

**Ironwood State Prison
Medical Inspection Results
Cycle 5**



July 2017

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

Office of the Inspector General IRONWOOD STATE PRISON Medical Inspection Results Cycle 5



Robert A. Barton
Inspector General

Roy W. Wesley
Chief Deputy Inspector General

Shaun R. Spillane
Public Information Officer

July 2017

TABLE OF CONTENTS

Executive Summary	i
Overall Assessment: <i>Inadequate</i>	i
Clinical Case Review and OIG Clinician Inspection Results	iii
Compliance Testing Results.....	iv
Population-Based Metrics	v
Introduction.....	1
About the Institution	1
Objectives, Scope, and Methodology.....	3
Case Reviews.....	4
Patient Selection for Retrospective Case Reviews.....	4
Benefits and Limitations of Targeted Subpopulation Review	5
Case Reviews Sampled	5
Compliance Testing	7
Sampling Methods for Conducting Compliance Testing.....	7
Scoring of Compliance Testing Results.....	7
Overall Quality Indicator Rating for Case Reviews and Compliance Testing	8
Population-Based Metrics.....	8
Medical Inspection Results	9
1 — <i>Access to Care</i>	11
Case Review Results.....	11
Compliance Testing Results.....	13
Recommendations.....	14
2 — <i>Diagnostic Services</i>	15
Case Review Results.....	15
Compliance Testing Results.....	16
Recommendations.....	17
3 — <i>Emergency Services</i>	18
Case Review Results.....	18
Recommendations.....	19
4 — <i>Health Information Management</i>	20
Case Review Results.....	20
Compliance Testing Results.....	22
Recommendations.....	23
5 — <i>Health Care Environment</i>	24
Compliance Testing Results.....	24
Recommendations.....	26
6 — <i>Inter- and Intra-System Transfers</i>	27
Case Review Results.....	27
Compliance Testing Results.....	28
Recommendations.....	29

7 — <i>Pharmacy and Medication Management</i>	30
Case Review Results	30
Compliance Testing Results	31
Recommendations	33
8 — <i>Prenatal and Post-Delivery Services</i>	34
9 — <i>Preventive Services</i>	35
Compliance Testing Results	35
Recommendations	36
10 — <i>Quality of Nursing Performance</i>	37
Case Review Results	37
Recommendations	40
11 — <i>Quality of Provider Performance</i>	41
Case Review Results	41
Recommendations	46
12 — <i>Reception Center Arrivals</i>	47
13 — <i>Specialized Medical Housing</i>	48
Case Review Results	48
Compliance Testing Results	50
Recommendations	51
14 — <i>Specialty Services</i>	52
Case Review Results	52
Compliance Testing Results	54
Recommendations	55
15 — <i>Administrative Operations (Secondary)</i>	56
Compliance Testing Results	56
Recommendations	58
Population-Based Metrics	59
Appendix A — Compliance Test Results	62
Appendix B — Clinical Data	75
Appendix C — Compliance Sampling Methodology	78
California Correctional Health Care Services’ Response	85

LIST OF TABLES AND FIGURES

ISP Executive Summary Table	ii
ISP Health Care Staffing Resources as of February 2017	2
ISP Master Registry Data as of February 6, 2017	2
ISP Results Compared to State and National HEDIS Scores	61
Table B-1: ISP Sample Sets.....	75
Table B-2: ISP Chronic Care Diagnoses	76
Table B-3: ISP Event — Program	77
Table B-4: ISP Case Review Sample Summary	77

EXECUTIVE SUMMARY

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

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

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

Overall Assessment: Inadequate

The OIG performed its Cycle 5 medical inspection at Ironwood State Prison (ISP) from February to April 2017. The inspection included in-depth reviews of 44 patient files conducted by clinicians, as well as reviews of documents from 337 patient files, covering 88 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 13 health care quality indicators applicable to the institution. To conduct clinical case reviews, the OIG employs a clinician team consisting of a physician and a registered nurse consultant, while compliance testing is done by a team of registered nurses trained in monitoring medical policy compliance. Of the indicators, seven were rated by both case review clinicians and compliance inspectors, three were rated by case review clinicians only, and three were rated by compliance inspectors only. The *ISP Executive Summary Table* on the following page identifies the applicable individual indicators and scores for this institution.

ISP Executive Summary Table

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

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

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 923 patient care events.¹ Of the 13 indicators applicable to ISP, 10 were evaluated by clinician case review; 8 were *adequate*, and 2 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

- ISP provided good access to primary care services. With significant preparation, the providers and staff were able to maintain this level of access during the introduction and adaptation of a new electronic medical record.
- Diagnostic services were strong at ISP, with diagnostic tests being performed, results being reviewed by providers, and patients being notified of results in a timely manner.
- The emergency care provided at ISP was good. The institution's ability to triage and provide necessary services for acutely ill patients continued to be a strong point.

Program Weaknesses — Clinical

- The quality of provider performance was poor. Providers performed subpar reviews of documentation and failed to manage significantly abnormal medical findings, such as chest pain and poorly controlled diabetes.
- While outpatient nursing was adequate, the nursing care in the specialized medical housing at ISP was inadequate. There was poor nursing performance and documentation. Patients did not receive the proper care for wounds, or to protect them from falling.
- Specialty medical housing at ISP was found to be inadequate due to poor nursing performance and documentation.
- ISP providers rarely held provider only meetings with their colleagues to discuss complex cases and standardized care at ISP. Most meetings involved other clinical staff, which and functionally diluted the utility of the meetings and prevented higher-level discussion among the providers.

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

Compliance Testing Results

Of the 13 health care indicators applicable to ISP, 10 were evaluated by compliance inspectors.² They rated two indicators *proficient*, six *adequate*, and two *inadequate*. There were 88 individual compliance questions within those 10 indicators, generating 1,041 data points that tested ISP's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.³ Those 88 questions are detailed in *Appendix A — Compliance Test Results*.

Program Strengths — Compliance

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

- Patients received chronic care appointments within required time frames, and nursing staff reviewed patient sick call requests and performed timely face-to-face visits.
- Patients' radiology and laboratory services were provided within required time frames.
- The institution scanned non-dictated documents and medication administration records (MARs) into the electronic medical record within required time frames. Providers timely reviewed hospital discharge reports, and institution staff timely scanned discharge reports into the electronic medical record.
- ISP clinics were appropriately cleaned and sanitized, adequate hygiene supplies were available in clinic locations, and clinics had an environment conducive to providing medical services.
- Patients received their chronic care medications, new medication orders, and hospital discharge medications within required time frames, and patients who transferred from one yard to another received their medication at the next dosing interval.
- Patients received their high-priority and routine specialty service appointments within required time frames.

Program Weaknesses — Compliance

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

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

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

- Patients did not always receive follow-up appointments with their providers after specialty service appointments.
- Providers did not timely review pathology reports.
- Reusable invasive and non-invasive equipment was not always properly sterilized or disinfected in some clinics, and some clinics and clinic exam rooms lacked some essential equipment and supplies.
- Not all medication line locations showed adequate security controls over narcotic medications, and several medication lines did not properly store non-narcotic medication that did not require refrigeration.
- ISP clinicians did not properly monitor patients taking tuberculosis medications, and the institution did not always properly screen patients annually for tuberculosis.
- The institution did not always receive, and providers did not always review, specialty service reports within required time frames. In addition, ISP did not always provide pending specialty service appointments to patients who transferred into the institution.

Population-Based Metrics

In general, ISP performed well as measured by population-based metrics. In comprehensive diabetes care, ISP outperformed all statewide and national health care plans in all five diabetic measures reviewed.

With regard to immunization measures, ISP's scores were lower when compared to Kaiser and the United States Department of Veteran's Affairs (VA), but matched commercial plans for influenza vaccinations for younger adults. The institution outperformed Medicare and the VA with providing influenza vaccinations to older adults, but scored less well against these two health plans for providing pneumococcal vaccinations for older adults. ISP outperformed all state and national health care plans for colorectal cancer screenings.

Overall, ISP's performance as measured by population-based metrics indicated that the chronic care program was good in comparison to other health care plans reviewed, and the institution can improve by providing patient education concerning the benefits of preventive services.

INTRODUCTION

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

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

ABOUT THE INSTITUTION

Ironwood State Prison (ISP) houses primarily general population, minimum- and medium-custody male offenders. Consisting of four main housing facilities and a separate minimum-custody facility, the institution operates multiple medical clinics where staff handle requests for routine medical services. ISP also treats patients needing urgent or emergency care in its triage and treatment area (TTA), treats patients requiring additional daily care or accommodations in its outpatient housing unit (OHU), and provides specialty services in a specialty clinic. Located outside of Blythe, ISP has been designated by California Correctional Health Care Services (CCHCS) as a "basic" care institution. Basic institutions are located in rural areas, away from tertiary care centers and specialty care providers whose services would likely be used frequently by higher-risk patients. Basic institutions have the capability to provide only limited specialty medical services and consultation for a generally healthy patient population.

On 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. ISP was scheduled for a reaccreditation review in May 2017.

Based on staffing data the OIG obtained from the institution, ISP's vacancy rate among medical managers, primary care providers, supervisors, and rank-and-file nurses was 10 percent in February 2017, with the highest vacancy percentage among management at 25 percent. ISP had one vacancy among primary care providers.

ISP Health Care Staffing Resources as of February 2017

Description	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff		Totals	
	Number	%	Number	%	Number	%	Number	%	Number	%
Authorized Positions	4	5%	6	7%	10.5	13%	61	75%	81.5	100%
Filled Positions	3	75%	5	83%	9	86%	56	92%	73	90%
Vacancies	1	25%	1	17%	1.5	14%	5	8%	8.5	10%
Recent Hires (within 12 months)	0	0%	1	20%	0	0%	11	20%	12	16%
Staff Utilized from Registry	0	0%	0	0%	0	0%	0	0%	0	0%
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%	1	20%	2	22%	2	4%	5	7%

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

As of February 6, 2017, the Master Registry for ISP showed that the institution had a total population of 3,053. Within that total population, 0.5 percent was designated as high medical risk, Priority 1 (High 1), and 1.2 percent was designated as high medical risk, Priority 2 (High 2). Patients' assigned risk levels are based on the complexity of their required medical care related to their specific diagnoses, frequency of higher levels of care, age, and abnormal laboratory results and procedures. High 1 has at least two high-risk conditions; High 2 has only one. Patients at high medical risk are more susceptible to poor health outcomes than those at medium or low medical risk. Patients at high medical risk also typically require more health care services than do patients with lower assigned risk levels. The chart below illustrates the breakdown of the institution's medical risk levels at the start of the OIG medical inspection.

ISP Master Registry Data as of February 6, 2017

Medical Risk Level	Number of Patients	Proportion
High 1	14	0.5%
High 2	37	1.2%
Medium	2,531	82.9%
Low	471	15.4%
Total	3,053	100.0%

OBJECTIVES, SCOPE, AND METHODOLOGY

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

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

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

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

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

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

CASE REVIEWS

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

Patient Selection for Retrospective Case Reviews

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

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

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

1. If the institution is able to provide adequate clinical care to the most challenging patients with multiple complex and interdependent medical problems, it will be providing adequate care to patients with less complicated health care issues. Because clinical expertise is required to determine whether the institution has provided adequate clinical care, the OIG utilizes experienced correctional physicians and registered nurses to perform this analysis.
2. The health of less complex patients is more likely to be affected by processes such as timely appointment scheduling, medication management, routine health screening, and

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

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

Benefits and Limitations of Targeted Subpopulation Review

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

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

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

Case Reviews Sampled

As indicated in *Appendix B, Table B-1: ISP Sample Sets*, the OIG clinicians evaluated medical charts for 44 unique patients. *Appendix B, Table B-4: ISP Case Review Sample Summary*, clarifies that both nurses and physicians reviewed charts for 11 of those patients, for 55 reviews in total. Physicians performed detailed reviews of 20 charts, and nurses performed detailed reviews of 11

charts, totaling 31 detailed reviews. For detailed case reviews, physicians or nurses looked at all encounters occurring in approximately six months of medical care. Nurses also performed a limited or focused review of medical records for an additional 24 patients. These generated 923 clinical events for review (*Appendix B, Table B-3: ISP Event-Program*). The inspection tool provides details on whether the encounter was adequate or had significant deficiencies, and identifies deficiencies by programs and processes to help the institution focus on improvement areas.

While the sample method specifically pulled only six chronic care patient records, i.e., five diabetes patients and one anticoagulation patient (*Appendix B, Table B-1: ISP Sample Sets*), the 44 unique patients sampled included patients with 109 chronic care diagnoses, including 10 additional patients with diabetes (for a total of 15) (*Appendix B, Table B-2: ISP Chronic Care Diagnoses*). The OIG's sample selection tool allowed evaluation of many chronic care programs because the complex and high-risk patients selected from the different categories often had multiple medical problems. While the OIG did not evaluate every chronic disease or health care staff member, the overall operation of the institution's system and staff were assessed for adequacy.

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

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 applicable quality indicator as either *proficient* (excellent), *adequate* (passing), or *inadequate* (failing). 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 February to April 2017, registered nurse inspectors attained answers to 88 objective medical inspection test (MIT) questions designed to assess the institution's compliance with critical policies and procedures applicable to the delivery of medical care. To conduct most tests, inspectors randomly selected samples of patients for whom the testing objectives were applicable and reviewed their electronic unit health records. In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed health records for 337 individual patients and analyzed specific transactions within their records for evidence that critical events occurred. Inspectors also reviewed management reports and meeting minutes to assess certain administrative operations. In addition, during the week of February 6, 2017, registered nurse 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 1,041 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 Cycle 5 medical inspection testing, the OIG reduced the number of compliance samples tested for 18 indicator tests from a sample of 30 patients to a sample of 25 patients. The OIG also removed some inspection tests upon stakeholder agreement that either were duplicated in the case reviews or had limited value. Lastly, for Cycle 4 medical inspections, the OIG tested two secondary (administrative) indicators; *Internal Monitoring, Quality Improvement, and Administrative Operations*; and *Job Performance, Training, Licensing, and Certifications*, and have combined these tests into one *Administrative Operations* indicator for Cycle 5 inspections.

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

Scoring of Compliance Testing Results

After compiling the answers to the 88 questions for the 10 applicable indicators, the OIG derived a score for each quality indicator by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Based on those

results, the OIG assigned a rating to each quality indicator of *proficient* (greater than 85 percent), *adequate* (between 75 percent and 85 percent), or *inadequate* (less than 75 percent).

OVERALL QUALITY INDICATOR RATING FOR CASE REVIEWS AND COMPLIANCE TESTING

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

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

POPULATION-BASED METRICS

The OIG identified a subset of Healthcare Effectiveness Data Information Set (HEDIS) measures applicable to the CDCR patient population. To identify outcomes for ISP, the OIG reviewed some of the compliance testing results, randomly sampled additional 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

The quality indicators assess the clinical aspects of health care. As shown on the *ISP Executive Summary Table* on page *ii* of this report, 13 of the OIG's indicators were applicable to ISP. Of those 13 indicators, 7 were rated by both the case review and compliance components of the inspection, 3 were rated by the case review component alone, and 3 were rated by the compliance component alone. The *Administrative Operations* indicator is secondary and, therefore, was not relied upon for the institution's overall score.

Summary of Case Review Results: The clinical case review component assessed 10 primary (clinical) indicators applicable to ISP. Of these 10 indicators, OIG clinicians rated 8 *adequate* and 2 *inadequate*.

The OIG physicians rated the overall adequacy of care for each of the 20 detailed case reviews they conducted. Of these 20 cases, 11 were *adequate* and 9 were *inadequate*. In the 923 events reviewed, there were 326 deficiencies, of which 78 were of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

Adverse Events Identified During Case Review: Adverse events are medical errors that cause or have a high probability of causing serious patient harm. Medical care is a complex and dynamic process with many moving parts, subject to human error even within the best health care organizations. 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 four adverse events identified in the case reviews at ISP:

- In case 9, the provider failed to order an appropriate follow-up for a patient with diabetes that was seriously out of control. Appropriate management would have been weekly follow-up and daily blood glucose checks. Instead, the provider cancelled all scheduled follow-up provider appointments and ordered a provider visit in six months.
- In case 19, the provider failed to order a temporary blood thinner as directed by the hospital physician. This temporary medication would protect the patient with a new blood clot from further harm while the slower oral medication was starting to work. Fortunately, no harm came to the patient.
- In case 20, the provider evaluated a patient with newly diagnosed diabetes (type 1) who required insulin. The patient's blood sugar was extremely high (497 mg/dL). No insulin or blood sugar checks were ordered. The ordered follow-up in 12 months was inappropriate. The patient required hospital care for his diabetes three weeks later.

- In case 26, a patient with a possible heart attack and stroke failed to have appropriate air transport to the nearest hospital with the ability to treat acute strokes.

Summary of Compliance Results: The compliance component assessed 10 of the 13 indicators applicable to ISP. Of these 10 indicators, OIG inspectors rated two *proficient*, six *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*.

1 — ACCESS TO CARE

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

Case Review Rating:

Adequate

Compliance Score:

Adequate

(83.1%)

Overall Rating:

Adequate

Case Review Results

The OIG clinicians reviewed 292 provider, nurse, specialty, and hospital events that required a follow-up appointment and identified 27 deficiencies relating to *Access to Care*. Among the 27 deficiencies, 17 were significant, or likely to cause patient harm. Significant deficiencies were identified in cases 2, 7, 9, 11, 12, 20, 21, 22, 23, 24, 25, 26, 27, 38, and 46.

Provider Follow-up Appointments

There were 78 provider follow-up encounters. The OIG discovered three deficiencies, two of which were significant:

- In case 27, the provider ordered a two-week follow-up so a provider could check the patient's blood pressure. This follow-up appointment did not occur.
- In case 47, an RN-requested provider appointment was delayed two weeks.

RN Sick Call Access

The OIG reviewed 45 sick call events. One significant deficiency was identified. The vast majority of sick call encounters were scheduled timely and addressed appropriately.

- In case 38, the patient had a foot lesion and was triaged by the nurse for a next-day face-to-face evaluation, but this evaluation did not occur until 14 days later.

RN-to-Provider Referrals

Eight RN-to-provider referrals were reviewed, and only one minor deficiency was noted. No pattern of deficiencies was discovered.

RN Follow-up Appointments

Four RN follow-up encounters were reviewed. One significant deficiency was found.

- In case 20, a provider ordered the nurse to recheck an infected wound in two days. The appointment was two days late.

Provider Follow-up After Specialty Services

The OIG reviewed 54 provider appointments that were scheduled after specialty services. These appointments are necessary because they allow providers to evaluate consultant recommendations. ISP performed well in this area. Appointments were consistently scheduled. However, one significant deficiency was noted:

- In case 12, after the patient saw the neurologist, the follow-up visit with the ISP provider occurred two weeks late.

Intra-System Transfers

There were nine intra-system transfer events reviewed. On three occasions, the RN initiated provider appointments but they did not occur within the specified time frame. Performance in this area is also discussed in the *Inter- and Intra-System Transfers* indicator.

Follow-up After Hospitalization

There were 31 hospitalization follow-up events reviewed; all follow-ups occurred timely.

Follow-up After Urgent/Emergent Care

There were five follow-ups after emergent care reviewed; all follow-ups occurred timely.

Specialized Medical Housing

Among the 62 OHU follow-up appointments reviewed, only two minor access deficiencies were identified. Performance in this area is also discussed in the *Specialized Medical Housing* indicator.

Specialty Access and Follow-up

Access to specialists was generally good. Of the 132 specialty events reviewed, four significant deficiencies were identified (cases 12, 21, 22, and 26); in all four cases, the ordered specialist care was significantly delayed. Performance in this area is also discussed in the *Specialty Services* indicator.

Diagnostic Results Follow-up

Providers reviewed diagnostic results and utilized the Notification of Diagnostic Test Results form (CDCR Form 7393) to indicate if follow-up appointments were necessary. ISP providers usually provided adequate follow-up after they received abnormal diagnostic results, but there were significant deficiencies:

- In case 12, on three separate occasions (two of which constituted significant deficiencies), a chronic care appointment regarding abnormal laboratory results did not occur within 14 days as ordered.

Clinician Onsite Inspection

ISP's medical staff was conscious of the importance of patients' access to care. This was evident during huddles and discussions among the medical staff. The week prior to the OIG clinicians' visit, ISP had implemented the new Electronic Health Record System (EHRS).⁴ The medical leadership had proactively anticipated potential delays regarding access to care and increased patient-provider encounters to avoid a future backlog while the institution adapted to the new medical record system. This demonstrated positive vision on the part of the administrative staff as well as the dedication of the primary care team.

Clinician Summary

In general, ISP performed well with regard to *Access to Care*, and the OIG clinicians rated this indicator *adequate*.

Compliance Testing Results

The institution performed in the *adequate* range in the *Access to Care* indicator, with a compliance score of 83.1 percent. The institution performed in the *proficient* range on the following five tests:

- Inspectors sampled 30 Health Care Services Request forms (CDCR Form 7362) submitted by patients across all facility clinics. Nursing staff reviewed all patients' request forms on the same day they were received. In addition, nursing staff timely completed a face-to-face triage encounter for 29 of those 30 patients (97 percent). The nurse encounter for one patient's visit occurred one day late (MIT 1.003, 1.004).
- Patients at ISP had access to health care services request forms at all six housing units the OIG inspected (MIT 1.101).
- Among 25 recent chronic care appointments, 23 patients (92 percent) received timely routine appointments. One patient's appointment was 41 days late. The other patient had still not had an appointment at the time of the OIG's review, which was already 142 days late (MIT 1.001).
- Among 14 sampled patients who were discharged from a community hospital, 12 (86 percent) received timely provider follow-up appointments upon their return to ISP. Two patients received their follow-up appointments six and eight days late (MIT 1.007).

⁴ The OIG's case review was based on data exclusively from the eUHR, which was supplied several weeks prior to the clinicians' onsite visit.

The following two tests scored in the *adequate* range:

- Of 12 sampled health care service requests on which nursing staff referred the patient for a provider appointment, 9 of the patients (75 percent) received a timely appointment. For one patient, the follow-up appointment occurred two days late. For another patient, the appointment was conducted by a registered nurse but should have been conducted by a provider (MIT 1.005).
- The OIG sampled 25 patients who either transferred into ISP with a preexisting chronic care provider visit need or received a new provider referral from the ISP screening nurse upon arrival; 19 of the patients (76 percent) had timely provider visits. For three patients, the appointments were held from 6 to 15 days late, and for three other patients, they were held from 78 to 99 days late (MIT 1.002).

The institution showed room for improvement in the following two areas:

- Only 15 of 27 sampled patients who received a high-priority or routine specialty service (56 percent) also received a timely follow-up appointment with a provider. Among the 12 patients who did not receive a timely follow-up appointment, eight patients' high-priority specialty service follow-up appointments were one to six days late, and one saw a TTA provider but never the primary care provider. Two patients' routine specialty service follow-up appointments were two and four days late, and one was 61 days late (MIT 1.008).
- OIG inspectors initially sampled 30 patients who submitted a sick call request. Of the 30 sampled patients, three patients ultimately required a second provider follow-up visit. However, of these three patients, only two actually received their follow-up appointments timely (67 percent). For one patient, the follow-up visit occurred 16 days late (MIT 1.006).

Recommendations

No specific recommendations.

2 — *DIAGNOSTIC SERVICES*

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

Case Review Rating:

Adequate

Compliance Score:

Adequate

(80.0%)

Overall Rating:

Adequate

Case Review Results

The OIG clinicians reviewed 95 diagnostic events and found eight deficiencies, five of which were significant. ISP successfully completed and performed timely diagnostic services (onsite EKGs, X-rays, and laboratory results). Providers reviewed reports timely, and patients were notified of the test results quickly. All of the deficiencies were either failures to perform ordered diagnostic tests or missing medical records.

Test Completion

Nearly all of the imaging studies were performed and reviewed appropriately. Four of the significant deficiencies resulted in the failure of a provider ordered laboratory.

- In case 18, laboratory tests were not performed as ordered due to expired collection containers, so it was impossible to identify the patient's type of acute infection.
- In case 23, a hip X-ray was ordered due to chronic pain but never performed.
- In case 25, on two separate occasions, test to detect blood in stool were ordered but never performed or refused.

Health Information Management

Three minor deficiencies occurred when non-critical imaging studies were not scanned into the electronic medical records. Two significant deficiencies resulted from a failure to scan a critical laboratory result:

- In case 7, a bacterial culture report was not signed or reviewed by a provider prior to being scanned.

- In case 20, laboratory blood test results, including a critical glucose reading, were not scanned into the medical records.

Pathology Services

Case review did not reveal any deficiencies in pathology services.

Conclusion

The ISP staff provided appropriate radiology and laboratory support for the providers and medical staff, resulting in timely and appropriate diagnostic services. The OIG clinicians rated this indicator *adequate*.

Compliance Testing Results

The institution received an *adequate* compliance score of 80.0 percent in the *Diagnostic Services* indicator, which encompasses radiology, laboratory, and pathology services. For clarity, each type of diagnostic service is discussed separately below.

Radiology Services

- All ten of the radiology services sampled were timely performed (MIT 2.001). However, for one patient, the provider reviewed the corresponding diagnostic services report three days late, then communicated the results three days late; for another patient, the provider reviewed the report four days late and also communicated the results four days late (80 percent) (MIT 2.002, 2.003).

Laboratory Services

- All of the laboratory services sampled were timely performed (MIT 2.004). For nine of the ten sampled services, the provider timely reviewed the diagnostic report (90 percent). In one case, the provider did not initial and date the laboratory report to evidence having reviewed the report (MIT 2.005). Providers timely communicated the results of all ten sampled services (MIT 2.006).

Pathology Services

- The institution timely received seven of ten sampled final pathology reports (70 percent). One report was received five days late, while the other two were not received at all (MIT 2.007). With regard to providers' review, providers evidenced review by initialing and dating six out of eight sampled final pathology reports (75 percent). Two reports were each reviewed two days late (MIT 2.008). Further, providers communicated pathology results timely to only two of the eight patients who received services (25 percent). For four patients, the provider communicated the results between one and 11 days late. For two additional

patients, inspectors did not find evidence in the medical record that the patients received notification of their test results (MIT 2.009).

Recommendations

No specific recommendations.

3 — *EMERGENCY SERVICES*

An emergency medical response system is essential to providing effective and timely emergency medical response, assessment, treatment, and transportation 24 hours per day. Provision of urgent/emergent care is based on a patient's emergency situation, clinical condition, and need for a higher level of care. The OIG reviews emergency response services including first aid, basic life support (BLS), and advanced cardiac life support (ACLS) consistent with the American Heart Association guidelines for cardiopulmonary resuscitation (CPR) and emergency cardiovascular care, and the provision of services by knowledgeable staff appropriate to each individual's training, certification, and authorized scope of practice. The OIG evaluates this quality indicator entirely through clinicians' reviews of case files and conducts no separate compliance testing element.

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

Case Review Results

The OIG clinicians reviewed 45 urgent or emergent events and found 37 deficiencies. The majority of deficiencies were related to incomplete nursing assessments and documentation. Five deficiencies were significant and could have potentially contributed to patient harm. Most patients requiring urgent or emergent services, however, received timely and appropriate care, and the OIG clinicians rated this indicator *adequate*.

CPR Response

Events involving CPR were timely and appropriately handled at ISP. In the cases reviewed, custody staff promptly initiated CPR and alerted health care staff. The nurses expeditiously responded to CPR events and performed appropriate emergency interventions.

Provider Performance

The TTA providers' performance was generally adequate. When the providers were on the premises, they addressed the patients' medical conditions and created concise plans with clear documentation. However, seven of the ten minor deficiencies in this area occurred when the on-call provider failed to complete a progress note, which is an important part of a patient's medical record. This note documents the communication among health care participants, provides justification for the critical decisions made by both nurses and providers, and has the potential to provide valuable insight into the provider's thought process and decisions.

Nursing Performance

Deficiencies in emergency nursing services often involved poor documentation and incomplete assessments. There were four significant nursing deficiencies:

- In case 2, the patient was seen in the TTA for abdominal pain. The nurse failed to perform and document an appropriate abdominal exam. Ibuprofen was administered for abdominal pain, and the patient was released two minutes later. The nurse inappropriately released the patient prior to confirming that the patient's pain had been relieved. Additionally, the patient's elevated blood pressure was not reassessed or addressed.
- Also in case 2, on a later date, the patient had chest pain. The nurse failed to administer nitroglycerin or aspirin and failed to promptly perform an EKG.
- In case 26, the patient presented to the TTA with signs of a possible stroke. The nurse failed to follow emergency medical services protocols and initiate air transport to an outside hospital.
- Also in case 26, on a later date, the patient had chest pain. The nurse failed to promptly administer nitroglycerin.

Clinician Onsite Inspection

During the onsite visit, the OIG clinicians learned that ISP had one provider primarily assigned to the TTA. In addition to providing urgent or emergent care, the provider was responsible for the patients in the OHU and addressed urgent offsite specialists' recommendations. ISP medical leadership also recognized the deficiencies in nursing's management of patients with stroke symptoms (such as in case 26), and had already begun nursing education.

Emergency Medical Response Review

The Emergency Medical Response Review Committee (EMRRC) met regularly and discussed most emergency transports. Although some emergency transports were not presented during the EMRRC, the chief physician and surgeon (CP&S) and supervising registered nurse (SRN) did conduct a clinical review. The EMRRC or clinical review captured most deficiencies.

Conclusion

In the majority of emergency cases reviewed, appropriate assessment, intervention, and monitoring occurred, and displayed a well-performing emergency system. Therefore, the OIG clinicians rated the *Emergency Services* indicator *adequate*.

Recommendations

No specific recommendations.

4 — **HEALTH INFORMATION MANAGEMENT**

Health information management is a crucial link in the delivery of medical care. Medical personnel require accurate information in order to make sound judgments and decisions. This indicator examines whether the institution adequately manages its health care information. This includes determining whether the information is correctly labeled, organized, and made available in the electronic medical record; whether the various medical records (internal and external, e.g., hospital reports, specialty reports, and progress notes) are obtained and scanned timely into patients' electronic medical records; 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:

*Proficient
(87.2%)*

Overall Rating:

Adequate

For this indicator, the case review and compliance scores yielded different results, with case review providing an *adequate* rating and compliance testing resulting in a *proficient* score. The OIG internal review process considered the factors that lead to both results. Although the compliance testing found strong performance in most areas, the case review found seven significant deficiencies in the form of important documents that were not adequately processed. As a result, the medical inspection team determined the overall score for this indicator was *adequate*.

During the OIG's testing period, ISP had not yet converted fully to the new Electronic Health Record System (EHRS); therefore, all testing occurred in the electronic Unit Health Record (eUHR) system. ISP converted to EHRS in March 2017.

Case Review Results

The OIG clinicians reviewed 923 events and found 47 deficiencies related to health information management, of which 7 were significant. Significant deficiencies were identified in cases 7, 20, 21, and 25, and three times in case 23.

Inter-Departmental Transmission

Inter-departmental transmission, or communication among the institution's departments, is critical to prevent the loss of medical information during patient transfers. While there was no significant pattern of deficiencies, one significant deficiency was identified:

- In case 21, the dictated OHU discharge summary was not scanned into the patient's electronic medical records.

Hospital Records

Twenty-one hospital and ten emergency room events were reviewed at ISP. The institution managed the retrieval of community hospital records well. Discharge summaries were timely received and scanned.

Diagnostic Reports

In general, the institution performed well with regard to the management of diagnostic records, showing no pattern of errors and only two significant deficiencies (cases 7 and 20), both of which are discussed in the *Diagnostic Services* indicator.

Urgent/Emergent Records

In this area, ISP showed patterns of minor deficiencies, which are further discussed in the *Emergency Services* indicator. This sub-section identified incomplete or missing documentation from the providers and nurses within the urgent care:

- In cases 2, 6, 12, 16, and 19, the on-call provider failed to document telephone communications with nursing staff.
- In cases 2, 4, 5, 6, 17, and 26, nurses superficially documented emergent events in the TTA.

Scanning Performance

In cases 6, 16, 19, 22, and 23, scanning errors occurred from absent, mislabeled, or misfiled documents. These errors can create efficiency problems with the medical staff as they often have to spend a substantial amount of time searching for these results in the chart. As more information is scanned, these documents are often lost in the medical records and create problems with duplicate tests ordered and delayed or missed diagnoses. Four of these errors were significant due to the importance of the information (these are also discussed in the *Specialty Services* indicator).

- In case 22, a cardiac monitor was mislabeled “audiology” in the electronic medical record.
- Also in case 22, two other specialist records were incorrectly labeled “other” in the electronic medical record.
- In case 25, a liver scan for cirrhosis was never scanned into the electronic medical record.

Clinician Onsite Inspection

As witnessed during the onsite inspection, the medical records department delivered and gathered various health records from the clinics three times per day. These records included laboratory results, imaging studies, specialist consult notes, and hospital discharge summaries. The medical records staff did not collect the information until it was reviewed by the providers. Once collected, these documents were taken back to the medical records area and scanned. However, the offsite

specialty service RN reported that specialist “urgent” offsite consults were given directly to the urgent care provider for expedited review. During the morning huddles, the primary care team gathered and prepared documentation for discussion. These meetings were interactive and informative, and the staff were familiar with the patients discussed during the huddle.

Clinician Summary

ISP performed well in the retrieval and delivery of community emergency department and hospital discharge summaries; records were timely scanned. However, absent, misfiled, or mislabeled documents were identified, and specialist consults were occasionally scanned without a provider’s signature to indicate review. Still, morning huddles were well thought out and facilitated communication of important medical information. The OIG’s clinical review revealed only infrequent deficiencies, and the improvements made since the prior year were tangible. The OIG clinicians rated this indicator *adequate*.

Compliance Testing Results

The institution received a *proficient* score of 87.2 percent in the *Health Information Management (Medical Records)*, and performed well on the following tests:

- The institution timely scanned all 20 sampled non-dictated progress notes, patients’ initial health screening forms, and requests for health care services into the electronic medical record (MIT 4.001).
- The OIG also tested 14 of the patients’ discharge records to determine if staff timely scanned the records into the patient’s electronic medical record. All of the 14 samples were compliant (MIT 4.004).
- ISP medical records staff timely scanned medication administration records (MARs) into the patients’ electronic medical records in 19 of 20 samples tested (95 percent). One MAR was scanned nine days late (MIT 4.005).
- Inspectors reviewed electronic medical record files for 14 patients who were admitted to a community hospital and then returned to ISP. Providers reviewed all the hospital discharge reports; however, one report did not include a date to indicate the review occurred within three calendar days of discharge (93 percent) (MIT 4.007).
- Throughout compliance testing, inspectors also review documents to determine if they were accurately scanned into the eUHR. The OIG scores this test on scale by which zero errors would result in a 100 percent score, and 24 errors would result in a score of zero; during testing for ISP, inspectors found three documents scanned improperly. As a result, the institution scored 88 percent (MIT 4.006).

The institution performed in the *adequate* range on the following test:

- Staff scanned 16 of 20 specialty service consultant reports sampled into the patient's health record file within five calendar days (80 percent). Four documents were scanned between one and 11 days late (MIT 4.003).

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

- The institution scored 55 percent for the timely scanning of dictated or transcribed provider progress notes into patients' electronic health records. Only 11 of the 20 sampled progress notes were timely scanned within five calendar days of the patient encounter. Nine other sampled progress notes were scanned between one and 23 days late (MIT 4.002).

Recommendations

The OIG recommends that ISP staff, prior to scanning specialist consultation reports, check the documents for a provider's signature indicating review and, if the signature is missing, return the document to the provider for review.

5 — *HEALTH CARE ENVIRONMENT*

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

Case Review Rating:
Not Applicable
Compliance Score:
Adequate
(82.8%)
Overall Rating:
Adequate

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

Compliance Testing Results

The institution received an *adequate* compliance score of 82.8 percent in the *Health Care Environment* indicator, and performed well on the following six tests:

- Staff appropriately disinfected, cleaned, and sanitized all nine clinics at ISP (MIT 5.101).
- Inspectors examined ISP’s nine clinics to verify that adequate hygiene supplies were available and sinks were operable; all clinics were compliant (MIT 5.103).
- Health care staff at all nine clinics followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste (MIT 5.105).
- The non-clinic bulk medical supply storage areas met the supply management process and support needs of the medical health care program, earning ISP a score of 100 percent on this test (MIT 5.106).
- All nine clinics had an environment adequately conducive to providing medical services (MIT 5.109).
- OIG inspectors observed health care clinicians in each clinic to ensure they employed proper hand hygiene protocols. In eight of nine clinics tested, clinicians adhered to universal hand hygiene precautions, scoring 89 percent. In one other clinic, OIG inspectors observed that not all nurses sanitized their hands prior to examining patients (MIT 5.104).

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

- Inspectors examined emergency response bags to determine if they were inspected daily and inventoried monthly and whether they contained all essential items. Emergency response bags were compliant in five of the six clinical locations where they were stored (83 percent). At one location, the crash cart was missing a carbon dioxide detector (MIT 5.111).

- Seven of nine clinics inspected followed adequate medical supply storage and management protocols (78 percent). In one clinic, medical supplies in an exam room were not clearly identified, and one other clinic location had food items stored inside a medical clinic cabinet (MIT 5.107).

ISP showed room for improvement in the following three areas:

- Only four of nine clinic locations (44 percent) met compliance requirements for essential core medical equipment and supplies. The remaining five clinics were missing one or more functional pieces of properly calibrated core equipment or other medical supplies necessary to conduct a comprehensive exam. The missing items included a Snellen eye exam chart, a medication refrigerator, exam table paper, a nebulization unit, an operational ophthalmoscope, hemocult cards and developer, bio-hazard waste durable receptacles or labeled plastic bags, and lubricating jelly. In addition, two automated vital sign machines did not have current calibration stickers (MIT 5.108).
- Only four of nine clinic exam rooms observed (44 percent) had appropriate space, configuration, supplies, and equipment to allow clinicians to perform a proper clinical examination. Three clinic locations had exam tables or chairs with torn vinyl that could harbor infectious agents (*Figure 1*). Access to the exam tables was impeded at two clinic locations. One clinic location had confidential patient records that were accessible to inmate porters, and another location had a medical supply cabinet that was not in working condition (MIT 5.110).
- In five of the seven clinics inspected, clinical health care staff ensured that reusable invasive and non-invasive medical equipment was properly sterilized or disinfected (71 percent). One clinic did not have exam table paper for patient visits, and one other location had surgical instruments without the sterilization date and sterilized instrument packages that were torn, which breached instrument sterility (MIT 5.102).



Figure 1: Torn vinyl on exam table

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. When OIG inspectors interviewed health care managers, they did not identify any significant concerns. At the time of the OIG's medical inspection, ISP had multiple yard clinics that were in the process of being expanded to improve access to patient care. These projects started in December 2016, and the projects were scheduled to be completed by December 2017 (MIT 5.999).

Recommendations

No specific recommendations.

6 — *INTER- AND INTRA-SYSTEM TRANSFERS*

This indicator focuses on the management of patients' medical needs and continuity of patient care during the inter- and intra-facility transfer process. The patients reviewed for *Inter- and Intra-System Transfers* include patients received from other CDCR facilities and patients 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 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:

Adequate

Compliance Score:

*Adequate
(75.0%)*

Overall Rating:

Adequate

Case Review Results

Clinicians reviewed 50 encounters relating to the *Inter- and Intra-System Transfers* indicator, including information from both the sending and receiving institutions. These included 30 hospital-related events, including 23 hospitalizations, 21 of which resulted in a transfer back to ISP. The other two hospitalizations resulted in the patients' deaths.

Transfers In

The OIG reviewed 12 events relating to patients transferring into ISP and found 12 deficiencies, two of which were significant (cases 7 and 27). Most deficiencies regarding patient arrivals were related to incomplete nursing assessments and initiation of nursing and provider appointments.

- In case 7, the patient arrived with a provider appointment due the next day to address hypertension and a skin lesion. However, the nurse inappropriately scheduled the appointment for two months later.
- In cases 20, 28, and 29, the nurses failed to assess the patients' vital signs.
- In case 27, the patient was prescribed ibuprofen for pain. He had developed a rash and stated that the rash occurred after taking ibuprofen. The nurse failed to perform a thorough rash and allergy assessment and failed to obtain a provider's order to discontinue the medication. The patient received additional ibuprofen the following day.

Transfers Out

Five events relating to transfers out were reviewed, and two deficiencies were identified, one of which was significant, as follows:

- In case 31, the patient had an abnormal heart rhythm, congestive heart failure, diabetes, and hypertension. He was prescribed a beta blocker (heart rhythm and heart failure medication). He was housed in the OHU at ISP. On the morning of transfer, his heart rate was rapid at 110 beats per minute. The nurse failed to consider his medical history, to assess medication compliance, and to perform a thorough assessment. Additionally, the nurse failed to contact a provider. When the patient arrived at the receiving institution, his pulse was 140 beats per minute. He was immediately transferred to a community hospital for the abnormal rhythm and extremely rapid heart rate.

Hospitalizations

Patients returning from hospitalizations or from outside emergency departments are some of the highest-risk encounters due to two factors. First, these patients are generally hospitalized for a severe illness or injury. Second, they are at risk due to potential lapses in care that can occur during any transfer, e.g., from the hospital to the institution. At ISP, there were nine deficiencies related to hospital transfers. All deficiencies were minor and related to incomplete nursing assessments.

Conclusion

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

Compliance Testing Results

The institution obtained an *adequate* score of 75.0 percent in the *Inter- and Intra-System Transfers* indicator, receiving *proficient* scores in the following three tests:

- Nursing staff timely completed the assessment and disposition sections of the screening form for all 24 sampled patients (MIT 6.002).
- The OIG inspected the transfer packages of four patients who were transferring out of the facility to determine whether the packages included required medications and support documentation. All four transfer packages were compliant (MIT 6.101).
- Inspectors tested 20 patients who transferred out of ISP to other CDCR institutions to determine whether their scheduled specialty service appointments were listed on the health care transfer form. ISP nursing staff identified the scheduled appointments on the transfer forms for 19 of the sampled patients (95 percent). For one patient, nursing staff did not document a pending specialty service on the transfer form (MIT 6.004).

ISP scored in the *adequate* range on the test below:

- Of the 30 sampled patients who transferred into ISP, 5 had existing medication orders that required nursing staff to issue or administer medications upon the patients' arrival. Four of the five patients (80 percent) received their medications timely. One patient received his keep-on-person (KOP) medication 15 days late (MIT 6.003).

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

- The OIG tested 25 patients who transferred into ISP from other CDCR institutions to determine whether they received a complete initial health screening from nursing staff on the day they arrived. ISP received a score of zero on this test because nursing staff neglected to answer or to describe a "yes" answer to at least one of the screening form questions for four patients, and did not record one or more required vital signs for any of the patients (MIT 6.001).

Recommendations

No specific recommendations.

7 — **PHARMACY AND MEDICATION MANAGEMENT**

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

Case Review Rating:
Adequate

Compliance Score:
Adequate
(81.1%)

Overall Rating:
Adequate

Case Review Results

The OIG clinicians evaluate pharmacy and medication management as secondary processes as they relate to the quality of clinical care provided. Compliance testing is a more targeted approach and is heavily relied on for the overall rating for this indicator. The OIG clinicians evaluated 81 events related to medications and found eight deficiencies, one of which was significant (case 6).

Medication Continuity

In general, ISP performed well ensuring medication continuity with only one significant deficiency identified:

- In case 6, the patient was prescribed hydrochlorothiazide (diuretic) as part of a blood pressure regimen. This prescription expired, and the reorder was delayed for one week.

Medication Administration

ISP nursing performed well in medication administration.

Clinician Onsite Inspection

During the OIG’s onsite visit, the primary care team communicated well. In the huddle, expiring medications were presented to the primary care providers for review. The team members were familiar with their patients and often renewed expiring prescriptions in this forum.

Clinician Summary

ISP pharmacy services functioned well. In most clinical cases reviewed, ISP ensured that patients received medications timely and accurately. The case review clinicians rated this indicator *adequate*.

Compliance Testing Results

The institution received an *adequate* compliance score of 81.1 percent in the *Pharmacy and Medication Management* indicator. For discussion purposes, this indicator is divided into three sub-indicators: medication administration, observed medication practices and storage controls, and pharmacy protocols.

Medication Administration

In this sub-indicator, the institution received an *adequate* score of 85.0 percent, with *proficient* scores in the following four areas:

- Inspectors found that all 25 sampled patients received their newly ordered medications in a timely manner (MIT 7.002).
- ISP ensured that 14 of 15 sampled patients who transferred from one housing unit to another (93 percent) received their medications without interruption. One patient's next dosing interval was not documented (MIT 7.005).
- Among 21 sampled patients, 18 (86 percent) timely received their chronic care medications. Three patients did not receive at least one of their medications at all, and two of those patients also did not timely receive their ordered KOP medications (MIT 7.001).
- ISP timely provided new and previously prescribed medications to 12 of 14 sampled patients upon their return to the institution from a community hospital (86 percent). Two patients had their medications made available one and two days late (MIT 7.003).

The institution showed room for improvement in the following area:

- Among five patients who were en route from one institution to another and had a temporary layover at ISP, three (60 percent) received their medications without interruption. For two patients, medications were administered one and two days late (MIT 7.006).

Observed Medication Practices and Storage Controls

In this sub-indicator, the institution received an *adequate* score of 78.8 percent. ISP performed in the *proficient* range in the following areas:

- At all five of the inspected medication line locations, nursing staff were compliant with proper hand hygiene protocols and employed appropriate administrative controls and followed appropriate protocols during medication preparation (MIT 7.104, 7.105).
- Non-narcotic refrigerated medications were properly stored in six of the seven applicable clinics and medication line storage locations (86 percent). The TTA did not have a designated area for refrigerated medication to be returned to the pharmacy (MIT 7.103).

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

- At four of five applicable medication preparation and administrative locations (80 percent), nursing staff followed appropriate administrative controls and protocols when distributing medications to patients. At one location, patients did not have protection from inclement weather at the outdoor medication line (MIT 7.106).

ISP scored in the *inadequate* range in the following areas:

- ISP properly stored non-narcotic medications not requiring refrigeration in four of the eight applicable clinic and medication line storage locations (50 percent). In four locations, one or more of the following deficiencies were observed: the medication area lacked a designated area for return-to-pharmacy medications; multiuse medication was not labeled with the date it was opened; and medication was stored at temperatures that exceeded the manufacturer's temperature guidelines (MIT 7.102).
- The institution employed adequate security controls over narcotic medications in only four of the seven applicable clinic and medication line locations (57 percent). At three clinics, the narcotics log book lacked evidence on multiple dates that a controlled substance inventory was performed by two licensed nursing staff (MIT 7.101).

Pharmacy Protocols

In this sub-indicator, the institution received an *adequate* score of 80.0 percent, comprised of scores received at the institution's main pharmacy. The institution was *proficient* in the following areas:

- In its main pharmacy, the institution followed general security, organization, and cleanliness management protocols; properly stored and monitored non-narcotic medications that required refrigeration; and maintained adequate controls over and properly accounted for narcotic medications (MIT 7.107, 7.109, 7.110).
- The institution's pharmacist in charge timely processed all 25 sampled medication error reports (MIT 7.111).

The institution showed room for improvement in the following area:

- In its main pharmacy, ISP did not properly store non-refrigerated medication. Medications designated to be returned to an outside pharmaceutical company were located directly on the ground and subject to moisture or contamination (MIT 7.108).

Non-Scored Tests

- In addition to testing reported medication errors, OIG 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; however, at ISP, the OIG found no applicable severe medication errors (MIT 7.998).

- The OIG tests patients housed in isolation units to determine if they had immediate access to their prescribed KOP rescue inhalers and nitroglycerin medications, but there were no applicable patients at ISP to test (MIT 7.999).

Recommendations

No specific recommendations.

8 — *PRENATAL AND POST-DELIVERY SERVICES*

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

As ISP is a male-only institution, this indicator is not applicable.

Case Review Rating:

Not Applicable

Compliance Score:

Not Applicable

Overall Rating:

Not Applicable

9 — *PREVENTIVE SERVICES*

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

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(67.7%)
Overall Rating:
Inadequate

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

Compliance Testing Results

The institution performed in the *inadequate* range in the *Preventive Services* indicator, with a compliance score of 67.7 percent and *inadequate* scores in the following areas:

- The institution performed poorly monitoring patients receiving tuberculosis (TB) medications. For 10 of 14 sampled patients, the institution either failed to complete monitoring at all required intervals, failed to document any monitoring, or failed to scan the monitoring form into the patient’s medical record in a timely manner (29 percent) (MIT 9.002).
- ISP scored 33 percent for conducting annual TB screenings. Although all 30 sampled patients were screened for TB within the prior year, 10 of the 15 patients identified as Code 22 (requiring a TB skin test in addition to a signs & symptoms check) were properly tested. For two of those patients, nursing staff did not document either the administered (start) or read (end) date and time, so it was impossible to determine whether the test was read in the required 48-to-72-hour window. For three other Code 22 patients, the test results were read after 72 hours had passed. The other 15 patients were identified as Code 34 (requiring only a signs & symptoms check). Staff did not properly complete the history section of the form for any of those 15 patients (MIT 9.003).
- The OIG tested whether ISP offered required influenza, pneumonia, and hepatitis vaccinations to patients who suffered from a chronic condition; 7 of the 11 patients sampled (64 percent) received them. Of the four patients who did not have current vaccinations, none had a record of recently being offered the vaccinations (MIT 9.008).

The institution did perform in the *proficient* range in the following three areas:

- ISP offered annual influenza vaccinations to 24 of 25 sampled patients subject to the annual screening requirement (96 percent). For one patient, there was no evidence either that health care staff offered an influenza vaccination or that the patient refused it (MIT 9.004).
- ISP scored 93 percent for administering timely TB medications to patients with TB; 13 of 14 patients received their medication timely, but for one patient, there was no MAR found to provide evidence of timely administration (MIT 9.001).
- Colorectal cancer screenings were offered to 23 of 25 sampled patients subject to the annual screening requirement (92 percent). For two patients, there was no medical record evidence either that health care staff offered a colorectal cancer screening within the previous 12 months or that the patient had a normal colonoscopy within the last ten years (MIT 9.005).

Recommendations

No specific recommendations.

10 — *QUALITY OF NURSING PERFORMANCE*

The *Quality of Nursing Performance* indicator is a qualitative evaluation of the institution's nursing services. The evaluation is completed entirely by OIG nursing clinicians within the case review process, and, 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, urgent walk-in visits, referrals for medical services

Case Review Rating:

Adequate

Compliance Score:

Not Applicable

Overall Rating:

Adequate

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 sick call 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 in the *Specialized Medical Housing* indicator. Nursing services provided in the triage and treatment area (TTA) or related to emergency medical responses are reported in the *Emergency Services* indicator.

Case Review Results

The OIG clinicians reviewed 242 nursing encounters, of which 96 were in the outpatient setting. Most outpatient nursing encounters were sick call requests, walk-in visits, and follow-up visits. There were 142 deficiencies identified related to nursing performance, 17 of which were significant (cases 2, 7, 10, 12, 16, 17, 25, 26, 27, 30, and 31). The OIG clinicians rated the *Quality of Nursing Performance* indicator *adequate*.

Nursing Assessment

The majority of ISP outpatient nursing assessments were timely and appropriate. Most significant nursing assessment deficiencies occurred during emergency events, inter- and intra-system transfers, and specialized medical housing stays, and are discussed in those indicators.

Nursing Intervention

ISP nurses displayed deficiencies regarding intervention. Although the nursing assessments were frequently adequate, the nurses did not always recognize the need for reassessment or intervention. Most of these deficiencies are discussed in the *Emergency Services, Inter- and Intra-System*

Transfers, and *Specialized Medical Housing* indicators, but one significant deficiency occurred in an outpatient encounter:

- In case 25, the diabetic patient submitted a sick call request for a groin abscess. The outpatient nurses failed to reassess an elevated blood pressure of 171/98 and failed to refer the patient to a provider.

Nursing Documentation

Complete and accurate nursing documentation is an essential component of patient care. Without documentation, changes in clinical presentation are often missed or delayed, and quality of care becomes challenging to assess. At ISP, incomplete nursing documentation was identified. On several occasions, as they completed wound care, nurses failed to document the appearance of the wound. Nurses also sometimes failed to document pertinent communication between providers and nurses. While most documentation deficiencies did not affect the overall level of care the patients received, there was opportunity for improvement.

Sick Call

The OIG clinicians reviewed 43 nursing sick calls. Generally, ISP nurses promptly triaged sick call requests, timely assessed the patients, and provided adequate care. Most deficiencies were minor and unlikely to cause patient harm.

Care Management

A care manager is defined by CCHCS as a primary care RN who develops, implements, and evaluates patient care services and care plans for an assigned patient panel. The care manager provides direction for the assigned patient panel, collaborates with the patients one on one to develop and maintain treatment plans, interfaces with and refers patients to other services as appropriate, reviews data and coordinates patient care activities and education, and directs the members of the care coordination team to ensure that patients receive necessary health care services in a safe, timely, and medically appropriate manner.

ISP had one RN care manager assigned to each medical clinic. In the reviewed cases, RN care management was not evident. Patients were usually seen by the provider for their chronic care management and by the primary care RN for their episodic illnesses and health care needs. LVNs provided diabetes-related nursing care. Nine LVN diabetic care encounters were reviewed, and three deficiencies were noted in the following two cases:

- In case 2, on two separate encounters, the LVN case manager saw the patient for diabetic care nursing visits. On both occasions, the nurse failed to assess recent finger stick glucose results.
- In case 20, during a diabetic care visit, the LVN failed to inspect the patient's feet even though nursing had noted a foot wound two weeks prior.

Urgent and Emergent Care

ISP TTA nurses' performance was adequate. This performance is further discussed in the *Emergency Services* indicator.

After Hospital Returns

Twenty community hospital return nursing visits were reviewed, in which six minor deficiencies were identified. These deficiencies related to incomplete assessment and documentation. Performance in this area is also discussed in the *Intra- and Inter System Transfers* indicator.

Specialized Medical Housing

Nursing care in the OHU was inadequate. Patterns of incomplete nursing assessment, documentation, and interventions were identified within this area. The OIG clinicians were concerned with one of the LVN's ability to promptly recognize clinically significant changes and the need for further assessment. Additionally, RN assessments were not always completed after LVNs and RNs communicated. Performance in this area is also discussed in the *Specialized Medical Housing* indicator.

Inter- and Intra-System Transfers

In this indicator, ISP nursing care was rated *adequate*. Most deficiencies related to incomplete nursing assessments and initiation of nursing and provider appointments. Performance in this area is also discussed in the *Inter- and Intra-System Transfers* indicator.

Offsite Returns and Specialty Services

The OIG clinicians reviewed 11 nursing encounters when patients returned from their specialty appointments. Patients returning from offsite specialty appointments were processed in the TTA. Recommendations were reviewed and providers were appropriately contacted. No significant nursing deficiencies were identified in this area. Performance in this area is also discussed in the *Specialty Services* indicator.

Medication Administration

In general, ISP nurses performed well in this area. Medications were administered consistently and safely. Performance in this area is also discussed in the *Pharmacy and Medication Management* indicator.

Clinician Onsite Inspection

The week prior to the OIG clinician onsite inspection, ISP had implemented the electronic health record system (EHRS). To help with this major transition, CCHCS had sent several RNs from its headquarters to ISP. These RNs participated in the huddles and assisted the medical teams.

The OIG clinicians attended a morning huddle in the outpatient clinics and TTA. In the medical clinics, the clinic RN facilitated the huddle. Custody staff, a dental assistant, medication line nurses, the primary physician, provider schedulers, the supervising RN, and a headquarters' RN attended. The staff participated in the discussion and provided information as outlined in the huddle script. Nurses discussed specific patient questions with the provider. The provider was familiar with the patient population and provided appropriate directions. The OIG clinicians also attended a joint TTA-OHU huddle, at which the chief nurse executive was an active participant, along with the supervising RN, team members from specialty services, the OHU, mental health, and utilization management. The OHU RN presented a brief review of the patients housed in the OHU and distributed the census document. The specialty RN reviewed patients expected to return from offsite services, and the utilization management nurse reported that ISP had no patients admitted to any community hospitals.

The OIG clinicians visited several clinical areas and spoke with the acting chief nurse executive and various nursing staff, including nurses in specialty services, telemedicine, TTA, OHU, outpatient clinics, and supervising registered nurses. The nursing staff identified no communication barriers between themselves and providers or custody officers regarding patient care. The chief nurse executive had reviewed OIG clinicians' case review questions and was eager to ensure that nurses provided quality patient care. She also recognized the need for LVN and RN care review audits in the OHU, and planned to implement this soon.

Clinician Summary

The *Quality of Nursing Performance* was rated *adequate*. The outpatient nursing care demonstrated timely, appropriate nurse triage. Opportunities for improvement in urgent or emergent services and inter- and intra-system transfers were evident. Most significant deficiencies in these areas were isolated and did not display patterns of inadequate nursing practices. The few concerns in the OHU represented only a small fraction of nursing care within ISP.

Recommendations

The OIG recommends the following:

- That ISP conduct OHU-specific audits and corresponding nurse training;
- That the audit assess both LVN and RN care on all shifts;
- That nursing supervisors also assess LVN and RN communication on the first and third shifts; and
- That ISP ensure open communication and thorough documentation; and that results be reported to the institution's quality management team.

11 — *QUALITY OF PROVIDER PERFORMANCE*

In this indicator, the OIG physicians provide a qualitative evaluation of the adequacy of provider care at the institution. Appropriate evaluation, diagnosis, and management plans are reviewed for programs including, but not limited to, 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 288 medical provider encounters and identified 93 deficiencies related to provider performance, of which 31 were significant. ISP provided medical care as a basic institution and primarily functioned through its several medical clinics. The institution also had urgent care staff who triaged, evaluated, and treated patients more expeditiously, and resulted in the occasional patient transfer to a higher level of care. ISP's outpatient housing unit cared for the more acutely ill or mobility impaired patients. ISP's providers usually made appropriate care decisions for their mostly healthy population. As care became more complex, however, the providers failed in the medical management of their patients. They conducted superficial medical record reviews and demonstrated an inability to recognize treatment opportunities for patients with chronic disease. This care notably deviated from CCHCS's care guidelines.

Assessment and Decision-Making

ISP providers failed to confront a wide array of problems. Four of the significant deficiencies characterized this pattern. These deficiencies signified a lack of thoroughness in the medical management of the patient.

- In case 7, the provider failed to perform a comprehensive physical exam after the patient's return from a community hospital emergency room for management of a leg infection. The physical exam included only a general appearance and musculoskeletal examination.
- In case 9, the patient transferred from another institution. He was a medically complex, high-risk patient. The receiving RN ordered a chronic care appointment with a provider to be held within one week, but the ISP provider delayed this appointment by three weeks without supporting documentation.
- In case 11, the provider noted worsening diabetic control attributed (HgA1c of 9.7) to a liquid nutritional supplement. The provider failed to change the supplement to a diabetic one with lower sugar, or to increase the insulin regimen to compensate for the additional sugar consumed in the supplement.

- In case 26, the provider failed to address the community hospitalist's recommendations for a cardiology consultation for a patient with chest pain. Also, the provider inappropriately approved a surgical procedure while the patient had a possible new stroke and unexplained chest pain.

Review of Records

Five of the significant deficiencies consisted of poor reviews of medical information from the electronic medical records (blood sugar checks, consult notes, and prior progress notes). A superficial review delays appropriate management and can be injurious to the patient.

- In case 10, the provider failed to address the optometrist's recommendations for treatment of inner eyelid calcium buildup, resulting in chronic eye irritation.
- In case 11, providers failed to review the monthly blood sugar logs that indicated a pattern of elevated blood glucose. This failure led to delayed diabetic medical management with worsening blood sugar control.
- In case 12, the provider failed to perform a thorough record review during the patient's chronic care visit. Therefore, the patient's recent nausea requiring medication was not noted or addressed. The provider also failed to address the episode of blood in the patient's urine and recently treated hepatitis C.
- In case 22, the provider failed to start glaucoma medications as recommended by the ophthalmologist.
- In case 24, the provider failed to appropriately review an endocrinology consult. The endocrinologist recommended a decrease of the patient's nighttime long-acting insulin dose by 2 units. The specialist also requested a follow-up in one month. The provider erroneously decreased the insulin dose by 12. The provider also failed to order the endocrinology follow-up appointment. In addition, the provider ordered a markedly long interval for chronic care follow-up of six months.

Emergency Care

Emergency care continued to be performed well at the institution. The providers triaged and adequately managed patients during the urgent care process. The decision to transfer patients to a higher level of care during acute medical crises was treated expertly. No significant deficiencies were discovered.

Chronic Care

In a basic institution, chronic care management is at the center of the medical wellbeing of the majority of patients. Among the 13 significant deficiencies that occurred in chronic care, 7 were

attributed to one provider. Additionally, 11 of the 13 significant chronic care deficiencies were identified in the care of cardiac and diabetic patients. This trend was also identified in OIG's Cycle 4 review.

- In case 2, the provider failed to order a cardiology consultation for a patient who had multiple cardiac risk factors (advanced age, diabetes, high blood pressure, and high cholesterol). The patient had recently returned from a community emergency room for chest pain.
- In case 6, the provider evaluated the patient and reviewed prior laboratory results. However, the provider failed to order a statin (medication for high cholesterol) to decrease the risk of cardiovascular disease. The OIG calculated this patient's risk of having a heart attack as 16.9 percent over the next ten years.
- In case 8, the provider failed to perform a comprehensive physical exam on a newly arrived transfer patient with a history of cardiovascular disease.
- In case 9, there were multiple instances of poor diabetic management and delayed treatment opportunities. The provider failed to order blood sugar checks, did not recommend appropriate changes to diabetic medications, failed to act on worsening laboratory data, and ordered excessively long follow-up intervals. The provider also failed to address the patient's coronary artery disease, hepatitis C, and seizure disorder, and failed to review prior medical encounters.
- In case 10, the provider failed to order a statin to decrease the risk of cardiovascular disease. The OIG calculated this patient's risk as 7.8 percent over the next 10 years.
- In case 12, the provider failed to order a cardiology consultation for a patient who had multiple cardiac risk factors. The patient had recently returned from a community emergency room for chest pain. This case is also discussed in the *Specialized Medical Housing* indicator.
- In case 20, the provider evaluated a patient with a new onset of poorly controlled diabetes, type 1 (insulin-dependent). The provider failed to order blood sugar checks to monitor this patient after the same provider had ordered an inappropriate oral treatment. Additionally, the provider failed to perform a physical exam of a new foot ulcer.
- Also in case 20, the patient experienced several low blood sugar episodes. The provider failed to adequately assess the insulin dosage.
- In case 25, the patient had a fibroscan (imaging study for liver scarring) that showed liver cirrhosis. The providers failed to address the abnormal test result. In addition, patients with

cirrhosis need screening tests for varices (swollen blood vessels) in the esophagus, as well as screening for liver cancer. The provider failed to order these two screening tests.

- Again case 25, the provider reviewed laboratory test results indicating the patient's diabetes was poorly controlled. The provider failed to order prompt diabetic monitoring and provider follow-up.
- In case 26, the provider failed to address a recent stroke and chest pain prior to sending the patient to a specialist for a non-urgent surgical procedure. This case is also discussed in the *Specialty Services* indicator.

Specialty Services

ISP's specialty services workflow had improved from Cycle 4's OIG review. ISP's primary care provider was the primary reviewer of the consultant's recommendations. The primary care provider was able to ascertain the specialist's recommendations and with new insight could make appropriate modifications to the patient's medical management. This was an improvement from the prior inspection, and reduced specialty services medical management errors. However, the OIG clinicians continued to identify consultant notes scanned into the medical records without physician signature indicating that the provider did not review them. This occurred in cases 8, 10, 12, 16, 22, 23, and 24. This deficiency can lead to haphazard reviews, to the frequent loss of scheduled consultant follow-ups, and to delayed review of the consultants' recommendations. Also, within specialty services, four significant deficiencies were attributed to poor anticoagulation management:

- In case 8, the patient had a high risk of developing further blood clots. He was prescribed a blood thinner. He required frequent laboratory testing and careful medication monitoring. On two occasions, the provider failed to order the repeat blood tests required in anticoagulation medication management (two significant deficiencies). This delayed management and could have resulted in harm to the patient.
- In case 19, the patient had a recent diagnosis of multiple pulmonary emboli (blood clots in the lungs). This placed the patient at a high risk of serious harm or death without proper blood-thinning medication. The provider inappropriately ordered dabigatran (blood thinner) to start in two days. This placed the patient at risk for additional clots over that time.
- Also in case 19, on a separate occasion, the patient returned from a community hospital with a worsened deep vein thrombosis. The providers failed to order the hospital-recommended medication enoxaparin (immediate-acting blood thinner). The providers continued to increase the warfarin (slow-acting blood thinner) dose while inappropriately allowing the patient to have a sub-therapeutic anticoagulation treatment for 20 additional days. This placed the patient at unnecessary risk of harm.

Health Information Management

The OIG clinicians did not identify serious provider deficiencies related to health information management.

Pharmacy and Medication Management

There were no significant provider deficiencies identified during this review related to pharmacy.

Clinician Onsite Inspection

The OIG onsite clinical inspection provided valuable insight into ISP's institutional and provider workflows. The ISP providers stated they had proactively increased their work load in an effort to prepare for potential delays caused by the implementation of EHRS. They reported seeing 12 to 15 patients a day during this preparation, which is consistent with other institutions. At the time of the OIG clinicians' onsite inspection, ISP was in its second week with EHRS. The providers were seeing only four to seven patients daily and appeared to be adapting well.

Most of the providers were satisfied with their support staff and thought highly of their executive staff. They were satisfied with their employment at ISP overall. During the bimonthly population management meeting, the providers reviewed outliers within the institution's medical registry of chronic care patients and created plans for future management.

During the OIG's period of review, ISP's executive staff (CEO, CME, and chief physician & surgeon) were also assigned the same roles at Chuckawalla Valley State Prison. They were inundated with work pertaining to the clinical and administrative responsibilities and expressed being overwhelmed. The quality management of provider performance seemed to have been sacrificed for other health care system operations of its two institutions. The OIG clinicians learned of a four-month, unexpected leave of absence for the chief physician and surgeon. The institution was concerned that this vacancy could further affect daily clinical operations because the providers also had to share the responsibilities of the chief physician and surgeon during the absence.

The executive staff also expressed great concern with the providers' stagnant salaries and decreased benefits packages over the last several years. They claimed CCHCS had lost its "competitive edge" in terms of recruiting and retaining qualified providers, both full-time and registry, in the desert institutions. They believed that this contributed to an unstable staffing model and prevented the providers from administering consistent and ideal care to the patient population. This environment also affected the executive staff, as they consistently tried to meet the institutional patient needs while maintaining the administrative needs of CCHCS.

However, the OIG clinicians saw a lack of supervisory provider oversight and guidance, and poor quality of provider care consistent with the Cycle 4 review. Better supervision was needed to guide the team to a more successful outcome.

Conclusion

Of the 20 cases reviewed, 11 were adequate and 9 were inadequate. After taking all factors into consideration, the OIG clinicians rated the *Quality of Provider Performance* indicator *inadequate*.

Recommendations

The OIG recommends providers meet daily and discuss urgent and emergent patient care events and address chronic care and difficult patient management. These meetings will further develop an improved rapport and collegial atmosphere as the providers share and redefine patient care within the institution.

The OIG recommends ISP conduct an assessment of its current population management practices.

12 — *RECEPTION CENTER ARRIVALS*

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

Case Review Rating:

Not Applicable

Compliance Score:

Not Applicable

Overall Rating:

Not Applicable

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

13 — *SPECIALIZED MEDICAL HOUSING*

This indicator addresses whether the institution follows appropriate policies and procedures when admitting patients to onsite inpatient facilities, including completion of timely nursing and provider assessments. The chart review assesses all aspects of medical care related to these housing units, including quality of provider and nursing care. ISP's only specialized medical housing unit is the Out Patient Housing Unit (OHU).

Case Review Rating:
Inadequate
Compliance Score:
Proficient
(86.7%)
Overall Rating:
Inadequate

For this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *inadequate* rating and the compliance testing resulting in a *proficient* score. The OIG's internal review process considered those factors that led to both scores and ultimately rated this indicator *inadequate*. The key factors were that the case review had a larger sample size, and the case review focused on the quality of care provided. As a result, the case review testing results were deemed a more accurate reflection of the appropriate overall indicator rating.

Case Review Results

At the time of the OIG's onsite inspection in March 2017, the 14-medical-bed OHU was under repair and had only 5 beds available for patient care. The OIG clinicians reviewed 265 provider and nursing OHU encounters and identified 111 deficiencies. These encounters included admissions to the OHU for a higher level of care because of a high-risk medical need or a functional impairment requiring more intensive nursing management.

Provider Performance

The quality of provider performance in the OHU was generally adequate. However, at times, the providers conducted superficial reviews and assessments and displayed poor patient management. Fortunately, the patients were seen frequently and their medical concerns were usually addressed within an appropriate time frame. Of the 123 OHU provider encounters reviewed, 29 deficiencies were identified, 4 of which were significant. Three of the four significant deficiencies occurred in one case, and the other deficiency is described in greater detail in the *Quality of Provider Performance* indicator (case 8).

- In case 12, the providers on multiple occasions failed to address the complexity of the patient's medical issues. During the encounter after the patient's first 30 days in the OHU, the provider failed to review a recent neurology consult, monitor foot lesions, or address poorly controlled diabetes. On a separate encounter, the provider failed to address an acute onset of blood in the urine and chronic nausea. The last deficiency identified in this case occurred when the provider noted a recent emergency room chest pain evaluation and

concern of “substantial cardiac disease.” The provider, inexplicably, failed to obtain a cardiology consultation.

- In case 19, the patient had blood clots in the lungs. This condition warranted frequent laboratory tests and corresponding medication adjustment. The provider failed to order laboratory tests and address a community hospital’s medication recommendations.

Nursing Performance

Nursing performance in the OHU was inadequate. Of the 96 nursing events, 66 deficiencies were identified; 7 were significant. Incomplete assessments, documentation, and interventions were frequent. On several occasions, during the third nursing shift, a patient’s condition changed and warranted an RN assessment, but either the LVN failed to contact the RN, or the RN failed to perform an assessment when contacted.

- In case 12, the diabetic patient had a foot wound. The RN documented dead tissue on the foot. This was a significant change in the wound, but the RN failed to notify the provider.
- In case 16, the patient complained of painful urination, blood in his urine, and side pain. The RN failed to assess when these symptom began. Later that day, during the third nursing shift, an LVN contacted the provider. The LVN did not document the patient’s symptoms or the reason the provider was contacted, and did not contact an RN. An hour later, the patient was sent to the hospital for a rapid heart rate and high blood pressure. An LVN or RN did not complete nursing assessments and documentation related to this event.
- In case 17, this diabetic patient had a prior stroke and residual right-sided weakness. On numerous occasions, the nurses noted his weakness and limited range of motion but failed to proactively implement fall precautions. Very soon thereafter, he slipped in the shower, causing a foot abrasion; fall precaution measures were not implemented, and a provider was not notified of the fall or injuries. Unfortunately, he had another, subsequent fall in the shower. The RN failed to perform an assessment, and fall safety measures were still not implemented. During this same review, the patient had a groin wound. The nurses’ wound documentation, assessments, and interventions were inadequate. The nurse also failed to contact a provider with a finding of a foul odor (potential sign of infection) emanating from the patient’s groin wound. Daily feet inspections were also ordered for a potential wound; these nursing inspections did not occur.
- In case 30, the patient complained of shortness of breath. His lung sounds were diminished and weak. He also had a swollen abdomen. The RN failed to promptly assess vital signs and did not contact a provider for over an hour. When the provider on call arrived, an emergent transfer to a higher level of care was ordered.

- In case 31, the patient had heart failure, high blood pressure, abnormal heart rhythms, sleep apnea, and morbid obesity. He was given metoprolol (blood pressure medication known to decrease heart rate). However, for several days his heart rate increased and was over 100 beats per minute. The OHU nurses failed to assess his medication compliance and to notify a provider. This case is also discussed in the *Inter- and Intra-System Transfers* indicator.

Clinician Onsite Inspection

Water damage to seven of the OHU rooms had recently occurred. This damage occurred in late December 2016 and resulted in prompt patient transfer to other locations. These rooms had not yet been repaired and were being cleaned and dried. The OHU smelled damp from the flooding.

The chief nurse executive stated that OHU nursing quality audits were temporarily not being performed. This was attributed to EHRS-related training, and a nursing audit was planned for the near future.

Clinician Summary

Providers rely on nurses to perform thorough assessments, document clearly, and promptly communicate clinical changes. The OIG reviewed both nursing and provider encounters. A more accurate reflection of the management within the OHU came from the review of nursing care. The number of nursing deficiencies, and the patterns of incomplete or absent assessments, interventions, and documentation were worrisome. The LVNs' failure to contact the RNs, and the RNs' failures to perform assessments, were also concerning. Additionally, almost one year prior to the OIG clinicians' onsite visit, an OHU staffing change was implemented. Previously, an RN was assigned to the OHU each shift. However, the new staffing removed RNs on the first and third shifts, and an LVN became the primary patient contact. ISP failed to perform a proactive patient care assessment after this change occurred. The OIG rated the *Specialized Medical Housing* indicator *inadequate*.

Compliance Testing Results

ISP received a *proficient* compliance score of 86.7 percent in the *Specialized Medical Housing* indicator, performing well in the following two areas:

- Inspectors tested the working order of the institution's two OHU patient room call buttons and found that call buttons were not operational, but the buttons were clearly labeled and identified, and a local operating procedure was in place to document 30-minute welfare checks. Staff also confirmed that staff conducted 30-minute welfare checks in the OHU. According to knowledgeable staff who regularly worked in the OHU, during an emergent event, responding staff were able to access a patient's room in less than one minute, which ISP's management believed to be reasonable. As a result, ISP received a score of 100 percent (MIT 13.101).

- For nine of the ten sampled patients (90 percent), nursing staff timely completed an initial health assessment on the day the patient was admitted to the OHU. For one patient, a nursing assessment could not be located in the electronic medical record (MIT 13.001).

The institution showed room for improvement in the following area:

- The OIG tested whether providers completed their Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes at required intervals. Providers completed timely SOAPE notes for seven of the ten sampled patients (70 percent). One patient's provider visit was three days late, and two patients' each had one provider visit that was 12 days late (MIT 13.003).

Recommendations

No specific recommendations.

14 — *SPECIALTY SERVICES*

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

Case Review Rating:
Adequate

Compliance Score:
Adequate
(79.8%)

Overall Rating:
Adequate

Case Review Results

The OIG clinicians reviewed 132 events related to *Specialty Services*, which included 108 specialty consultations and procedures and 11 nursing encounters. There were 36 deficiencies in this category, of which 10 were significant. Significant deficiencies were identified once each in cases 10, 12, 17, 21, 25, and 26, and four times in case 22.

Access to Specialty Services

Specialty access was not a concern for the providers of ISP. There were sufficient consultants available to address the specialty needs of the institution. Of the ten significant deficiencies, however, four were in access to care. These deficiencies were for significant delays in consultant follow-ups after the provider's order:

- In case 12, the provider's order for cataract extraction was not scheduled or addressed for five months.
- In case 21, a neurology one-month follow-up was delayed nearly two months.
- In case 22, ophthalmology two-week follow-up was delayed eight weeks.
- In case 26, a neurology one-month follow-up did not occur until four months later.

Nursing Performance

- In case 10, specialty nurses failed to provide glucose level reports to the endocrinologist.

Provider Performance

The provider performance in specialty services had improved from the prior inspection. An improved workflow of the primary care provider receiving the consultant recommendations led to increased familiarity with the patient's medical condition and more timely treatment plans. The

deficiencies noted are discussed in the *Quality of Provider Performance* indicator. One significant deficiency was attributed to provider performance:

- In case 17, the patient had chronic dermatological disease with an acute rash and skin breakdown. The provider failed to order a two-week dermatology follow-up.

Health Information Management

Among the 36 deficiencies in specialty services, 26 were attributed to health information management. The majority of these deficiencies were either the mislabeling of consultants' progress notes within the medical records or the scanning of the progress notes prior to a provider review. A provider review prior to the scanning of the medical consult ensures that urgent recommendations are communicated to the primary care team:

- In case 22, a Holter monitor (cardiac test) report was mislabeled "audiology," and several other specialty consults were labeled "other" when scanned into the medical record.
- In case 25, fibroscan results were never scanned into the medical records.

Pharmacy and Medical Management

ISP provided specialist-recommended medications timely. There was no pattern of deficiencies identified.

Clinician Onsite Inspection

During the onsite visit, the providers and ancillary staff were pleased with the quality of specialty services. Specialty services scheduled appointments and received consultant recommendations timely. This critical service performed well, and the staff was well versed on the paper workflow.

The offsite specialty services and telemedicine clinic nurses were adjusting to the recent EHRS implementation. The OIG clinicians learned offsite specialty services recommendations were immediately scanned into the EHRS system. An electronic copy was also forwarded to a provider for review and implementation of recommendations. However, in the telemedicine areas, recommendations were forwarded to medical records for scanning, risking delayed provider notification.

Conclusion

The OIG's case review clinicians rated the *Specialty Services* indicator *adequate*.

Compliance Testing Results

The institution received an *adequate* compliance score of 79.8 percent in the *Specialty Services* indicator, and received a *proficient* score in the following three areas:

- For all 15 patients sampled, high-priority specialty services appointments occurred within 14 calendar days of the provider's order (MIT 14.001).
- The OIG tested the timeliness of ISP's denials of providers' specialty services requests for 20 patients; all 20 denials were timely (MIT 14.006).
- For 14 of the 15 patients sampled (93 percent), routine specialty services appointments occurred within 90 calendar days of the provider's order; however, one patient received his routine specialty service 21 days late (MIT 14.003).

The institution performed in the *inadequate* range in the following four areas:

- When patients are approved or scheduled for specialty services at one institution and then transfer to another, policy requires that the receiving institution reschedule and provide the patient's appointment. Only 12 of the 20 patients sampled who transferred to ISP with an approved specialty service (60 percent) received it within the required time frame. Six patients received their pending specialty service appointment from one day to three months late, and two other patients never received their specialty service appointment (MIT 14.005).
- When ISP providers ordered high-priority specialty services for patients, the ordering providers did not always review the specialty reports within the required time frame, and the report was not always received timely. Providers reviewed 10 of the 15 sampled high-priority specialty reports timely (67 percent). For two patients, the institution received the specialty report 2 and 12 days late, and for three other patients, the provider reviewed the specialty report from one to 23 days late (MIT 14.002).
- Providers timely received and reviewed 10 of the 15 routine specialty reports that inspectors sampled (67 percent). For four patients, providers reviewed the reports from one to ten days late, and a fifth report was reviewed 68 days late (MIT 14.004).
- Among 18 applicable patients sampled for whom ISP's health care management denied a specialty service, only 13 patients (72 percent) received a timely notification of the denied service, including the provider meeting with the patient within 30 days to discuss alternate treatment strategies. For two patients, the provider's follow-up visit occurred 7 and 12 days late, while for three patients, there was no provider follow-up to discuss the denial at all (MIT 14.007).

Recommendations

The OIG recommends that ISP telemedicine services duplicate the scanning process of offsite specialty returns and scan specialist recommendations to the providers. This will allow ISP's providers to promptly review recommendations and implement orders.

15 — *ADMINISTRATIVE OPERATIONS (SECONDARY)*

This indicator focuses on the institution’s administrative health care oversight functions. The OIG evaluates whether the institution promptly processes patient medical appeals and addresses all appealed issues. Inspectors also verify that the institution follows reporting requirements for adverse/sentinel events and patient deaths. The OIG verifies that the Emergency Medical Response Review Committee (EMRRC) performs required reviews and that staff perform required emergency response drills. Inspectors also assess whether the Quality Management Committee (QMC) meets regularly and adequately addresses program performance. For those institutions with licensed facilities, inspectors also verify that required committee meetings are held. In addition, OIG examines whether the institution adequately manages its health care staffing resources by evaluating whether job performance reviews are completed as required; specified staff possess current, valid credentials and professional licenses or certifications; nursing staff receive new employee orientation training and annual competency testing; and clinical and custody staff have current medical emergency response certifications. The *Administrative Operations* indicator is a secondary indicator, and, therefore, was not relied on for the overall score for the institution.

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(68.9%)
Overall Rating:
Inadequate

Compliance Testing Results

The institution received an *inadequate* compliance score of 68.9 percent in the *Administrative Operations* indicator. The institution showed room for improvement in the following five areas:

- The institution did not take adequate steps to ensure the accuracy of its Dashboard data. ISP did not provide substantial evidence of discussion of the methodologies used to conduct periodic data validation or the results of that data validation testing. The Quality Management Committee (QMC) meetings did not include discussion of methodologies used to train staff who collected Dashboard data. Therefore, ISP received a score of zero (MIT 15.004).
- The OIG inspected records for five nurses to determine if their nursing supervisors properly completed monthly performance reviews. Inspectors identified the following deficiencies for the five nurses’ monthly nursing reviews (MIT 15.104):
 - The supervisor did not complete the required number of reviews for two nurses.
 - The supervisor’s review did not summarize aspects that were well done for five nurses, and did not summarize aspects that were needing improvement for two nurses.

- None of ISP's five providers had a proper clinical performance appraisal completed on their behalf. The reviewer did not complete the required 360 Degree Evaluation for any of the five providers (MIT 15.106).
- Nursing staff did not always receive new employee orientation training within 30 days of being hired. Two nurses received their new employee orientation training 18 to 31 days late (MIT 15.111).
- Inspectors reviewed the six recent months' QMC meeting minutes. At only two of the meetings, the QMC evaluated program performance and took action when the committee identified improvement opportunities (33 percent). According to the minutes, institutional scorecard data was not reviewed at four of the meetings (MIT 15.003).

The institution received scores of 100 percent in the following areas:

- The institution promptly processed all patient medical appeals in each of the most recent 12 months (MIT 15.001).
- The OIG inspected incident package documentation for 12 emergency medical responses reviewed by ISP's Emergency Medical Response Review Committee (EMRRC) during the prior six-month period; all of the sampled packages complied with policy (MIT 15.005).
- Inspectors reviewed drill packages for three medical emergency response drills conducted in the prior quarter; all the packages contained all required summary reports and related documentation. In addition, the drills included participation by both health care and custody staff (MIT 15.101).
- Based on a sample of ten second-level medical appeals, the institution's responses addressed all of the patients' appealed issues (MIT 15.102).
- Medical staff promptly submitted the initial Inmate Death Report (CDCR Form 7229A) to CCHCS's Death Review Unit for all three applicable deaths that occurred at ISP in the prior 12-month period (MIT 15.103).
- All ten nurses sampled were current with their clinical competency validations (MIT 15.105).
- All providers at the institution were current with their professional licenses (MIT 15.107).
- All providers and nurses on active duty were current with their emergency response certifications (MIT 15.108).
- All nurses and the pharmacist in charge were current with their professional licenses and certification requirements (MIT 15.109).

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

Non-Scored Results

- The OIG gathered non-scored data regarding the completion of death review reports by CCHCS's Death Review Committee (DRC). Three deaths occurred during the OIG's review period, and all of them were unexpected (Level 1) deaths. The DRC was required to complete its death review summary report within 60 calendar days from the date of death and submit the report to the institution's CEO within seven calendar days thereafter. However, the DRC completed its report 59 to 126 days late (119 to 186 days after the deaths) and submitted it to ISP's CEO 75 to 135 days late (142 to 202 days after the deaths) (MIT 15.998).
- ISP's health care staffing resources are discussed in the *About the Institution* section on page 2 (MIT 15.999).

Recommendations

No specific recommendations.

POPULATION-BASED METRICS

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

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

Methodology

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

Comparison of Population-Based Metrics

For 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 well with its management of diabetes compared to most state and national plans.

When compared statewide, ISP outperformed Medi-Cal and Kaiser Permanente (North and South regions) in all five measures. In addition, when compared nationally, ISP outperformed Medicaid, Medicare, the United States Department of Veterans Affairs (VA), and commercial health plans in all five diabetic measures.

Immunizations

Comparative data for immunizations was only fully available for the VA and partially available for Kaiser, commercial plans, Medicaid, and Medicare. With respect to administering influenza vaccinations to younger adults, ISP outperformed Medicaid and matched commercial health plans. However, ISP performed less well than Kaiser, both North and South, and scored 7 percentage points lower than the VA. The 50 percent patient refusal rate negatively affected the institution's score for this measure. However, ISP outperformed both Medicare and the VA for influenza vaccinations for older adults. Lastly, with regard to administering pneumococcal vaccines to older adults, ISP scored lower than both Medicare and the VA.

Cancer Screening

With respect to colorectal cancer screening, ISP scored higher than all health care plans, statewide and national.

Summary

ISP's population-based metrics performance reflected a well-run chronic care program, and is comparable to the other health care plans reviewed. The institution may improve its scores for immunizations by reducing patient refusals through patient education.

ISP Results Compared to State and National HEDIS Scores

Clinical Measures	California					National		
	ISP Cycle 5 Results ¹	HEDIS Medi-Cal 2015 ²	HEDIS Kaiser (No.CA)2016 ³	HEDIS Kaiser (So.CA) 2016 ³	HEDIS Medicaid 2016 ⁴	HEDIS Com- mercial 2016 ⁴	HEDIS Medicare 2016 ⁴	VA Average 2015 ⁵
Comprehensive Diabetes Care								
HbA1c Testing (Monitoring)	100%	86%	94%	94%	86%	90%	93%	98%
Poor HbA1c Control (>9.0%) ^{6, 7}	10%	39%	20%	23%	45%	34%	27%	19%
HbA1c Control (<8.0%) ⁶	74%	49%	70%	63%	46%	55%	63%	-
Blood Pressure Control (<140/90) ⁶	88%	63%	83%	83%	59%	60%	62%	74%
Eye Exams	90%	53%	68%	81%	53%	54%	69%	89%
Immunizations								
Influenza Shots - Adults (18–64)	48%	-	56%	57%	39%	48%	-	55%
Influenza Shots - Adults (65+)	80%	-	-	-	-	-	72%	76%
Immunizations: Pneumococcal	67%	-	-	-	-	-	71%	93%
Cancer Screening								
Colorectal Cancer Screening	87%	-	79%	82%	-	63%	67%	82%

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

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

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

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

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

6. For this indicator, the entire applicable ISP population was tested.

7. For this measure only, a lower score is better. For Kaiser, the OIG derived the Poor HbA1c Control indicator using the reported data for the <9.0% HbA1c control indicator.

APPENDIX A — COMPLIANCE TEST RESULTS

Ironwood State Prison Range of Summary Scores: 67.73%–87.20%	
Indicator	Compliance Score (Yes %)
1–Access to Care	83.07%
2–Diagnostic Services	80.00%
3–Emergency Services	Not Applicable
4–Health Information Management (Medical Records)	87.20%
5–Health Care Environment	82.76%
6–Inter- and Intra-System Transfers	75.00%
7–Pharmacy and Medication Management	81.10%
8–Prenatal and Post-Delivery Services	Not Applicable
9–Preventive Services	67.73%
10–Quality of Nursing Performance	Not Applicable
11–Quality of Provider Performance	Not Applicable
12–Reception Center Arrivals	Not Applicable
13–Specialized Medical Housing (OHU, CTC, SNF, Hospice)	86.67%
14–Specialty Services	79.84%
15–Administrative Operations	68.89%

Reference Number	1–Access to Care	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
1.001	Chronic care follow-up appointments: Was the patient’s most recent chronic care visit within the health care guideline’s maximum allowable interval or within the ordered time frame, whichever is shorter?	23	2	25	92.00%	0
1.002	For endorsed patients received from another CDCR institution: If the nurse referred the patient to a provider during the initial health screening, was the patient seen within the required time frame?	19	6	25	76.00%	0
1.003	Clinical appointments: Did a registered nurse review the patient’s request for service the same day it was received?	30	0	30	100.00%	0
1.004	Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed?	29	1	30	96.67%	0
1.005	Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter?	9	3	12	75.00%	18
1.006	Sick call follow-up appointments: If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified?	2	1	3	66.67%	27
1.007	Upon the patient’s discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame?	12	2	14	85.71%	0
1.008	Specialty service follow-up appointments: Do specialty service primary care physician follow-up visits occur within required time frames?	15	12	27	55.56%	3
1.101	Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms?	6	0	6	100.00%	0
Overall percentage:					83.07%	

Reference Number	<i>2–Diagnostic Services</i>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
2.001	Radiology: Was the radiology service provided within the time frame specified in the provider’s order?	10	0	10	100.00%	0
2.002	Radiology: Did the primary care provider review and initial the diagnostic report within specified time frames?	8	2	10	80.00%	0
2.003	Radiology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	8	2	10	80.00%	0
2.004	Laboratory: Was the laboratory service provided within the time frame specified in the provider’s order?	9	0	9	100.00%	1
2.005	Laboratory: Did the primary care provider review and initial the diagnostic report within specified time frames?	9	1	10	90.00%	0
2.006	Laboratory: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	10	0	10	100.00%	0
2.007	Pathology: Did the institution receive the final diagnostic report within the required time frames?	7	3	10	70.00%	0
2.008	Pathology: Did the primary care provider review and initial the diagnostic report within specified time frames?	6	2	8	75.00%	2
2.009	Pathology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	2	6	8	25.00%	2
Overall percentage:					80.00%	

3–Emergency Services

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

Reference Number	4–Health Information Management	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated healthcare documents (provider progress notes) scanned within 3 calendar days of the patient encounter date?	20	0	20	100.00%	0
4.002	Are dictated/transcribed documents scanned into the patient’s electronic health record within five calendar days of the encounter date?	11	9	20	55.00%	0
4.003	Are High-Priority specialty notes (either a Form 7243 or other scanned consulting report) scanned within the required time frame?	16	4	20	80.00%	0
4.004	Are community hospital discharge documents scanned into the patient’s electronic health record within three calendar days of hospital discharge?	14	0	14	100.00%	0
4.005	Are medication administration records (MARs) scanned into the patient’s electronic health record within the required time frames?	19	1	20	95.00%	0
4.006	During the inspection, were medical records properly scanned, labeled, and included in the correct patients’ files?	21	3	24	87.50%	0
4.007	For patients discharged from a community hospital: Did the preliminary hospital discharge report include key elements and did a primary care provider review the report within three calendar days of discharge?	13	1	14	92.86%	0
Overall percentage:					87.20%	

Reference Number	5–Health Care Environment	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
5.101	Are clinical health care areas appropriately disinfected, cleaned and sanitary?	9	0	9	100.00%	0
5.102	Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	5	2	7	71.43%	2
5.103	Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	9	0	9	100.00%	0
5.104	Does clinical health care staff adhere to universal hand hygiene precautions?	8	1	9	88.89%	0
5.105	Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	9	0	9	100.00%	0
5.106	Warehouse, Conex and other non-clinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program?	1	0	1	100.00%	0
5.107	Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	7	2	9	77.78%	0
5.108	Do clinic common areas and exam rooms have essential core medical equipment and supplies?	4	5	9	44.44%	0
5.109	Do clinic common areas have an adequate environment conducive to providing medical services?	9	0	9	100.00%	0
5.110	Do clinic exam rooms have an adequate environment conducive to providing medical services?	4	5	9	44.44%	0
5.111	Emergency response bags: Are TTA and clinic emergency medical response bags inspected daily and inventoried monthly, and do they contain essential items?	5	1	6	83.33%	3
Overall percentage:					82.76%	

Reference Number	6–Inter- and Intra-System Transfers	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
6.001	For endorsed patients received from another CDCR institution or COCF: Did nursing staff complete the initial health screening and answer all screening questions on the same day the patient arrived at the institution?	0	25	25	0.00%	0
6.002	For endorsed patients received from another CDCR institution or COCF: When required, did the RN complete the assessment and disposition section of the health screening form; refer the patient to the TTA, if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening?	24	0	24	100.00%	1
6.003	For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption?	4	1	5	80.00%	20
6.004	For patients transferred out of the facility: Were scheduled specialty service appointments identified on the patient’s health care transfer information form?	19	1	20	95.00%	0
6.101	For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents?	4	0	4	100.00%	0
Overall percentage:					75.00%	

Reference Number	7–Pharmacy and Medication Management	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.001	Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows?	18	3	21	85.71%	4
7.002	Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames?	25	0	25	100.00%	0
7.003	Upon the patient’s discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames?	12	2	14	85.71%	0
7.004	For patients received from a county jail: Were all medications ordered by the institution’s reception center provider administered, made available, or delivered to the patient within the required time frames?	Not Applicable				
7.005	Upon the patient’s transfer from one housing unit to another: Were medications continued without interruption?	14	1	15	93.33%	0
7.006	For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption?	3	2	5	60.00%	0
7.101	All clinical and medication line storage areas for narcotic medications: Does the Institution employ strong medication security over narcotic medications assigned to its clinical areas?	4	3	7	57.14%	7
7.102	All clinical and medication line storage areas for non-narcotic medications: Does the Institution properly store non-narcotic medications that do not require refrigeration in assigned clinical areas?	4	4	8	50.00%	6
7.103	All clinical and medication line storage areas for non-narcotic medications: Does the institution properly store non-narcotic medications that require refrigeration in assigned clinical areas?	6	1	7	85.71%	7
7.104	Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes?	5	0	5	100.00%	0
7.105	Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients?	5	0	5	100.00%	0
7.106	Medication preparation and administration areas: Does the Institution employ appropriate administrative controls and protocols when distributing medications to patients?	4	1	5	80.00%	0
7.107	Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and satellite pharmacies?	1	0	1	100.00%	0

Reference Number	7–Pharmacy and Medication Management	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.108	Pharmacy: Does the institution’s pharmacy properly store non-refrigerated medications?	0	1	1	0.00%	0
7.109	Pharmacy: Does the institution’s pharmacy properly store refrigerated or frozen medications?	1	0	1	100.00%	0
7.110	Pharmacy: Does the institution’s pharmacy properly account for narcotic medications?	1	0	1	100.00%	0
7.111	Does the institution follow key medication error reporting protocols?	25	0	25	100.00%	0
Overall percentage:					81.10%	

8–Prenatal and Post-Delivery Services	
The institution has no female patients, so this indicator is not applicable.	

Reference Number	9–Preventive Services	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
9.001	Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed?	13	1	14	92.86%	0
9.002	Patients prescribed TB medication: Did the institution monitor the patient monthly for the most recent three months he or she was on the medication?	4	10	14	28.57%	0
9.003	Annual TB Screening: Was the patient screened for TB within the last year?	10	20	30	33.33%	0
9.004	Were all patients offered an influenza vaccination for the most recent influenza season?	24	1	25	96.00%	0
9.005	All patients from the age of 50 - 75: Was the patient offered colorectal cancer screening?	23	2	25	92.00%	0
9.006	Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy?	Not Applicable				
9.007	Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy?	Not Applicable				
9.008	Are required immunizations being offered for chronic care patients?	7	4	11	63.64%	14
9.009	Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	Not Applicable				
Overall percentage:					67.73%	

10–Quality of Nursing Performance

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

11–Quality of Provider Performance

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

12–Reception Center Arrivals

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

Reference Number	13–Specialized Medical Housing	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient on the day of admission, or within eight hours of admission to CMF’s Hospice?	9	1	10	90.00%	0
13.002	For CTC and SNF only: Was a written history and physical examination completed within the required time frame?	Not Applicable				
13.003	For OHU, CTC, SNF, and Hospice: Did the primary care provider complete the Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes on the patient at the minimum intervals required for the type of facility where the patient was treated?	7	3	10	70.00%	0
13.101	For OHU and CTC Only: Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter patient’s cells?	1	0	1	100.00%	0
Overall percentage:					86.67%	

Reference Number	14—Specialty Services	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	Did the patient receive the high priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service?	15	0	15	100.00%	0
14.002	Did the primary care provider review the high priority specialty service consultant report within the required time frame?	10	5	15	66.67%	0
14.003	Did the patient receive the routine specialty service within 90 calendar days of the primary care provider order or Physician Request for Service?	14	1	15	93.33%	0
14.004	Did the primary care provider review the routine specialty service consultant report within the required time frame?	10	5	15	66.67%	0
14.005	For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames?	12	8	20	60.00%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	20	0	20	100.00%	0
14.007	Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame?	13	5	18	72.22%	2
Overall percentage:					79.84%	

Reference Number	15–Administrative Operations	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.001	Did the institution promptly process inmate medical appeals during the most recent 12 months?	12	0	12	100.00%	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?	2	4	6	33.33%	0
15.004	Did the institution’s Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	0	1	1	0.00%	0
15.005	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	12	0	12	100.00%	0
15.006	For institutions with licensed care facilities: Does the Local Governing Body (LGB), or its equivalent, meet quarterly and exercise its overall responsibilities for the quality management of patient health care?	Not Applicable				
15.101	Did the institution complete a medical emergency response drill for each watch and include participation of health care and custody staff during the most recent full quarter?	3	0	3	100.00%	0
15.102	Did the institution’s second level medical appeal response address all of the 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?	3	0	3	100.00%	0
15.104	Does the institution’s Supervising Registered Nurse conduct periodic reviews of nursing staff?	0	5	5	0.00%	0
15.105	Are nursing staff who administer medications current on their clinical competency validation?	10	0	10	100.00%	0
15.106	Are structured clinical performance appraisals completed timely?	0	5	5	0.00%	0
15.107	Do all providers maintain a current medical license?	7	0	7	100.00%	0
15.108	Are staff current with required medical emergency response certifications?	2	0	2	100.00%	1
15.109	Are nursing staff and the Pharmacist-in-Charge current with their professional licenses and certifications, and is the pharmacy licensed as a correctional pharmacy by the California State Board of Pharmacy?	6	0	6	100.00%	1

Reference Number	15–Administrative Operations	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.110	Do the institution’s pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	1	0	1	100.00%	0
15.111	Are nursing staff current with required new employee orientation?	0	1	1	0.00%	0
Overall percentage:					68.89%	

APPENDIX B — CLINICAL DATA

Table B-1: ISP Sample Sets	
Sample Set	Total
Anticoagulation	1
Death Review/Sentinel Events	2
Diabetes	5
Emergency Services – CPR	3
Emergency Services – Non-CPR	2
High Risk	4
Hospitalization	4
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	15
Specialty Services	2
	44

Table B-2: ISP Chronic Care Diagnoses

Diagnosis	Total
Anemia	1
Anticoagulation	1
Arthritis/Degenerative Joint Disease	4
Asthma	3
COPD	2
Cancer	4
Cardiovascular Disease	5
Chronic Kidney Disease	1
Chronic Pain	5
Cirrhosis/End Stage Liver Disease	2
DVT/PE	1
Deep Venous Thrombosis/Pulmonary Embolism	4
Diabetes	15
Gastroesophageal Reflux Disease	2
Hepatitis C	14
Hyperlipidemia	14
Hypertension	21
Mental Health	1
Migraine Headaches	1
Rheumatological Disease	1
Seizure Disorder	2
Sleep Apnea	3
Thyroid Disease	2
	109

Table B-3: ISP Event — Program

Program	Total
Diagnostic Services	98
Emergency Care	55
Hospitalization	44
Intra-System Transfers in	15
Intra-System Transfers out	4
Not Specified	5
Outpatient Care	308
Specialized Medical Housing	262
Specialty Services	132
	923

Table B-4: ISP Case Review Sample Summary

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

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

Ironwood State Prison			
Quality Indicator	Sample Category (number of samples)	Data Source	Filters
<i>Access to Care</i>			
MIT 1.001	Chronic Care Patients (25)	Master Registry	<ul style="list-style-type: none"> • Chronic care conditions (at least one condition per patient—any risk level) • Randomize
MIT 1.002	Nursing Referrals (25)	OIG Q: 6.001	<ul style="list-style-type: none"> • See <i>Intra-system Transfers</i>
MITs 1.003-006	Nursing Sick Call (5 per clinic) (30)	MedSATS	<ul style="list-style-type: none"> • Clinic (each clinic tested) • Appointment date (2–9 months) • Randomize
MIT 1.007	Returns from Community Hospital (14)	OIG Q: 4.008	<ul style="list-style-type: none"> • See <i>Health Information Management (Medical Records)</i> (returns from community hospital)
MIT 1.008	Specialty Services Follow-up (30)	OIG Q: 14.001 & 14.003	<ul style="list-style-type: none"> • See <i>Specialty Services</i>
MIT 1.101	Availability of Health Care Services Request Forms (6)	OIG onsite review	<ul style="list-style-type: none"> • Randomly select one housing unit from each yard
<i>Diagnostic Services</i>			
MITs 2.001–003	Radiology (10)	Radiology Logs	<ul style="list-style-type: none"> • Appointment date (90 days–9 months) • Randomize • Abnormal
MITs 2.004–006	Laboratory (10)	Quest	<ul style="list-style-type: none"> • Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.007–009	Pathology (10)	InterQual	<ul style="list-style-type: none"> • Appt. date (90 days–9 months) • Service (pathology related) • Randomize

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Health Information Management (Medical Records)			
MIT 4.001	Timely Scanning (20)	OIG Qs: 1.001, 1.002, & 1.004	<ul style="list-style-type: none"> Non-dictated documents 1st 10 IPs MIT 1.001, 1st 5 IPs MITs 1.002, 1.004
MIT 4.002	(20)	OIG Q: 1.001	<ul style="list-style-type: none"> Dictated documents First 20 IPs selected
MIT 4.003	(20)	OIG Qs: 14.002 & 14.004	<ul style="list-style-type: none"> Specialty documents First 10 IPs for each question
MIT 4.004	(14)	OIG Q: 4.008	<ul style="list-style-type: none"> Community hospital discharge documents First 20 IPs selected
MIT 4.005	(20)	OIG Q: 7.001	<ul style="list-style-type: none"> MARs First 20 IPs selected
MIT 4.006	(3)	Documents for any tested inmate	<ul style="list-style-type: none"> Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.007	Returns From Community Hospital (14)	Inpatient claims data	<ul style="list-style-type: none"> Date (2–8 months) Most recent 6 months provided (within date range) Rx count Discharge date Randomize (each month individually) First 5 patients from each of the 6 months (if not 5 in a month, supplement from another, as needed)
Health Care Environment			
MIT 5.101-105 MIT 5.107–111	Clinical Areas (9)	OIG inspector onsite review	<ul style="list-style-type: none"> Identify and inspect all onsite clinical areas.
Inter- and Intra-System Transfers			
MIT 6.001-003	Intra-System Transfers (25)	SOMS	<ul style="list-style-type: none"> Arrival date (3–9 months) Arrived from (another CDCR facility) Rx count Randomize
MIT 6.004	Specialty Services Send-Outs (20)	MedSATS	<ul style="list-style-type: none"> Date of transfer (3–9 months) Randomize
MIT 6.101	Transfers Out (10)	OIG inspector onsite review	<ul style="list-style-type: none"> R&R IP transfers with medication

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Pharmacy and Medication Management			
MIT 7.001	Chronic Care Medication (25)	OIG Q: 1.001	<ul style="list-style-type: none"> See <i>Access to Care</i> At least one condition per patient—any risk level Randomize
MIT 7.002	New Medication Orders (25)	Master Registry	<ul style="list-style-type: none"> Rx count Randomize Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns from Community Hospital (14)	OIG Q: 4.008	<ul style="list-style-type: none"> See <i>Health Information Management (Medical Records)</i> (returns from community hospital)
MIT 7.004	RC Arrivals – Medication Orders <i>N/A at this institution</i>	OIG Q: 12.001	<ul style="list-style-type: none"> See <i>Reception Center Arrivals</i>
MIT 7.005	Intra-Facility Moves (15)	MAPIP transfer data	<ul style="list-style-type: none"> Date of transfer (2–8 months) To location/from location (yard to yard and to/from ASU) Remove any to/from MHCB NA/DOT meds (and risk level) Randomize
MIT 7.006	En Route (5)	SOMS	<ul style="list-style-type: none"> Date of transfer (2–8 months) Sending institution (another CDCR facility) Randomize NA/DOT meds
MITs 7.101-103	Medication Storage Areas (varies by test)	OIG inspector onsite review	<ul style="list-style-type: none"> Identify and inspect clinical & med line areas that store medications
MITs 7.104–106	Medication Preparation and Administration Areas (varies by test)	OIG inspector onsite review	<ul style="list-style-type: none"> Identify and inspect onsite clinical areas that prepare and administer medications
MITs 7.107-110	Pharmacy (1)	OIG inspector onsite review	<ul style="list-style-type: none"> Identify & inspect all onsite pharmacies
MIT 7.111	Medication Error Reporting (25)	Monthly medication error reports	<ul style="list-style-type: none"> All monthly statistic reports with Level 4 or higher Select a total of 5 months
MIT 7.999	Isolation Unit KOP Medications <i>(N/A at this institution)</i>	Onsite active medication listing	<ul style="list-style-type: none"> KOP rescue inhalers & nitroglycerin medications for IPs housed in isolation units
Prenatal and Post-Delivery Services			
MIT 8.001-007	Recent Deliveries <i>N/A at this institution</i>	OB Roster	<ul style="list-style-type: none"> Delivery date (2–12 months) Most recent deliveries (within date range)
	Pregnant Arrivals <i>N/A at this institution</i>	OB Roster	<ul style="list-style-type: none"> Arrival date (2–12 months) Earliest arrivals (within date range)

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Preventive Services			
MITs 9.001–002	TB Medications (14)	Maxor	<ul style="list-style-type: none"> • Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • Randomize
MIT 9.003	TB Code 22, Annual TST (15)	SOMS	<ul style="list-style-type: none"> • Arrival date (at least 1 year prior to inspection) • TB Code (22) • Randomize
MIT 9.004	TB Code 34, Annual Screening (15)	SOMS	<ul style="list-style-type: none"> • Arrival date (at least 1 year prior to inspection) • TB Code (34) • Randomize
MIT 9.005	Influenza Vaccinations (25)	SOMS	<ul style="list-style-type: none"> • Arrival date (at least 1 year prior to inspection) • Randomize • Filter out IPs tested in MIT 9.008
MIT 9.006	Colorectal Cancer Screening (25)	SOMS	<ul style="list-style-type: none"> • Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • Randomize
MIT 9.007	Mammogram <i>N/A at this institution</i>	SOMS	<ul style="list-style-type: none"> • Arrival date (at least 2 yrs prior to inspection) • Date of birth (age 52–74) • Randomize
MIT 9.008	Pap Smear <i>N/A at this institution</i>	SOMS	<ul style="list-style-type: none"> • Arrival date (at least three yrs prior to inspection) • Date of birth (age 24–53) • Randomize
MIT 9.009	Chronic Care Vaccinations (25)	OIG Q: 1.001	<ul style="list-style-type: none"> • Chronic care conditions (at least 1 condition per IP—any risk level) • Randomize • Condition must require vaccination(s)
MIT 9.009	Valley Fever (number will vary) <i>N/A at this institution</i>	Cocci transfer status report	<ul style="list-style-type: none"> • Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • All

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Reception Center Arrivals			
MITs 12.001–008	RC <i>N/A at this institution</i>	SOMS	<ul style="list-style-type: none"> • Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • Randomize
Specialized Medical Housing			
MITs 13.001–004	CTC (10)	CADDIS	<ul style="list-style-type: none"> • Admit date (1–6 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • Randomize
MIT 13.101	Call Buttons CTC (all)	OIG inspector onsite review	<ul style="list-style-type: none"> • Review by location
Specialty Services Access			
MITs 14.001–002	High-Priority (15)	MedSATS	<ul style="list-style-type: none"> • Approval date (3–9 months) • Randomize
MITs 14.003–004	Routine (15)	MedSATS	<ul style="list-style-type: none"> • Approval date (3–9 months) • Remove optometry, physical therapy or podiatry • Randomize
MIT 14.005	Specialty Services Arrivals (20)	MedSATS	<ul style="list-style-type: none"> • Arrived from (other CDCR institution) • Date of transfer (3–9 months) • Randomize
MIT 14.006-007	Denials (20)	InterQual	<ul style="list-style-type: none"> • Review date (3–9 months) • Randomize
	(0)	IUMC/MAR Meeting Minutes	<ul style="list-style-type: none"> • Meeting date (9 months) • Denial upheld • Randomize

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
<i>Administrative Operations</i>			
MIT 15.001	Medical Appeals (all)	Monthly medical appeals reports	<ul style="list-style-type: none"> Medical appeals (12 months)
MIT 15.002	Adverse/Sentinel Events (0)	Adverse/sentinel events report	<ul style="list-style-type: none"> Adverse/sentinel events (2–8 months)
MITs 15.003–004	QMC Meetings (6)	Quality Management Committee meeting minutes	<ul style="list-style-type: none"> Meeting minutes (12 months)
MIT 15.005	EMRRC (12)	EMRRC meeting minutes	<ul style="list-style-type: none"> Monthly meeting minutes (6 months)
MIT 15.006	LGB (0)	LGB meeting minutes	<ul style="list-style-type: none"> Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills (3)	Onsite summary reports & documentation for ER drills	<ul style="list-style-type: none"> Most recent full quarter Each watch
MIT 15.102	2 nd Level Medical Appeals (10)	Onsite list of appeals/closed appeals files	<ul style="list-style-type: none"> Medical appeals denied (6 months)
MIT 15.103	Death Reports (3)	Institution-list of deaths in prior 12 months	<ul style="list-style-type: none"> Most recent 10 deaths Initial death reports
MIT 15.104	RN Review Evaluations (5)	Onsite supervisor periodic RN reviews	<ul style="list-style-type: none"> RNs who worked in clinic or emergency setting six or more days in sampled month Randomize
MIT 15.105	Nursing Staff Validations (10)	Onsite nursing education files	<ul style="list-style-type: none"> On duty one or more years Nurse administers medications Randomize
MIT 15.106	Provider Annual Evaluation Packets (5)	OIG Q:16.001	<ul style="list-style-type: none"> All required performance evaluation documents
MIT 15.107	Provider licenses (7)	Current provider listing (at start of inspection)	<ul style="list-style-type: none"> Review all
MIT 15.108	Medical Emergency Response Certifications (all)	Onsite certification tracking logs	<ul style="list-style-type: none"> All staff <ul style="list-style-type: none"> Providers (ACLS) Nursing (BLS/CPR) Custody (CPR/BLS)
MIT 15.109	Nursing staff and Pharmacist in Charge Professional Licenses and Certifications (all)	Onsite tracking system, logs, or employee files	<ul style="list-style-type: none"> All required licenses and certifications

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
<i>Administrative Operations</i>			
MIT 15.110	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations (all)	Onsite listing of provider DEA registration #s & pharmacy registration document	<ul style="list-style-type: none"> • All DEA registrations
MIT 15.111	Nursing Staff New Employee Orientations (all)	Nursing staff training logs	<ul style="list-style-type: none"> • New employees (hired within last 12 months) •
MIT 15.998	Death Review Committee (0)	OIG summary log - deaths	<ul style="list-style-type: none"> • Between 35 business days & 12 months prior • CCHCS death reviews

**CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES'
RESPONSE**

June 30, 2017

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 2017 to April 2017. California Correctional Health Care Services (CCHCS) acknowledges all OIG findings.

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

Sincerely,



JANET LEWIS
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
Roy Wesley, Chief Deputy Inspector General, OIG
Ryan Baer, Senior Deputy Inspector General, 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., Deputy Director, Medical Services, CCHCS
Jane Robinson, R.N., Deputy Director, Nursing Services, CCHCS
Robert Herrick, Regional Health Care Executive, Region IV, CCHCS
Elizabeth dosSantos Chen, D.O., Regional Deputy Medical Executive, Region IV, CCHCS
Jorge Gomez, Regional Nursing Executive, Region IV, CCHCS
Eric Andersson, Chief Executive Officer, ISP
Annette Lambert, Deputy Director, Quality Management, Clinical Information and Improvement Services, CCHCS
Lara Saich, Chief, Health Care Regulations and Policy Section, CCHCS