate-patient date of hospital discharge?	16	4	20	80.00%	0
4.005	Are medication administration records (MARs) scanned into the eUHR within the required time frames?	15	5	20	75.00%	0
4.006	During the eUHR review, did the OIG find that documents were correctly labeled and included in the correct inmate-patient's file?	0	12	12	0.00%	0
4.007	Did clinical staff legibly sign health care records, when required?	23	9	32	71.88%	0
4.008	<b>For inmate-patients discharged from a community hospital:</b> Did the preliminary hospital discharge report include key elements and did a PCP review the report within three calendar days of discharge?	15	8	23	65.22%	0
<b>Overall percentage:</b>					<b>64.64%</b>	

Reference Number	<i>Health Care Environment</i>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
5.101	<b>Infection Control:</b> Are clinical health care areas appropriately disinfected, cleaned and sanitary?	9	0	9	100.00%	0
5.102	<b>Infection control:</b> Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	8	0	8	100.00%	1
5.103	<b>Infection Control:</b> Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	7	2	9	77.78%	0
5.104	<b>Infection control:</b> Does clinical health care staff adhere to universal hand hygiene precautions?	4	3	7	57.14%	2
5.105	<b>Infection control:</b> Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	9	0	9	100.00%	0
5.106	<b>Warehouse, Conex and other non-clinic storage areas:</b> Does the medical supply management process adequately support the needs of the medical health care program?	1	0	1	100.00%	0
5.107	<b>Clinical areas:</b> Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	8	1	9	88.89%	0
5.108	<b>Clinical areas:</b> Do clinic common areas and exam rooms have essential core medical equipment and supplies?	6	3	9	66.67%	0
5.109	<b>Clinical areas:</b> Do clinic common areas have an adequate environment conducive to providing medical services?	8	1	9	88.89%	0
5.110	<b>Clinical areas:</b> Do clinic exam rooms have an adequate environment conducive to providing medical services?	4	4	8	50.00%	1
5.111	<b>Emergency response bags:</b> Are TTA and clinic emergency medical response bags inspected daily and inventoried monthly, and do they contain essential items?	4	3	7	57.14%	2
5.999	<b>For Information Purposes Only:</b> Does the institution's health care management believe that all clinical areas have physical plant infrastructures sufficient to provide adequate health care services?	Information Only				
<b>Overall percentage:</b>					<b>80.59%</b>	



Reference Number	<i>Inter- and Intra-System Transfers</i>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
6.001	<b>For endorsed inmate-patients received from another CDCR institution or COCF:</b> Did nursing staff complete the initial health screening and answer all screening questions on the same day the inmate-patient arrived at the institution?	25	5	30	83.33%	0
6.002	<b>For endorsed inmate-patients received from another CDCR institution or COCF:</b> When required, did the RN complete the assessment and disposition section of the health screening form; refer the inmate-patient to the TTA, if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening?	26	0	26	100.00%	4
6.003	<b>For endorsed inmate-patients received from another CDCR institution or COCF:</b> If the inmate-patient had an existing medication order upon arrival, were medications administered or delivered without interruption?	4	0	4	100.00%	26
6.004	<b>For inmate-patients transferred out of the facility:</b> Were scheduled specialty service appointments identified on the Health Care Transfer Information Form 7371?	20	0	20	100.00%	0
6.101	<b>For inmate-patients transferred out of the facility:</b> Do medication transfer packages include required medications along with the corresponding Medical Administration Record (MAR) and Medication Reconciliation?	6	0	6	100.00%	4
<b>Overall percentage:</b>					<b>96.70%</b>	

Reference Number	<i>Pharmacy and Medication Management</i>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.001	Did the inmate-patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows?	17	5	22	77.27%	8
7.002	Did health care staff administer or deliver new order prescription medications to the inmate-patient within the required time frames?	28	2	30	93.33%	0
7.003	<b>Upon the inmate-patient's discharge from a community hospital:</b> Were all medications ordered by the institution's primary care provider administered or delivered to the inmate-patient within one calendar day of return?	14	9	23	60.87%	0
7.004	<b>For inmate-patients received from a county jail:</b> Were all medications ordered by the institution's reception center provider administered or delivered to the inmate-patient within the required time frames?	Not Applicable				
7.005	<b>Upon the inmate-patient's transfer from one housing unit to another:</b> Were medications continued without interruption?	25	5	30	83.33%	0
7.006	<b>For inmate-patients en route who lay over at the institution:</b> If the temporarily housed inmate-patient had an existing medication order, were medications administered or delivered without interruption?	5	2	7	71.43%	0
7.101	<b>All clinical and medication line storage areas for narcotic medications:</b> Does the institution employ strong medication security controls over narcotic medications assigned to its clinical areas?	1	6	7	14.29%	7
7.102	<b>All clinical and medication line storage areas for non-narcotic medications:</b> Does the institution properly store non-narcotic medications that do not require refrigeration in assigned clinical areas?	3	9	12	25.00%	2
7.103	<b>All clinical and medication line storage areas for non-narcotic medications:</b> Does the institution properly store non-narcotic medications that require refrigeration in assigned clinical areas?	2	5	7	28.57%	7
7.104	<b>Medication preparation and administration areas:</b> Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes?	3	2	5	60.00%	0
7.105	<b>Medication preparation and administration areas:</b> Does the institution employ appropriate administrative controls and protocols when preparing medications for inmate-patients?	5	0	5	100.00%	0
7.106	<b>Medication preparation and administration areas:</b> Does the institution employ appropriate administrative controls and protocols when distributing medications to inmate-patients?	2	3	5	40.00%	0
7.107	<b>Pharmacy:</b> 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	<i>Pharmacy and Medication Management</i>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.108	<b>Pharmacy:</b> Does the institution's pharmacy properly store non-refrigerated medications?	1	0	1	100.00%	0
7.109	<b>Pharmacy:</b> Does the institution's pharmacy properly store refrigerated or frozen medications?	1	0	1	100.00%	0
7.110	<b>Pharmacy:</b> Does the institution's pharmacy properly account for narcotic medications?	1	0	1	100.00%	0
7.111	<b>Pharmacy:</b> Does the institution follow key medication error reporting protocols?	24	6	30	80.00%	0
7.998	<b>For Information Purposes Only:</b> During eUHR compliance testing and case reviews, did the OIG find that medication errors were properly identified and reported by the institution?	Information Only				
7.999	<b>For Information Purposes Only:</b> Do inmate-patients in isolation housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications?	Information Only				
<b>Overall percentage:</b>					<b>70.88%</b>	

<i>Prenatal and Post-delivery Services</i>	Scored Answers
This indicator is not applicable to this institution.	<b>Not Applicable</b>

Reference Number	<i>Preventive Services</i>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
9.001	<b>Inmate-patients prescribed INH:</b> Did the institution administer the medication to the inmate-patient as prescribed?	17	3	20	85.00%	0
9.002	<b>Inmate-patients prescribed INH:</b> Did the institution monitor the inmate-patient monthly for the most recent three months he or she was on the medication?	12	8	20	60.00%	0
9.003	<b>Annual TB Screening:</b> Was the inmate-patient screened for TB within the last year?	14	16	30	46.67%	0
9.004	Were all inmate-patients offered an influenza vaccination for the most recent influenza season?	30	0	30	100.00%	0
9.005	<b>All inmate-patients from the age of 50 through the age of 75:</b> Was the inmate-patient offered colorectal cancer screening?	27	3	30	90.00%	0
9.006	<b>Female inmate-patients from the age of 50 through the age of 74:</b> Was the inmate-patient offered a mammogram in compliance with policy?	Not Applicable				
9.007	<b>Female inmate-patients from the age of 21 through the age of 65:</b> Was the inmate-patient offered a pap smear in compliance with policy?	Not Applicable				
9.008	Are required immunizations being offered for chronic care inmate-patients?	11	3	14	78.57%	16
9.009	Are inmate-patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	Not Applicable				
<b>Overall percentage:</b>					<b>76.71%</b>	

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

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

<b><i>Reception Center Arrivals</i></b>	<b>Scored Answers</b>
This indicator is not applicable to this institution.	<b>Not Applicable</b>

Reference Number	<b><i>Specialized Medical Housing (OHU, CTC, SNF, Hospice)</i></b>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	<b>For all higher level care facilities:</b> Did the registered nurse complete an initial assessment of the inmate-patient on the day of admission, or within eight hours of admission to CMF's Hospice?	10	0	10	100.00%	0
13.002	<b>For OHU, CTC, &amp; SNF only:</b> Did the primary care provider for OHU or attending physician for a CTC & SNF evaluate the inmate-patient within 24 hours of admission?	7	3	10	70.00%	0
13.003	<b>For OHU, CTC, &amp; SNF only:</b> Was a written history and physical examination completed within 72 hours of admission?	8	2	10	80.00%	0
13.004	<b>For all higher level care facilities:</b> Did the primary care provider complete the Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes on the inmate-patient at the minimum intervals required for the type of facility where the inmate-patient was treated?	5	3	8	62.50%	2
13.101	<b>For OHU and CTC Only:</b> 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 inmate-patient's cells?	1	0	1	100.00%	0
<b>Overall percentage:</b>					<b>82.50%</b>	

Reference Number	<i>Specialty Services</i>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	Did the inmate-patient receive the high-priority specialty service within 14 calendar days of the PCP order?	15	0	15	100.00%	0
14.002	Did the PCP review the high priority specialty service consultant report within the required time frame?	14	1	15	93.33%	0
14.003	Did the inmate-patient receive the routine specialty service within 90 calendar days of the PCP order?	15	0	15	100.00%	0
14.004	Did the PCP review the routine specialty service consultant report within the required time frame?	14	1	15	93.33%	0
14.005	<b>For endorsed inmate-patients received from another CDCR institution:</b> If the inmate-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?	14	6	20	70.00%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	16	0	16	100.00%	0
14.007	Following the denial of a request for specialty services, was the inmate-patient informed of the denial within the required time frame?	7	6	13	53.85%	3
<b>Overall percentage:</b>					<b>87.22%</b>	

Reference Number	<i>Internal Monitoring, Quality Improvement, and Administrative Operations</i>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.001	Did the institution promptly process inmate medical appeals during the most recent 12 months?	12	0	12	100.00%	0
15.002	Does the institution follow adverse/sentinel event reporting requirements?	Not Applicable				
15.003	Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified?	3	3	6	50.00%	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?	1	0	1	100.00%	0
15.005	For each initiative in the Performance Improvement Work Plan (PIWP), has the institution performance improved or reached the targeted performance objective(s)?	1	6	7	14.29%	0
15.006	<b>For institutions with licensed care facilities:</b> 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				
15.007	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	0	10	10	0.00%	0
15.101	Did the institution complete a medical emergency response drill for each watch and include participation of health care and custody staff during the most recent full quarter?	0	3	3	0.00%	0
15.102	Did the institution's second level medical appeal response address all of the inmate-patient's appealed issues?	10	0	10	100.00%	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?	2	1	3	66.67%	0
15.996	<b>For Information Purposes Only:</b> Did the CCHCS Death Review Committee submit its inmate death review summary to the institution timely?	Information Only				
15.997	<b>For Information Purposes Only:</b> Identify the institution's protocols for tracking medical appeals.	Information Only				
15.998	<b>For Information Purposes Only:</b> Identify the institution's protocols for implementing health care local operating procedures.	Information Only				
15.999	<b>For Information Purposes Only:</b> Identify the institution's health care staffing resources.	Information Only				
<b>Overall percentage:</b>					<b>53.87%</b>	



Reference Number	<i>Job Performance, Training, Licensing, and Certifications</i>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
16.001	Do all providers maintain a current medical license?	8	0	8	100.00%	0
16.101	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	5	0	5	100.00%	0
16.102	Are nursing staff who administer medications current on their clinical competency validation?	10	0	10	100.00%	0
16.103	Are structured clinical performance appraisals completed timely?	5	0	5	100.00%	0
16.104	Are staff current with required medical emergency response certifications?	2	1	3	66.67%	0
16.105	Are nursing staff and the Pharmacist-in-Charge current with their professional licenses and certifications?	5	0	5	100.00%	1
16.106	Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	1	0	1	100.00%	0
16.107	Are nursing staff current with required new employee orientation?	0	1	1	0.00%	0
<b>Overall percentage:</b>					<b>83.33%</b>	

## APPENDIX B — CLINICAL DATA

Table B-1 ISP Sample Sets	
Sample Set	Total
CTC/OHU	3
Death Review/Sentinel Events	3
Diabetes	7
Emergency Services - CPR	1
Emergency Services - Non-CPR	5
High Risk	5
Hospitalization	5
Intra-system Transfers-In	3
Intra-system Transfers-Out	3
RN Sick Call	30
Specialty Services	5
	<b>70</b>

Table B-2 ISP Chronic Care Diagnoses	
Diagnosis	Total
Anemia	4
Arthritis/Degenerative Joint Disease	6
Asthma	12
COPD	2
Cancer	7
Cardiovascular Disease	3
Chronic Kidney Disease	3
Chronic Pain	11
Cirrhosis/End Stage Liver Disease	3
Diabetes	14
Gastroesophageal Reflux Disease	15
Hepatitis C	18
Hyperlipidemia	18
Hypertension	25
Mental Health	1
Seizure Disorder	1
Sleep Apnea	3
	<b>146</b>

**Table B-3 ISP Event - Program**

<b>Program</b>	<b>Total</b>
Diagnostic Services	120
Emergency Care	69
Hospitalization	58
Intra-system Transfers-In	14
Intra-system Transfers-Out	5
Not Specified	6
Outpatient Care	708
Reception Center Care	1
Specialized Medical Housing	178
Specialty Services	237
	<b>1,396</b>

**Table B-4 ISP Case Review Sample Summary**

	<b>Total</b>
MD Reviews Detailed	30
MD Reviews Focused	1
RN Reviews Detailed	19
RN Reviews Focused	34
Total Reviews	84
Total Unique Cases	70
Overlapping Reviews (MD & RN)	14

## APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

<b>Ironwood State Prison</b>			
<b>Quality Indicator</b>	<b>Sample Category (number of samples)</b>	<b>Data Source</b>	<b>Filters</b>
<i>Access to Care</i>			
MIT 1.001	Chronic care patients (30)	Master Registry	<ul style="list-style-type: none"> <li>• Chronic care conditions (at least one condition per inmate-patient—any risk level)</li> <li>• <b>Randomize</b></li> </ul>
MIT 1.002	Nursing Referrals (21)	OIG Q: 6.001	<ul style="list-style-type: none"> <li>• See <i>Intra-system Transfers</i></li> </ul>
MITs 1.003-006	Nursing sick call (5 per clinic) 30	MedSATS	<ul style="list-style-type: none"> <li>• Clinic (each clinic tested)</li> <li>• Appointment date (2–9 months)</li> <li>• <b>Randomize</b></li> </ul>
MIT 1.007	Returns from community hospital (30)	OIG Q: 4.008	<ul style="list-style-type: none"> <li>• See <i>Health Information Management (Medical Records)</i> (returns from community hospital)</li> </ul>
MIT 1.008	Specialty services follow-up (28)	OIG Q: 14.001 & 14.003	<ul style="list-style-type: none"> <li>• See <i>Specialty Services</i></li> </ul>
<i>Diagnostic Services</i>			
MITs 2.001–003	Radiology (10)	Radiology Logs	<ul style="list-style-type: none"> <li>• Appointment date (90 days–9 months)</li> <li>• <b>Randomize</b></li> <li>• Abnormal</li> </ul>
MITs 2.004–006	Laboratory (10)	Quest	<ul style="list-style-type: none"> <li>• Appt. date (90 days–9 months)</li> <li>• Order name (CBC or CMPs only)</li> <li>• <b>Randomize</b></li> <li>• Abnormal</li> </ul>
MITs 2.007–009	Pathology (10)	InterQual	<ul style="list-style-type: none"> <li>• Appt. date (90 days–9 months)</li> <li>• Service (pathology related)</li> <li>• <b>Randomize</b></li> </ul>
<i>Health Information Management (Medical Records)</i>			
MIT 4.001	Timely scanning (20)	OIG Qs: 1.001, 1.002, & 1.004	<ul style="list-style-type: none"> <li>• Non-dictated documents</li> <li>• 1<sup>st</sup> 10 IPs MIT 1.001, 1<sup>st</sup> 5 IPs MITs 1.002, 1.004</li> </ul>
MIT 4.002	(20)	OIG Q: 1.001	<ul style="list-style-type: none"> <li>• Dictated documents</li> <li>• First 20 IPs selected</li> </ul>
MIT 4.003	(20)	OIG Qs: 14.002 & 14.004	<ul style="list-style-type: none"> <li>• Specialty documents</li> <li>• First 10 IPs for each question</li> </ul>
MIT 4.004	(20)	OIG Q: 4.008	<ul style="list-style-type: none"> <li>• Community hospital discharge documents</li> <li>• First 20 IPs selected</li> </ul>
MIT 4.005	(20)	OIG Q: 7.001	<ul style="list-style-type: none"> <li>• MARs</li> <li>• First 20 IPs selected</li> </ul>
MIT 4.006	(12)	Documents for any tested inmate	<ul style="list-style-type: none"> <li>• Any misfiled or mislabeled document identified during OIG compliance review (12 or more = No)</li> </ul>
MIT 4.007	Legible signatures & review (32)	OIG Qs: 4.008, 6.001, 6.002, 7.001, 12.001, 12.002 & 14.002	<ul style="list-style-type: none"> <li>• First 8 IPs sampled</li> <li>• One source document per IP</li> </ul>

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
<b>Health Information Management (Medical Records) (continued)</b>			
MIT 4.008	Returns from community hospital  (23)	Inpatient claims data	<ul style="list-style-type: none"> <li>• Date (2–8 months)</li> <li>• Most recent 6 months provided (within date range)</li> <li>• Rx count</li> <li>• Discharge date</li> <li>• <b>Randomize</b> (each month individually)</li> <li>• First 5 inmate-patients from each of the 6 months (if not 5 in a month, supplement from another, as needed)</li> </ul>
<b>Health Care Environment</b>			
MIT 5.101-111	Clinical areas (9)	OIG inspector onsite review	<ul style="list-style-type: none"> <li>• Identify and inspect all onsite clinical areas.</li> </ul>
<b>Inter- and Intra-System Transfers</b>			
MIT 6.001-003	Intra-system transfers  (30)	SOMS	<ul style="list-style-type: none"> <li>• Arrival date (3–9 months)</li> <li>• Arrived from (another CDCR facility)</li> <li>• Rx count</li> <li>• <b>Randomize</b></li> </ul>
MIT 6.004	Specialty services send-outs (20)	MedSATS	<ul style="list-style-type: none"> <li>• Date of transfer (3–9 months)</li> <li>• <b>Randomize</b></li> </ul>
MIT 6.101	Transfers out (6)	OIG inspector onsite review	<ul style="list-style-type: none"> <li>• R&amp;R IP transfers with medication</li> </ul>
<b>Pharmacy and Medication Management</b>			
MIT 7.001	Chronic care medication  (22)	OIG Q: 1.001	<p><i>See Access to Care</i></p> <ul style="list-style-type: none"> <li>• At least one condition per inmate-patient—any risk level</li> <li>• <b>Randomize</b></li> </ul>
MIT 7.002	New Medication Orders (30)	Master Registry	<ul style="list-style-type: none"> <li>• Rx count</li> <li>• <b>Randomize</b></li> <li>• Ensure no duplication of IPs tested in MIT 7.001</li> </ul>
MIT 7.003	Returns from Community Hospital (23)	OIG Q: 4.008	<ul style="list-style-type: none"> <li>• <i>See Health Information Management (Medical Records) (returns from community hospital)</i></li> </ul>
MIT 7.004	RC arrivals – medication orders <i>N/A at this institution</i>	OIG Q: 12.001	<ul style="list-style-type: none"> <li>• <i>See Reception Center Arrivals</i></li> </ul>
MIT 7.005	Intra-facility moves  (30)	MAPIP transfer data	<ul style="list-style-type: none"> <li>• Date of transfer (2–8 months)</li> <li>• To location/from location (yard to yard and to/from ASU)</li> <li>• Remove any to/from MHCB</li> <li>• NA/DOT meds (and risk level)</li> <li>• <b>Randomize</b></li> </ul>
MIT 7.006	En Route  (7)	SOMS	<ul style="list-style-type: none"> <li>• Date of transfer (2–8 months)</li> <li>• Sending institution (another CDCR facility)</li> <li>• <b>Randomize</b></li> <li>• NA/DOT meds</li> </ul>

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
<b>Pharmacy and Medication Management (continued)</b>			
MITs 7.101-103	Medication storage areas (varies by test)	OIG inspector onsite review	<ul style="list-style-type: none"> <li>Identify and inspect clinical &amp; med line areas that store medications</li> </ul>
MITs 7.104–106	Medication Preparation and Administration Areas (5)	OIG inspector onsite review	<ul style="list-style-type: none"> <li>Identify and inspect onsite clinical areas that prepare and administer medications</li> </ul>
MITs 7.107-110	Pharmacy (1)	OIG inspector onsite review	<ul style="list-style-type: none"> <li>Identify &amp; inspect all onsite pharmacies</li> </ul>
MIT 7.111	Medication error reporting (30)	Monthly medication error reports	<ul style="list-style-type: none"> <li>All monthly statistic reports with Level 4 or higher</li> <li>Select a total of 5 months</li> </ul>
MIT 7.999	Isolation unit KOP medications (4)	Onsite active medication listing	<ul style="list-style-type: none"> <li>KOP rescue inhalers &amp; nitroglycerin medications for IPs housed in isolation units</li> </ul>
<b>Prenatal and Post-Delivery Services</b>			
MIT 8.001-007	Recent Deliveries <i>N/A at this institution</i>	OB Roster	<ul style="list-style-type: none"> <li>Delivery date (2–12 months)</li> <li><b>Most recent</b> deliveries (within date range)</li> </ul>
	Pregnant Arrivals <i>N/A at this institution</i>	OB Roster	<ul style="list-style-type: none"> <li>Arrival date (2–12 months)</li> <li><b>Earliest</b> arrivals (within date range)</li> </ul>
<b>Preventive Services</b>			
MITs 9.001–002	TB medications (20)	Maxor	<ul style="list-style-type: none"> <li>Dispense date (past 9 months)</li> <li>Time period on TB meds (3 months or 12 weeks)</li> <li><b>Randomize</b></li> </ul>
MIT 9.003	TB Code 22, annual TST (15)	SOMS	<ul style="list-style-type: none"> <li>Arrival date (at least 1 year prior to inspection)</li> <li>TB Code (22)</li> <li><b>Randomize</b></li> </ul>
MIT 9.004	TB Code 34, annual screening (15)	SOMS	<ul style="list-style-type: none"> <li>Arrival date (at least 1 year prior to inspection)</li> <li>TB Code (34)</li> <li><b>Randomize</b></li> </ul>
MIT 9.004	Influenza vaccinations (30)	SOMS	<ul style="list-style-type: none"> <li>Arrival date (at least 1 year prior to inspection)</li> <li><b>Randomize</b></li> <li>Filter out IPs tested in MIT 9.008</li> </ul>
MIT 9.005	Colorectal cancer screening (30)	SOMS	<ul style="list-style-type: none"> <li>Arrival date (at least 1 year prior to inspection)</li> <li>Date of birth (51 or older)</li> <li><b>Randomize</b></li> </ul>
MIT 9.006	Mammogram <i>N/A at this institution</i>	SOMS	<ul style="list-style-type: none"> <li>Arrival date (at least 2 yrs prior to inspection)</li> <li>Date of birth (age 52–74)</li> <li><b>Randomize</b></li> </ul>
MIT 9.007	Pap smear <i>N/A at this institution</i>	SOMS	<ul style="list-style-type: none"> <li>Arrival date (at least three yrs prior to inspection)</li> <li>Date of birth (age 24–53)</li> <li><b>Randomize</b></li> </ul>
MIT 9.008	Chronic care vaccinations (14)	OIG Q: 1.001	<ul style="list-style-type: none"> <li>Chronic care conditions (at least 1 condition per IP—any risk level)</li> <li><b>Randomize</b></li> <li>Condition must require vaccination(s)</li> </ul>

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
<b>Preventive Services (continued)</b>			
MIT 9.009	Valley fever (number will vary)  <i>N/A at this institution</i>	Cocci transfer status report	<ul style="list-style-type: none"> <li>• Reports from past 2–8 months</li> <li>• Institution</li> <li>• Ineligibility date (60 days prior to inspection date)</li> <li>• <b>All</b></li> </ul>
<b>Reception Center Arrivals</b>			
MITs 12.001–008	RC  <i>N/A at this institution</i>	SOMS	<ul style="list-style-type: none"> <li>• Arrival date (2–8 months)</li> <li>• Arrived from (county jail, return from parole, etc.)</li> <li>• <b>Randomize</b></li> </ul>
<b>Specialized Medical Housing</b>			
MITs 13.001–004	CTC  (10)	CADDIS	<ul style="list-style-type: none"> <li>• Admit date (1–6 months)</li> <li>• Type of stay (no MH beds)</li> <li>• Length of stay (minimum of 5 days)</li> <li>• <b>Randomize</b></li> </ul>
MIT 13.101	Call buttons OHU (all)	OIG inspector onsite review	<ul style="list-style-type: none"> <li>• Review by location</li> </ul>
<b>Specialty Services Access</b>			
MITs 14.001–002	High-priority (15)	MedSATS	<ul style="list-style-type: none"> <li>• Approval date (3–9 months)</li> <li>• <b>Randomize</b></li> </ul>
MITs 14.003–004	Routine (15)	MedSATS	<ul style="list-style-type: none"> <li>• Approval date (3–9 months)</li> <li>• Remove optometry, physical therapy or podiatry</li> <li>• <b>Randomize</b></li> </ul>
MIT 14.005	Specialty services arrivals (20)	MedSATS	<ul style="list-style-type: none"> <li>• Arrived from (other CDCR institution)</li> <li>• Date of transfer (3–9 months)</li> <li>• <b>Randomize</b></li> </ul>
MIT 14.006–007	Denials (16)	InterQual	<ul style="list-style-type: none"> <li>• Review date (3–9 months)</li> <li>• <b>Randomize</b></li> </ul>
	(13)	IUMC/MAR Meeting Minutes	<ul style="list-style-type: none"> <li>• Meeting date (9 months)</li> <li>• Denial upheld</li> <li>• <b>Randomize</b></li> </ul>
<b>Internal Monitoring, Quality Improvement, &amp; Administrative Operations</b>			
MIT 15.001	Medical appeals (all)	Monthly medical appeals reports	<ul style="list-style-type: none"> <li>• Medical appeals (12 months)</li> </ul>
MIT 15.002	Adverse/sentinel events  (0)	Adverse/sentinel events report	<ul style="list-style-type: none"> <li>• Adverse/sentinel events (2–8 months)</li> </ul>
MITs 15.003–004	QMC Meetings  (6)	Quality Management Committee meeting minutes	<ul style="list-style-type: none"> <li>• Meeting minutes (12 months)</li> </ul>
MIT 15.005	Performance improvement work plans (PIWP) (7)	Institution PIWP	<ul style="list-style-type: none"> <li>• PIWP with updates (12 months)</li> <li>• Medical initiatives</li> </ul>

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
<i>Internal Monitoring, Quality Improvement, &amp; Administrative Operations (continued)</i>			
MIT 15.006	LGB <i>N/A at this institution</i>	LGB meeting minutes	<ul style="list-style-type: none"> <li>Quarterly meeting minutes (12 months)</li> </ul>
MIT 15.007	EMRRC (12)	EMRRC meeting minutes	<ul style="list-style-type: none"> <li>Monthly meeting minutes (6 months)</li> </ul>
MIT 15.101	Medical emergency response drills (3)	Onsite summary reports & documentation for ER drills	<ul style="list-style-type: none"> <li>Most recent full quarter</li> <li>Each watch</li> </ul>
MIT 15.102	2 <sup>nd</sup> level medical appeals (10)	Onsite list of appeals/closed appeals files	<ul style="list-style-type: none"> <li>Medical appeals denied (6 months)</li> </ul>
MIT 15.103	Death Reports (3)	Institution-list of deaths in prior 12 months	<ul style="list-style-type: none"> <li>Most recent 10 deaths</li> <li>Initial death reports</li> </ul>
MIT 15.996	Death Review Committee (5)	OIG summary log - deaths	<ul style="list-style-type: none"> <li>Between 35 business days &amp; 12 months prior</li> <li>CCHCS death reviews</li> </ul>
MIT 15.998	Local operating procedures (LOPs) (all)	Institution LOPs	<ul style="list-style-type: none"> <li>All LOPs</li> </ul>
<i>Job Performance, Training, Licensing, and Certifications</i>			
MIT 16.001	Provider licenses (8)	Current provider listing (at start of inspection)	<ul style="list-style-type: none"> <li>Review all</li> </ul>
MIT 16.101	RN Review Evaluations (5)	Onsite supervisor periodic RN reviews	<ul style="list-style-type: none"> <li>RNs who worked in clinic or emergency setting six or more days in sampled month</li> <li><b>Randomize</b></li> </ul>
MIT 16.102	Nursing Staff Validations (10)	Onsite nursing education files	<ul style="list-style-type: none"> <li>On duty one or more years</li> <li>Nurse administers medications</li> <li><b>Randomize</b></li> </ul>
MIT 16.103	Provider Annual Evaluation Packets (all)	OIG Q:16.001	<ul style="list-style-type: none"> <li>All required performance evaluation documents</li> </ul>
MIT 16.104	Medical Emergency Response Certifications (all)	Onsite certification tracking logs	<ul style="list-style-type: none"> <li>All staff <ul style="list-style-type: none"> <li>Providers (ACLS)</li> <li>Nursing (BLS/CPR)</li> <li>Custody (CPR/BLS)</li> </ul> </li> </ul>
MIT 16.105	Nursing staff and Pharmacist-in-charge Professional Licenses and Certifications (all)	Onsite tracking system, logs, or employee files	<ul style="list-style-type: none"> <li>All required licenses and certifications</li> </ul>



Quality Indicator	Sample Category (number of samples)	Data Source	Filters
<i>Job Performance, Training, Licensing, and Certifications (continued)</i>			
MIT 16.106	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations  (all)	Onsite listing of provider DEA registration #s & pharmacy registration document	<ul style="list-style-type: none"> <li>All DEA registrations</li> </ul>
MIT 16.107	Nursing Staff New Employee Orientations  (all)	Nursing staff training logs	<ul style="list-style-type: none"> <li>New employees (hired within last 12 months)</li> </ul>

**CALIFORNIA CORRECTIONAL  
HEALTH CARE SERVICES'  
RESPONSE**

May 20, 2016

Robert A. Barton, Inspector General  
Office of the Inspector General  
10111 Old Placerville Road, Suite 110  
Sacramento, CA 95827

Dear Mr. Barton:

The purpose of this letter is to inform you that the Office of the Receiver has reviewed the draft report of the Office of the Inspector General (OIG) Medical Inspection Results for Ironwood State Prison (ISP) conducted from February 2016 to April 2016. California Correctional Health Care Services (CCHCS) acknowledges all OIG findings.

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

Sincerely,



JANET LEWIS  
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  
Jared Goldman, Counsel to the Receiver  
Roy Wesley, Chief Deputy Inspector General, OIG  
Christine Berthold, Senior Deputy Inspector General, OIG  
Ryan Baer, Senior Deputy Inspector General (A), OIG  
Scott Heatley, M.D., Ph.D., CCHP, Chief Physician and Surgeon, OIG  
Penny Horper, R.N., MSN, CPHQ, Nurse Consultant Program Review, OIG  
Yulanda Mynhier, Director, Health Care Policy and Administration, CCHCS  
Roscoe Barrow, Chief Counsel, CCHCS Office of Legal Affairs  
R. Steven Tharratt, M.D., MPVM, FACP, Director, Health Care Operations, CCHCS  
Renee Kanan, M.D., Chief Quality Officer, Quality Management, CCHCS  
Ricki Barnett, M.D., Deputy Director, Medical Services, CCHCS  
Cheryl Schutt, R.N., Deputy Director, Nursing Services, CCHCS  
Robert Herrick, Regional Health Care Executive, Region IV, CCHCS  
Elizabeth dos Santos Chen, D.O., Regional Deputy Medical Executive, Region IV, CCHCS  
Jorge Gomez, Regional Nursing Executive, Region IV, CCHCS  
Eric Andersson, Chief Executive Officer, ISP  
Lara Saich, Chief, Risk Management Branch, Policy and Risk Management Services, CCHCS  
Dawn DeVore, Staff Services Manager II, Program Compliance Section, CCHCS