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OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

May 2021

Cycle 6 Medical Inspection Report

California Medical Facility

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Introduction

Pursuant to California Penal Code section 6126 et seq., the Office of the Inspector General (the OIG) is responsible for periodically reviewing and reporting on the delivery of the ongoing medical care provided to incarcerated persons[1] in the California Department of Corrections and Rehabilitation (the department).[2]

In Cycle 6, the OIG continues to apply the same assessment methodologies used in Cycle 5, including clinical case review and compliance testing. These methods provide an accurate assessment of how the institution's health care systems function regarding patients with the highest medical risk who tend to access services at the highest rate. This information helps to assess the performance of the institution in providing sustainable, adequate care.[3]

We continue to review institutional care using 15 indicators, as in prior cycles. Using each of these indicators, our compliance inspectors collect data in answer to compliance- and performance-related questions as established in the *medical inspection tool* (MIT).[4] We determine a total compliance score for each applicable indicator and consider the MIT scores in the overall conclusion of the institution's performance. In addition, our clinicians complete document reviews of individual cases and also perform on-site inspections, which include interviews with staff.

In reviewing the cases, our clinicians examine whether providers used sound medical judgment in the course of caring for a patient. In the event we find errors, we determine whether such errors were clinically significant or led to a significantly increased risk of harm to the patient.[5] At the same time, our clinicians examine whether the institution's medical system mitigated the error. The OIG rates the indicators as ***proficient***, ***adequate***, or ***inadequate***.

1. In this report, we use the terms *patient* and *patients* to refer to *incarcerated persons*.

2. The OIG's medical inspections are not designed to resolve questions about the constitutionality of care, and the OIG explicitly makes no determination regarding the constitutionality of care the department provides to its population.

3. In addition to our own compliance testing and case reviews, the OIG continues to offer selected Healthcare Effectiveness Data and Information Set (HEDIS) measures for comparison purposes.

4. The department regularly updates its policies. The OIG updates our policy-compliance testing to reflect the department's updates and changes.

5. If we learn of a patient needing immediate care, we notify the institution's chief executive officer.

The OIG has adjusted Cycle 6 reporting in two ways. First, commencing with this reporting period, we interpret compliance and case review results together, providing a more holistic assessment of the care; and, second, we consider whether institutional medical processes lead to identifying and correcting provider or system errors. The review assesses the institution's medical care on both system and provider levels.

As we did during Cycle 5, our office is continuing to inspect both those institutions remaining under federal receivership and those delegated back to the department. There is no difference in the standards used for assessing a delegated institution versus an institution not yet delegated. At the time of the Cycle 6 inspection of California Medical Facility (CMF), the receiver had not delegated this institution back to the department.

We completed our sixth inspection of CMF and herein present our assessment of the health care provided at CMF during the inspection period between September 2019 and February 2020.[6] Notably, the data review period for this institution reaches back prior to the start of the novel coronavirus disease pandemic (COVID-19), so case review testing was not affected. However, some on-site testing was completed after the onset of the COVID-19 pandemic. Observations are noted within the report.

California Medical Facility (CMF) was established in 1955 and is located in Vacaville, California. CMF provides health care to patients who reside in a number of settings, including general population, outpatient housing units (OHUs), a licensed correctional treatment center (CTC), outpatient psychiatric facilities, and the first licensed prison hospice in the United States. CMF is designated an *intermediate care facility*; these types of institutions are located in predominantly urban areas, close to tertiary care centers and specialty care providers for the most cost-effective care.

6. Samples are obtained per case review methodology shared with stakeholders in prior cycles. The case reviews include emergency care reviews that occurred between May 2019 and February 2020, death reviews that occurred between October 2018 and July 2019, transfer reviews that occurred between August 2019 and January 2020, registered nurse (RN) sick call reviews that occurred between March 2019 and October 2019, and CTC reviews that occurred between July 2019 and February 2020.

Summary

We completed the Cycle 6 inspection of California Medical Facility (CMF) in August 2020. OIG inspectors monitored the institution's delivery of medical care that occurred between September 2019 and February 2020.

The OIG rated the overall quality of health care at CMF as ***inadequate***. We list the individual indicators and ratings applicable for this institution in Table 1 below.

Table 1. CMF Summary Table

Ratings

Proficient *Adequate* *Inadequate*

Health Care Indicators	Cycle 6 Ratings: Case Review	Cycle 6 Ratings: Compliance	Cycle 6 Ratings: Overall	Change Since Cycle 5*
Access to Care				=
Diagnostic Services				↓
Emergency Services		N/A		=
Health Information Management				=
Health Care Environment	N/A			↓
Transfers				=
Medication Management				↓
Prenatal and Postpartum Care	N/A	N/A	N/A	N/A
Preventive Services	N/A			=
Nursing Performance		N/A		=
Provider Performance		N/A		↑
Reception Center	N/A	N/A	N/A	N/A
Specialized Medical Housing				=
Specialty Services				=
Administrative Operations†	N/A			=

* The symbols in this column correspond to changes that occurred in indicator ratings between the medical inspections conducted during Cycle 5 and Cycle 6. The equals sign means there was no change in the rating. The single arrow means the rating rose or fell one level, and the double arrow means the rating rose or fell two levels (green, from *inadequate* to *proficient*; pink, from *proficient* to *inadequate*).

† **Administrative Operations** is a secondary indicator and is not considered when rating the institution's overall medical quality.

Source: The Office of the Inspector General medical inspection results.

To test the institution's policy compliance, our compliance inspectors (a team of registered nurses) monitored the institution's compliance with its medical policies by answering a standardized set of questions that measure specific elements of health care delivery. Our compliance inspectors examined 387 patient records and 1,275 data points and used the data to answer 94 policy questions. In addition, we observed CMF's processes during an on-site inspection in June 2020. Table 2 below lists CMF's average scores from Cycles 4, 5, and 6.

The OIG clinicians (a team of physicians and nurse consultants) reviewed 25 detailed cases, which contained 1,289 patient-related events. After examining the medical records, our clinicians conducted a follow-up on-site inspection in July 2020 to verify their initial findings. The OIG physicians rated the quality of care for 25 comprehensive case reviews.

Table 2. CMF Policy Compliance Scores

Scoring Ranges

100%–85.0%	84.9%–75.0%	74.9%–0

Medical Inspection Tool (MIT)	Policy Compliance Category	Average Score		
		Cycle 4	Cycle 5	Cycle 6
1	Access to Care	78.4%	80.6%	82.0%
2	Diagnostic Services	76.3%	65.0%	52.5%
4	Health Information Management	61.7%	61.5%	66.4%
5	Health Care Environment	72.5%	82.4%	69.7%
6	Transfers	72.8%	62.7%	62.6%
7	Medication Management	68.8%	78.5%	61.6%
8	Prenatal and Postpartum Care	N/A	N/A	N/A
9	Preventive Services	65.4%	68.3%	56.2%
12	Reception Center	N/A	N/A	N/A
13	Specialized Medical Housing	76.5%	91.2%	66.0%
14	Specialty Services	65.0%	53.0%	68.5%
15	Administrative Operations	61.8%	82.5%	79.4%

* In Cycle 4, there were two secondary (administrative) indicators, and this score reflects the average of those two scores. In Cycle 5 and moving forward, the two indicators were merged into one, with only one score as the result.

Source: The Office of the Inspector General medical inspection results.

Of these 25 cases, our physicians rated 21 ***adequate*** and four ***inadequate***. Our physicians did not find any adverse events during this inspection.

The OIG then considered the results from both case review and compliance testing, and drew overall conclusions, which we report in the 13 health care indicators.[7] Multiple OIG physicians and nurses performed quality control reviews; their subsequent collective deliberations ensured consistency, accuracy, and thoroughness. Our clinicians acknowledged institutional structures that catch and resolve mistakes that may occur throughout the delivery of care. As noted above, we listed the individual indicators and ratings applicable for this institution in Table 1, the CMF Summary Table.

In February 2020, the Health Care Services Master Registry showed that CMF had a total population of 5,501. A breakdown of the medical risk level of the CMF population as determined by the department is set forth in Table 3 below.[8]

Table 3. CMF Master Registry Data as of March 2020

Medical Risk Level	Number of Patients	Percentage
High 1	691	27.6%
High 2	652	26.1%
Medium	782	31.3%
Low	376	15.0%
Total	**2,501**	**100%**

Source: Data for the population medical risk level were obtained from the CCHCS Master Registry dated 3-3-20.

7. The indicators for **Reception Center** and **Prenatal Care** do not apply to CMF.
8. For a definition of ***medical risk***, see CCHCS HCDOM 1.2.14, Appendix 1.9.

Based on staffing data the OIG obtained from California Correctional Health Care Services (CCHCS), as identified in Table 4 below, CMF had one executive leadership vacancy, 0.4 vacant primary care provider positions, 5.2 vacant nursing supervisor positions, and 38.8 vacant nursing staff positions.

Table 4. CMF Health Care Staffing Resources as of March 2020

Positions	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff †	Total
Authorized Positions	11	19.4	31.2	341.9	403.5
Filled by Civil Service	10	19	26	303.1	358.1
Vacant	1	0.4	5.2	38.8	45.4
Percentage Filled by Civil Service	99.0%	98.0%	83.0%	87.0%	89.0%
Filled by Telemedicine	0	0	2	10	12
Percentage Filled by Telemedicine	0	0	6.4%	2.9%	3.0%
Filled by Registry	0	0	0	29	29
Percentage Filled by Registry	0	0	0	8.5%	7.2%
Total Filled Positions	10	19	28	342.1	399.1
Total Percentage Filled	91.0%	97.9%	89.7%	100.1%	98.9%
Appointments in Last 12 Months	3	4	6	30	43
Redirected Staff	0	0	0	0	0
Staff on Extended Leave‡	0	0	2	9	11
Adjusted Total: Filled Positions	**10**	**19**	**28**	**363.1**	**388.1**
Adjusted Total: Percentage Filled	**91.0%**	**98.0%**	**89.7%**	**106.2%**	**96.2%**

* Executive Leadership includes the Chief Physician and Surgeon.

† Nursing Staff includes the classifications of Senior Psychiatric Technician and Psychiatric Technician.

‡ In Authorized Positions.

Notes: The OIG does not independently validate staffing data received from the department. Positions are based on fractional time-base equivalents.

Source: Cycle 6 medical inspection preinspection questionnaire received March 2020, from California Correctional Health Care Services.

Medical Inspection Results

Deficiencies Identified During Case Review

Deficiencies are medical errors that increase the risk of patient harm. Deficiencies can be minor or significant, depending on the severity of the deficiency.

An *adverse event* occurs when the deficiency caused harm to the patient. All major health care organizations identify and track adverse events. We identify deficiencies and adverse events to highlight concerns regarding the provision of care and for the benefit of the institution's quality improvement program to provide an impetus for improvement.[9]

Our inspectors did not find any adverse events at CMF during the Cycle 6 inspection.

Case Review Results

OIG case reviewers (a team of physicians and nurse consultants) assessed 10 of the 13 indicators applicable to CMF. Of these 10 indicators, OIG clinicians rated five ***adequate*** and five ***inadequate***. The OIG physicians also rated the overall adequacy of care for each of the 25 detailed case reviews they conducted. Of these 25 cases, 22 were ***adequate*** and three were ***inadequate***. In the 1,289 events reviewed, there were 405 deficiencies, 155 of which the OIG clinicians considered to be of such magnitude that, if left unaddressed, would likely contribute to patient harm.

Our clinicians found the following strengths at CMF:

- As in Cycle 5, CMF provided good access to primary care services. Appointments almost always occurred as requested.
- CMF completed routine diagnostics within specified time frames.
- Most providers demonstrated good assessment and decision-making skills.
- Medical leadership identified providers who needed more coaching and have implemented closer monitoring of their work to facilitate improvement.

Our clinicians found CMF could improve in the following areas:

- As in Cycle 5, CMF did not ensure providers reviewed or endorsed off-site reports.
- The practice of requesting refills may lead to patients not receiving their medications. A few times, nurses placed requests

9. For a further discussion of an adverse event, see Table A–1.

for medications, and the medications were not dispensed to the patients because sick-call requests were not submitted.

- As in Cycle 5, CMF nurses did not consistently provide care according to policy. Sick-call nurses did not triage sick calls appropriately. CTC and OHU nurses did not consistently provide adequate wound care.

Compliance Testing Results

Our compliance inspectors assessed 10 of the 13 indicators applicable to CMF. Of these 10 indicators, our compliance inspectors rated two ***adequate*** and eight ***inadequate***. We tested only policy compliance in the **Health Care Environment**, **Preventive Services**, and **Administrative Operations** indicators as these indicators do not have a case review component.

CMF demonstrated a high rate of policy compliance in the following areas:

- Providers timely completed history and physical examinations for patients admitted to specialized medical housing. Furthermore, nursing staff completed initial assessments within the required time frames.
- Nursing staff reviewed health care services request forms and performed face-to-face encounters timely.

CMF demonstrated a low rate of policy compliance in the following areas:

- Providers did not often communicate results of diagnostic services timely. Most patient letters communicating these results were missing the date of the diagnostic service, the date of the results, and whether the results were within normal limits.
- CMF staff frequently failed to maintain medication continuity for chronic care patients, patients discharged from the hospital, and patients admitted to a specialized medical housing unit. Also, there was poor medication continuity for patients who transferred into the institution and for patients who had a temporary layover at CMF.
- CMF often did not ensure specialty service reports were received timely. Furthermore, providers often did not review these reports within the required time frames.
- CMF did not always ensure approved specialty services were provided timely to patients upon arrival at CMF.

Population-Based Metrics

In addition to our own compliance testing and case reviews, as noted above, the OIG presents selected measures from the Healthcare

Effectiveness Data and Information Set (HEDIS) for comparison purposes. The HEDIS is a set of standardized quantitative performance measures designed by the National Committee for Quality Assurance to ensure that the public has the data it needs to compare the performance of health care plans. Because the Veterans Administration no longer publishes its individual HEDIS scores, we removed them from our comparison for Cycle 6. Likewise, Kaiser (commercial plan) no longer publishes HEDIS scores. However, through the California Department of Health Care Services' *Medi-Cal Managed Care Technical Report*, the OIG obtained Kaiser Medi-Cal HEDIS scores to use in conducting our analysis, and we present them here for comparison.

HEDIS Results

We considered CMF's performance with population-based metrics to assess the macroscopic view of the institution's health care delivery. CMF's results were mixed compared with those found in State health plans for diabetic care measures. We list the five HEDIS measures in Table 5.

Comprehensive Diabetes Care

When compared with statewide Medi-Cal programs (California Medi-Cal, Kaiser Northern California (Medi-Cal), and Kaiser Southern California (Medi-Cal)), CMF performed better in three of the five diabetic measures. CMF scored lower than Kaiser Southern California for blood pressure control and scored equal to or less than Kaiser Northern California and Kaiser Southern California, respectively, with regard to eye examinations.

Immunizations

Statewide comparative data were not available for immunization measures; however, we include this data for informational purposes. CMF had a 62 percent influenza immunization rate for adults 18 to 64 years old, and an 82 percent influenza immunization rate for adults 65 years of age and older. The pneumococcal vaccination rate was 92 percent.[10]

Colorectal Cancer Screening

Statewide comparative data were not available for colorectal cancer screening; however, we include these data for informational purposes. CMF had an 81 percent colorectal cancer screening rate.

10. The pneumococcal vaccines administered are the 13 valent pneumococcal vaccine (PCV13) or the 23 valent pneumococcal vaccine (PPSV23), depending on the patient's medical conditions. For the adult population, the influenza or pneumococcal vaccine may have been administered at a different institution other than the one in which the patient was currently housed during the inspection period.

Table 5. CMF Results Compared With State HEDIS Scores

HEDIS Measure	CMF Cycle 6 Results*	California Medi-Cal 2018†	California Kaiser NorCal Medi-Cal 2018†	California Kaiser SoCal Medi-Cal 2018†
HbA1c Screening	**97%**	88%	94%	95%
Poor HbA1c Control (>9.0%)‡,§	**9%**	34%	24%	20%
HbA1c Control (<8.0%)‡	**80%**	55%	62%	70%
Blood Pressure Control (<140/90)‡	78%	67%	75%	**85%**
Eye Examinations	77%	63%	77%	**83%**
Influenza–Adults (18–64)	**62%**	–	–	–
Influenza–Adults (65+)	**82%**	–	–	–
Pneumococcal–Adults (65+)	**92%**	–	–	–
Colorectal Cancer Screening	**81%**	–	–	–

Notes and Sources

* Unless otherwise stated, data were collected in March 2020 by reviewing medical records from a sample of CMF'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.

† HEDIS Medi-Cal data were obtained from the California Department of Health Care Services publication titled, *Medi-Cal Managed Care External Quality Review Technical Report*, dated July 1, 2017–June 30, 2018 (published June 2020).

‡ For this indicator, the entire applicable CMF population was tested.

§ For this measure only, a lower score is better.

Source: Institution information provided by the California Department of Corrections and Rehabilitation. Health care plan data were obtained from the CCHCS Master Registry.

Recommendations

As a result of our assessment of CMF's performance, we offer the following recommendations to the department:

Access to Care

- Medical leadership should determine the cause of any challenges in providing timely chronic care appointments with providers and should implement remedial measures as appropriate.

Diagnostic Services

- The department should consider developing and implementing a letter template for patient results that autopopulates with all the elements required per CCHCS policy.
- Laboratory and nursing leadership should develop and implement auditing to ensure stat laboratory orders are completed within ordered time frames.
- Medical leadership should ascertain causative factors in the untimely provider endorsement of all diagnostic reports and sending of complete patient results letters.

Emergency Services

- Nursing leadership should determine the root cause of challenges that prevent nurses from completely and accurately documenting emergent events, and should implement remedial measures as appropriate.
- Nursing leadership should consider developing and implementing an internal audit to ensure that nurses completely and accurately document patient monitoring and assessments.
- The emergency medical response review committee (EMRRC) should more thoroughly review emergency response events and accurately detail findings.

Health Information Management

- Medical leadership should remind all staff to properly use correct labeling for patient letters when entering information into the electronic medical record.
- TTA nursing supervisors should audit stat laboratory draws to ensure providers are notified within specified time frames.
- Medical leadership should determine the root cause of challenges in timely provider reviews of diagnostic and off-site reports, and should implement remedial measures as appropriate.

Health Care Environment

- Nursing leadership should consider performing random spot checks to ensure that staff follow equipment and medical supply management protocols.
- Medical leadership should remind staff to follow universal hand hygiene precautions. Implementing random spot checks could improve compliance.
- Nursing leadership should have each clinic nurse supervisor review the monthly emergency medical response bag (EMRB) logs to ensure that the EMRBs are regularly inventoried and sealed.

Transfers

- Nursing leadership should determine the cause of challenges in the timely and uninterrupted delivery of medications to newly arriving patients and hospital discharge patients, and should implement remedial measures as appropriate.
- The department should consider developing and implementing an electronic alert to ensure nurses in receiving and release (R&R) properly complete initial health screening questions and follow up as needed.
- Nursing leadership should develop and implement auditing measures to ensure staff complete thorough assessments for patients returning from hospitalizations.

Medication Management

- Pharmacy and medical leadership should consider changing the asthma controller inhalers from *request refill* to *automatic refill* with the 1:1 inhaler exchange.
- Pharmacy leadership should consider reviewing the causes of the untimely delivery of all prescribed medications.
- Nursing leadership should remind nursing staff to follow safe medication administration practices, including completely and thoroughly documenting all medications, specifically, insulin and hypertensive medications.
- Medical leadership should determine the cause of challenges related to medication continuity for chronic care, transfer-in, hospital discharge, and en-route patients and should implement remedial measures as appropriate.

Preventive Services

- Medical leadership should remind nursing staff to perform weekly monitoring of patients and to address the symptoms of patients taking tuberculosis (TB) medications.

Nursing Performance

- Nursing leadership should consider incorporating camera and measurement tools to document wound care and other significant physical findings.
- Nursing leadership should determine the causes that prevent outpatient and specialized medical housing nurses from performing complete assessments and proper wound care, notifying the provider of any abnormal changes in patient condition, completing proper triage and scheduling of symptomatic sick call requests, providing patient discharge instructions, and accurately documenting care.

Provider Performance

- Medical leadership should ascertain causative factors in the untimely provider review of their electronic inboxes and report endorsement. Medical leadership should implement remedial measures as appropriate.
- Medical leadership should check provider documentation more frequently to ensure providers thoroughly review vitals, recent laboratory results, and pending appointments.

Specialized Medical Housing

- Nursing leadership for specialized medical housing should determine the causes that prevent outpatient nurses from performing complete assessments and proper wound care, notifying providers for any abnormal changes in patient condition, and documenting care accurately.
- Nursing leadership should review the root cause of challenges to ensure patients who are admitted into the CTC and the OHU receive their medications timely upon admission and should implement remedial measures as appropriate.
- Medical leadership should review the factors that may preclude specialized medical housing providers from documenting all pertinent physical examination findings.

Specialty Services

- Medical leadership should review the causes of the untimely retrieval of specialty reports and untimely provider review of the specialty reports; medical leadership should implement remedial measures as appropriate.

Administrative Operations

- The EMRRC should ensure the checklist form in the incident package is fully completed.
- Medical leadership should ensure that clinical competency evaluations and performance appraisals are completed timely.

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Access to Care

In this indicator, OIG inspectors evaluated the institution's ability to provide patients with timely clinical appointments. Our inspectors reviewed the scheduling and appointment timeliness for newly arrived patients, sick calls, and nurse follow-up appointments. We examined referrals to primary care providers, provider follow-ups, and specialists. Furthermore, we evaluated the follow-up appointments for patients who received specialty care or returned from an off-site hospitalization.

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
Adequate
(82.0%)

Results Overview

As in Cycle 5, CMF provided good access to care. Patients had good access to providers and nurses. When nurses and providers requested follow-up appointments for patients, the appointments occurred with few exceptions. Compliance testing showed chronic care appointments were not always completed on time. Patients usually saw specialists within the time frames providers requested; however, compliance testing found medium priority specialty referrals were not always timely. We rated this indicator ***adequate***.

Case Review Results

Our clinicians reviewed 259 provider, nurse, specialty, and hospital events that required the institution to generate appointments. We identified 20 deficiencies relating to this indicator, nine of which were significant.[11]

Access to Clinic Providers

CMF performed well with follow-up appointments nurses and providers ordered. Failure to ensure provider appointment availability can cause lapses in care. We reviewed 47 outpatient encounters in which provider follow-up appointments were ordered and identified six deficiencies.[12] The case below illustrates these deficiencies:

- In case 21, a provider requested a follow-up appointment with a provider for a patient in 14 days to review results from magnetic resonance imaging (MRI). However, the appointment occurred almost two months later. Although the patient was not harmed, the delay was below the standard of care.

Compliance testing showed that chronic care appointments did not occur timely (MIT 1.001, 60.0%); however, provider follow-up appointments (MIT 1.006, 100%) and RN-to-provider follow-up appointments (MIT 1.005, 92.3 %) occurred within the requested time frames.

11. We identified deficiencies in access to care in cases 3, 11, 12, 14, 18, 21, 22, 23, 27, 29, 30, 38, 41, 48, 76, and 77. Significant deficiencies occurred in cases 3, 11, 12, 21, 22, 23, 30, and 76.

12. Deficiencies in access to clinic providers were found in cases 12, 18, 21, 22, 29, and 41. Significant deficiencies were found in cases 12, 21, and 22.

Access to Specialized Medical Housing Providers

CMF provided good access to specialized medical housing providers. Compliance testing and case review found providers completed timely admission history and physical examinations for patients admitted to the correctional treatment center (CTC), outpatient housing unit (OHU), and hospice (MIT 13.002, 100%). Our case review clinicians did not identify any deficiencies in the completion of patient history and physicals upon a patient's admission to the specialized medical housing unit. However, a follow up patient evaluation and a progress note were late, respectively in the following cases:

- In case 14, a CTC provider evaluated the patient twelve days after the last encounter, which was beyond policy time frames.
- In case 30, a CTC provider did not document a progress note for fourteen days, which was beyond policy time frames.

Access to Clinic Nurses

CMF nurses always triaged patient sick calls the same day they were received (MIT 1.003, 100%) and frequently completed face-to-face patient appointments the same day (MIT 1.004, 89.7%). Case review identified two cases in which patients were not evaluated the same day the sick call was received.

RN care management and care coordination visits occurred within the specified time frames. The nurses monitored and educated patients about their chronic health conditions. RN follow-up appointments also occurred within the requested time frames.

Access to Specialty Services

CMF provided acceptable access to specialty services. Compliance testing showed high-priority access (MIT 14.001, 80.0%) and routine-priority access (MIT 14.007, 86.7%) were good, but medium-priority access (MIT 14.004, 60.0%) was not satisfactory. Access for specialty follow-up appointments were generally sufficient. Access for high-priority (MIT 14.003, 71.4%) and routine priority (MIT 14.009, 100%) follow-up appointments with specialists were acceptable to good, but access for medium priority (MIT 14.006, 60.0%) follow-up appointments with specialists was poor.

Our case review clinicians found CMF had good access to specialty services. Of the 138 specialty events we reviewed, we found only one minor deficiency regarding access to a specialist.

Follow-Up After Specialty Service

After April 2019, CCHCS policy no longer requires a follow-up appointment with a provider after most specialty appointments. Compliance testing found borderline performance (MIT 1.008, 73.8%) regarding access to providers after specialty services encounters.

In case reviews, we found nursing staff summarized specialists' recommendations and made the recommendations available to the providers. We identified deficiencies in the case below:

- In case 38, on two separate occasions an out-to-medical return nurse documented provider follow-up appointments within 14 days, but the appointments were not scheduled.

Follow-Up After Hospitalization

CMF performed very well with follow-up appointments after hospitalizations. Compliance testing scored 92.0 percent (MIT 1.007), and our case review clinicians found no deficiencies related to the scheduling of provider follow-up appointments after hospitalizations.

Follow-Up After Urgent or Emergent Care (TTA)

CMF providers saw their patients promptly after urgent or emergent care in the triage and treatment area (TTA). Our clinicians did not find any problems with access to follow-up appointments after TTA visits.

Follow-Up After Transferring Into the Institution

Our clinicians did not identify any delays in provider follow-up appointments for patients who transferred to CMF from other institutions. Patients who transferred from other institutions were seen within the required time frames (MIT 1.002, 80.0%). Our case review clinicians did not find any deficiencies in this area. We reviewed three transfer-in cases and found that all patients were seen by the provider as required.

On-Site Inspection

We met with scheduling supervisors and discussed the deficiencies we identified. We spoke with nurses and providers who reported no issues obtaining follow-up appointments with the nurses, providers, laboratory, or specialists. Providers reported having manageable workloads. Also, there were no reported appointment backlogs.

Recommendations

- Medical leadership should determine the cause of any challenges in providing timely chronic care appointments with providers and should implement remedial measures as appropriate.

Compliance Testing Results

Table 6. Access to Care

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
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? (1.001) *	15	10	0	60.0%
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002) *	20	5	0	80.0%
Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? (1.003) *	40	0	0	100%
Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed? (1.004) *	35	4	1	89.7%
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? (1.005) *	12	1	27	92.3%
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? (1.006) *	2	0	38	100%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame? (1.007) *	23	2	0	92.0%
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *,†	31	11	3	73.8%
Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? (1.101)	3	3	0	50.0%
			Overall percentage (MIT 1): **82.0%**	

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

† CCHCS changed its specialty policies in April 2019, removing the requirement for primary care physician follow-up visits following specialty services. As a result, we tested MIT 1.008 only for high-priority specialty services or when staff ordered follow-ups. The OIG continued to test the clinical appropriateness of specialty follow-ups through its case review testing.

Source: The Office of the Inspector General medical inspection results.

Table 7. Other Tests Related to Access to Care

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For patients received from a county jail: If, during the assessment, the nurse referred the patient to a provider, was the patient seen within the required time frame? (12.003) *	N/A	N/A	N/A	N/A
For patients received from a county jail: Did the patient receive a history and physical by a primary care provider within seven calendar days? (12.004) *	N/A	N/A	N/A	N/A
For CTC and SNF only (effective 4/2019, include OHU): Was a written history and physical examination completed within the required time frame? (13.002) *	10	0	0	100%
For OHU, CTC, SNF, and Hospice (applicable only for samples prior to 4/2019): Did the primary care provider complete the Subjective, Objective, Assessment, and Plan notes on the patient at the minimum intervals required for the type of facility where the patient was treated? (13.003) *,†	N/A	N/A	N/A	N/A
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? (14.001) *	12	3	0	80.0%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	5	2	8	71.4%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or the Physician Request for Service? (14.004) *	9	6	0	60.0%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	3	2	10	60.0%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007) *	13	2	0	86.7%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	9	0	6	100%

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

† CCHCS changed its policies and removed mandatory minimum rounding intervals for patients located in specialized medical housing. After April 2, 2019, MIT 13.003 only applied to CTCs that still had state-mandated rounding intervals. OIG case reviewers continued to test the clinical appropriateness of provider follow-ups within specialized medical housing units through case reviews.

Source: The Office of the Inspector General medical inspection results.

Overall Rating
Inadequate

Case Review Rating
Adequate

Compliance Score
Inadequate
(52.5%)

Diagnostic Services

In this indicator, OIG inspectors evaluated the institution's ability to timely complete radiology, laboratory, and pathology tests. Our inspectors determined whether the institution properly retrieved the resultant reports and whether providers reviewed the results correctly. In addition, in Cycle 6, we examined the institution's ability to timely complete and review stat (immediate) laboratory tests.

Results Overview

CMF performed poorly in completing and retrieving diagnostic tests. Specifically, the handling of stat diagnostics and pathology reports had room for improvement. The providers often did not endorse the diagnostic reports timely or send result letters to patients.

In this indicator, compliance testing resulted in an inadequate rating, while the case review analysis showed an adequate rating. Both compliance and case review clinicians found the handling of stat diagnostics was poor, but the handling of routine laboratory and radiology services was good. Both compliance and case review showed CMF had problems with endorsement of diagnostic studies, which were not completed within required time frames. Our case review clinicians found these deficiencies did not significantly affect patient care in the specific cases we reviewed. However, proper adherence to health information management policies reduces the risk of harm to patients. After reviewing all aspects, we rated this indicator as ***inadequate***.

Case Review Results

We reviewed 241 diagnostic events and found 31 deficiencies, 13 of which were significant. Of the 31 deficiencies identified, 28 were related to health information management and three pertained to diagnostic test completion.[13] Most deficiencies were due to late endorsements by providers. Five of 22 providers were responsible for all the late endorsements. Case review clinicians found poor stat laboratory performance at CMF, as the two stat laboratory tests in the case reviews were not done. Regarding deficiencies related to health information management, we considered test reports that were never retrieved or reviewed to be as severe of a problem as tests that were never performed.

Test Completion

The institution had excellent performance completing radiology services (MIT 2.001, 100%), but less so with completing laboratory services (MIT 2.004, 70.0%) within required time frames. Performance was also poor for stat laboratory services (MIT 2.007, 50.0%). Case review results concurred

13. We identified deficiencies in cases 3, 11, 12, 13, 14, 16, 17, 21, 23, 30, 38, and 77. Cases 3, 11, 12, 13, 14, 16, 17, 21, 23, 30, 38, and 77 were related to health information management of diagnostics.

with compliance test results. CMF performed well with completion of routine laboratory and radiology services. We only found problems with the completion of stat laboratory tests and a time-specified laboratory draw:

- In case 11, a provider ordered stat laboratory tests and an X-ray. The tests were not performed stat as ordered.
- In case 3, a provider ordered a stat magnesium blood test. The test had to be reordered the next day to be completed, which was beyond the stat time frame.
- In case 23, a provider ordered a time-sensitive blood draw, but it did not occur and had to be reordered to be completed.

Health Information Management

Compliance testing showed that providers reviewed radiology reports (MIT 2.002, 80.0%) and laboratory results (MIT 2.005, 100%) timely, but often did not send result letters to the patient (MIT 2.006, zero). Nurses performed poorly in notifying the provider of stat laboratory results (MIT 2.008, 20.0%). Although the institution retrieved pathology reports within policy time frames (MIT 2.010, 80.0%), it did not ensure providers reviewed (MIT 2.011, 40.0%) or sent letters (MIT 2.012, zero) to the patients.

Case review clinicians found similar problems with providers not endorsing diagnostic results.[14] Five of the 22 providers were responsible for these late endorsements.

- In case 38, providers did not endorse proBNP[15] laboratory results timely on two separate occasions. This placed the patient at increased risk of untreated heart failure.

Case review clinicians also identified a few instances where final results were scanned late. These occurred in cases 14 and 77.

Clinician On-Site Inspection

Laboratory supervisors described the steps necessary for laboratory results to show up in the electronic health record system (EHRS). The labs drawn on-site by phlebotomists are sent to an independent laboratory, Quest Diagnostics, which is contracted to run the tests. Quest Diagnostics transfers the results back into the EHRS and providers receive the results in their inboxes. Because laboratory tests that are ordered as miscellaneous tests have to be manually scanned into the EHRS, laboratory staff send a hard copy to health information management (HIM) for scanning. The laboratory supervisor checks pending inquiries daily and follows up if any results have not posted. Radiology examinations are sent electronically via the radiology

14. Providers did not endorse diagnostic reports or endorsed them late in cases 3, 11, 12, 13, 16, 17, 21, 23, 29, 38, and 77. Significant deficiencies occurred in cases 3, 16, and 38.

15. proBNP is a laboratory test that indicates congestive heart failure.

information system/picture archiving and communication system (RIS/PACS) to the radiologist, who reads the examination and prepares the report. The radiologist then sends the report back to the EHRS. Providers are expected to check their results folder, review and endorse the results, and send a patient results letter.

Recommendations

- The department should consider developing and implementing a letter template for patient results that autopopulates with all the elements required per CCHCS policy.
- Laboratory and nursing leadership should develop and implement internal auditing to ensure stat laboratory orders are completed within ordered time frames.
- Medical leadership should ascertain causative factors in the untimely provider endorsement of all diagnostic reports and sending of complete patient results letters.

Compliance Testing Results

Table 8. Diagnostic Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Radiology: Was the radiology service provided within the time frame specified in the health care provider's order? (2.001) *	10	0	0	100%
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) *	8	2	0	80.0%
Radiology: Did the ordering health care provider communicate the results of the radiology study to the patient within specified time frames? (2.003)	0	10	0	0
Laboratory: Was the laboratory service provided within the time frame specified in the health care provider's order? (2.004) *	7	3	0	70.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) *	10	0	0	100%
Laboratory: Did the health care provider communicate the results of the laboratory test to the patient within specified time frames? (2.006)	0	10	0	0
Laboratory: Did the institution collect the STAT laboratory test and receive the results within the required time frames? (2.007) *	5	5	0	50.0%
Laboratory: Did the nursing staff notify the health care provider within one (1) hour from receiving the STAT laboratory results? (2.008) *	2	8	0	20.0%
Laboratory: Did the health care provider endorse the STAT laboratory results within the required time frames? (2.009)	9	1	0	90.0%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	8	2	0	80.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	4	6	0	40.0%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	10	0	0
				Overall percentage (MIT 2): **52.5%**

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
(N/A)

Emergency Services

In this indicator, OIG clinicians evaluated the quality of emergency medical care. Our clinicians reviewed emergency medical services by examining the timeliness and appropriateness of clinical decisions made during medical emergencies. Our evaluation included examining the emergency medical response, cardiopulmonary resuscitation (CPR) quality, triage and treatment area (TTA) care, provider performance, and nursing performance. Our clinicians also evaluated the Emergency Medical Response Review Committee's (EMRRC) ability to identify problems with its emergency services. The OIG assessed the institution's emergency services through case review only; we did not perform compliance testing for this indicator.

Results Overview

As in Cycle 5, CMF delivered adequate emergency care. We recognized that most of the time medical staff and custody staff worked cohesively to render emergency aid, promptly initiate CPR, and efficiently transfer patients to a higher level of care. However, we identified documentation and assessment deficiencies in both provider and nursing performance. Supervising registered nurses missed some deficiencies in their review of emergency events; we identified these missed deficiencies in several cases. Overall, the OIG rated this indicator ***adequate***.

Case Review Results

Our clinicians reviewed 55 urgent and emergent events and found 47 emergency care deficiencies, six of which were significant.[16]

Emergency Medical Response

CMF staff responded promptly and appropriately to emergency medical responses throughout the institution. CPR was initiated by first responders; activation of emergency medical services occurred when appropriate; and additional essential medical care was provided by the TTA staff. We did not identify any lapses in emergency medical responses.

Cardiopulmonary Resuscitation Quality

The OIG reviewed five cases requiring cardiopulmonary resuscitation.[17] CMF staff immediately initiated CPR, activated emergency response, requested emergency medical response (EMS), and notified TTA staff in a timely manner. All emergency responses occurred in the housing units requiring TTA staff response, while one event occurred in the

16. Deficiencies occurred in cases 3, 4, 5, 6, 7, 8, 11, 18, 19, 23, 24, 25, 26, 29, 30, 37, 38, 76, and 77. Major deficiencies occurred in cases 6, 23, 24, 29, 38, and 76.

17. CPR occurred in cases 4, 5, 6, 7, and 8.

specialized medical housing unit. Emergency care was also provided by the CTC staff.

Provider Performance

CMF providers performed well in urgent and emergent situations, and in providing care after hours. Most of the time, they made good decisions and assessments, with the following exceptions:

- In case 24, a TTA provider changed a patient's antibiotics to treat cellulitis, a skin infection, but did not order the antibiotic to start the same day.
- In case 38, a TTA provider considered the diagnosis of congestive heart failure in a patient with shortness of breath. Signs of congestive heart failure include fluid overload, as shown by distended neck veins. However, the provider did not examine the patient's neck.

The provider on-call did not always generate a note to document the thought process and reasoning. We found this in cases 24, 76, and in the following:

- In case 23, a provider on-call was notified by the TTA RN that a patient refused to go to the TTA and had low blood pressure that worsened with upright posture. The provider did not document a note, did not order follow-up, and did not address the electrocardiogram (EKG).

In two cases, TTA RNs documented that a provider on-call was unreachable by phone. These two deficiencies did not significantly affect patient care: the patient was sent out to the hospital as necessary in one case, and the notification concerned elevated blood sugar levels in the other case.

Nursing Performance

CMF nurses performed well during emergency events most of the time. While their assessments were often incomplete, they provided adequate care to their patients and we identified no delays in initiating treatment.

Other areas for improvement are reassessing patients after they receive medication and providing patient discharge instructions on a consistent basis.

Nursing Documentation

CMF nurses provided good care but documented poorly. Documentation deficiencies were identified in 12 of the 20 cases we reviewed. We identified that times for emergency events were often missing, specifically the times the patient arrived in the TTA, the times EMS was called and when EMS arrived on scene, and the times the patient was transferred to a higher level of care. We also identified intermittent documentation of reports given to emergency medical services (EMS)

or emergency room (ER) staff. These documentation deficiencies were minor and did not affect patient care.

Emergency Medical Response Review Committee

The EMRRC met weekly and all emergency responses were reviewed timely. Nursing supervisors completed EMRRC audits, identified areas for improvement, and provided training to staff. However, in eight of the 11 events, the OIG identified deficiencies and noted inaccurate audit information.[18] Below is an example:

- In case 4, nursing staff did not assess skin moisture, skin temperature, and skin color, and did not document the presence or absence of ligature marks or additional trauma in a patient found hanging in his housing unit. The EMRRC review of this emergency event noted ligature marks on the patient's anterior neck and did not identify the inadequate assessment.

Most deficiencies we identified were related to incomplete or inaccurate times and did not affect patient care.

Clinician On-Site Inspection

CMF had a newly constructed triage and treatment area (TTA) that housed five completed and fully functional bays. The TTA had one fully stocked crash cart and several procedure carts. Staffing in the TTA consisted of two RNs on the first watch, and three RNs on the second and the third watches. A full-time provider was available Monday through Friday from 8 a.m. to 4 p.m. Nursing staff contacted the physician on-call after hours, on weekends, and on holidays. TTA staff are notified via radio and respond to all emergencies within the institution equipped with a gurney, emergency bags, and an AED. RNs utilize a pocket-sized information form to gather data, including times, vitals, observations, and interventions, while responding to emergency events. A code board lists the staff currently working during each shift as well as the responsibilities for each staff member for CPR events. This board is updated every shift.

The chief nurse executive advised us that the emergency medical response plan had rolled out to all staff and that emergency drills were current and ongoing.

18. EMRRC deficiencies were identified in cases 3, 4, 5, 7, and 11; deficiencies were identified twice in cases 23 and 37.

Recommendations

- Nursing leadership should determine the root cause of challenges that prevent nurses from completely and accurately documenting emergent events, and should implement remedial measures as appropriate.
- Nursing leadership should consider developing and implementing an internal audit to ensure that nurses completely and accurately document patient monitoring and assessments.
- The EMRRC should more thoroughly review emergency response events and accurately detail findings.

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
Inadequate
(66.4%)

Health Information Management

In this indicator, OIG inspectors evaluated the flow of health information, a crucial link in high-quality medical care delivery. Our inspectors examined whether the institution retrieved and scanned critical health information (progress notes, diagnostic reports, specialist reports, and hospital-discharge reports) into the medical record in a timely manner. Our inspectors also tested whether clinicians adequately reviewed and endorsed those reports. In addition, our inspectors checked whether staff labeled and organized documents in the medical record correctly.

Results Overview

Compliance testing and case review found CMF performed poorly in health information management. Compliance testing found that the areas of hospital discharge reporting, specialty reporting, diagnostic reporting, and document scanning were all in some need of improvement. Case review also found delays in the retrieval of hospital records, specialty records, and diagnostic records. Most of the deficiencies pertained to delays in providers' reviews of these reports. This continues a pattern we observed in Cycle 5. Due to poor compliance scores and the potential for missed or delayed care, we assigned this indicator the overall rating of ***inadequate***.

Case Review Results

The OIG clinicians reviewed 1,289 events and found 95 deficiencies related to health information management, 39 of which were significant.

Hospital-Discharge Reports

Compliance testing showed CMF often obtained the required elements of hospital discharge records and providers reviewed the discharge records (MIT 4.003, 90.0%). However, the discharge records frequently did not include a discharge summary (MIT 4.005, 72.0%).

Case reviewers examined 20 off-site emergency department and hospital visits and found similar results. CMF had problems retrieving hospital records and ensuring providers reviewed the records within policy time frames. Below are examples of the delays identified in case review:[19]

- In case 77, a patient was seen in an emergency department. The institution obtained the report nine days later. This was outside CCHCS policy time frames.
- In case 29, CMF did not ensure that a provider reviewed a patient's emergency department report. At the following provider appointments, the emergency visit was not reviewed

19. HIM deficiencies in hospital discharge reports occurred in cases 3, 10, 14, 16, 18, 23, 28, 29, 38, and 77.

nor discussed with the patient. This subjected the patient to an increased risk of poor care.

Specialty Reports

CMF performed poorly in the handling of specialty reports. Compliance testing showed a 70.0 percent retrieval of the reports (MIT 4.002) and low rates of provider reviews of routine-priority (MIT 14.002, 46.7%), high-priority (MIT 14.005, 26.7%), and medium-priority specialty reports (MIT 14.008, 35.7%). Case review analysis also found problems with retrieving reports and ensuring that providers endorsed these reports within policy time frames. We also discuss these findings in the **Specialty Services** indicator.

Diagnostic Reports

In compliance testing, CMF performed poorly with the HIM of diagnostic reports. Nursing staff often did not notify providers of stat laboratory results and providers often did not endorse these results (MIT 2.008, 20.0%). The providers scored low in reviewing pathology results (MIT 2.011, 40.0%) and did not communicate pathology results to the patient (MIT 2.012, 0%).

Case review found that several providers did not endorse their diagnostic reports within policy time frames. Providers did not always generate letters to notify patients of their laboratory results; however, providers generally discussed results with patients at the next subsequent encounter. Please refer to the **Diagnostic Services** indicator for further discussion on diagnostic reports.

Urgent and Emergent Records

OIG clinicians reviewed 55 emergency care events and found that CMF nurses and providers recorded these events sufficiently. Case reviewers found one minor deficiency: In case 7, an electrocardiogram (EKG) performed during a resuscitation event was not available in the EHRS. Refer to the **Emergency Services** indicator for additional information regarding emergency care documentation.

Scanning Performance

CMF performed poorly during the scanning process. Compliance testing found poor performance in scanning, labeling, and filing (MIT 4.004, zero). OIG clinicians also identified deficiencies related to mislabeled, misfiled, and missing documents.[20]

20. Deficiencies were found in cases 7, 18, 21, 22, 29, and 38.

Clinician On-Site Inspection

We discussed health information management processes with CMF health information management supervisors, ancillary staff, diagnostic supervisors, nurses, and providers. Medical records supervisors described the processes of retrieving documents from on-site and off-site reports. Health records technicians stated that their responsibilities only included scanning the reports into EHRS and routing them to the providers. Nursing leadership tasked TTA RNs and specialty RNs with notifying providers of specialists' recommendations.

Recommendations

- Medical leadership should remind all staff to properly use correct labeling for patient letters when entering information into the electronic medical record.
- TTA nursing supervisors should audit stat laboratory draws to ensure providers are notified within required time frames.
- Medical leadership should determine the root cause of challenges in timely provider reviews of diagnostic and off-site reports, and should implement remedial measures as appropriate.

Compliance Testing Results

Table 9. Health Information Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Are health care service request forms scanned into the patient's electronic health record within three calendar days of the encounter date? (4.001)	20	0	20	100%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	21	9	15	70.0%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	18	2	5	90.0%
During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? (4.004) *	0	24	0	0
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005) *	18	7	0	72.0%
Overall percentage (MIT 4): **66.4%**				

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Table 10. Other Tests Related to Health Information Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Radiology: Did the ordering health care provider review and endorse the radiology report within specified time frames? (2.002) *	8	2	0	80.0%
Laboratory: Did the health care provider review and endorse the laboratory report within specified time frames? (2.005) *	10	0	0	100%
Laboratory: Did the nursing staff notify the health care provider within one (1) hour from receiving the STAT laboratory results? (2.008) *	2	8	0	20.0%
Pathology: Did the institution receive the final pathology report within the required time frames? (2.010) *	8	2	0	80.0%
Pathology: Did the health care provider review and endorse the pathology report within specified time frames? (2.011) *	4	6	0	40.0%
Pathology: Did the health care provider communicate the results of the pathology study to the patient within specified time frames? (2.012)	0	10	0	0
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002) *	7	8	0	46.7%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	4	11	0	26.7%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) *	5	9	1	35.7%

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Health Care Environment

Overall Rating
Inadequate

Case Review Rating
(N/A)

Compliance Score
Inadequate
(69.7%)

In this indicator, OIG compliance inspectors tested clinics' waiting areas, infection control, sanitation procedures, medical supplies, equipment management, and examination rooms. Inspectors also tested clinics' ability to maintain auditory and visual privacy for clinical encounters. Compliance inspectors asked the institution's health care administrators to comment on their facility's infrastructure and its ability to support health care operations. The OIG rated this indicator solely on the compliance score, using the same scoring thresholds as in the Cycle 4 and Cycle 5 medical inspections. Our case review clinicians do not rate this indicator.

Compliance Testing Results

In this indicator, CMF's performance declined compared with its performance in Cycle 5. Multiple aspects of CMF's health care environment needed improvement: the medical warehouse contained expired medical supplies; multiple clinics lacked medical supplies or contained improperly calibrated or nonfunctional equipment; emergency medical response bag (EMRB) logs were missing staff verification; and staff did not regularly sanitize their hands before or after examining patients. These factors resulted in an ***inadequate*** rating for this indicator.

Outdoor Waiting Areas

CMF had no waiting areas that required patients to be outdoors.

Indoor Waiting Areas

We inspected indoor waiting areas. Health care custody staff reported that existing waiting areas had sufficient seating capacity. In addition, CMF had signs on the bench stating that the bench must be left empty to maintain six feet of social distancing between patients (see Photo 1, right).

Photo 1. Indoor waiting area (photographed on June 17, 2020).

During our inspection, we did not observe overcrowding or noncompliance with social distancing in any of the clinics' indoor waiting areas. However, we observed patients not wearing their masks properly (see Photo 2, below, and Photo 3, next page), and we did not notice health care staff or custody staff educating the patients regarding this matter. We noticed information posted in the clinics regarding social distancing and the proper use of masks.

Photo 2. Patient not wearing face mask properly (photographed on June 17, 2020).

Photo 3. The patient walked into the clinic with a lollipop and was not wearing his mask properly. The custody and the nursing staff did not educate the patient regarding proper mask usage (photographed on June 17, 2020).

Clinic Environment

Eight of the nine clinic environments were sufficiently conducive to medical care; they provided reasonable auditory privacy, appropriate waiting areas, wheelchair accessibility, and nonexamination room workspace (MIT 5.109, 88.9%). In one clinic, the configuration of the blood draw stations did not provide auditory privacy.

All the clinics we observed contained appropriate space, configuration, supplies, and equipment to allow clinicians to perform proper clinical examinations (MIT 5.110, 100%).

Clinic Supplies

Six of the 15 clinics followed adequate medical supply storage and management protocols (MIT 5.107, 40.0%). We found one or more of the following deficiencies in all nine clinics: unidentified medical supplies, cleaning materials stored with medical supplies, and staff members' personal items and food stored with medical supplies (see Photo 4, below).

Photo 4. Medical supplies stored with cleaning supplies and staff's personal items and food (photographed on June 17, 2020).

Nine of the 15 clinics met requirements for essential core medical equipment and supplies (MIT 5.108, 60.0%). The remaining six clinics lacked medical supplies or contained improperly calibrated or nonfunctional equipment. The missing items included a peak flow meter and an oto-ophthalmoscope. The staff had not properly calibrated a vital sign machine and weight scales. We found the Snellen reading chart was placed at an improper distance, a nonstandard Snellen reading chart had been printed, and tongue depressors were stored in an unsanitary manner (see Photo 5, below). We also found that CMF staff had not properly logged the results of the defibrillator performance test or the automated external defibrillator (AED) checklist within the last 30 days.

Photo 5. Unsanitary storage of tongue depressors (photographed on June 15, 2020).

We examined emergency medical response bags (EMRBs) to determine if they contained all essential items. We checked whether staff inspected the bags daily and inventoried them monthly. Only two of the seven EMRBs passed our test (MIT 5.111, 28.6%). We found one or more of the following deficiencies with five EMRBs: staff failed to ensure the EMRB compartments were sealed and intact, the EMRB lacked one naloxone medication, and staff had not inventoried the EMRBs when seal tags were replaced or had not inventoried the EMRBs in the past 30 days.

Photo 6. Expired oxygen tubing dated May 2020 (photographed on June 19, 2020).

Medical Supply Management

None of the medical supply storage areas located outside the medical clinics stored medical supplies adequately (MIT 5.106, zero). We found that multiple medical supplies were stored beyond the expiration date noted by the manufacturer (see Photo 6, left. In addition, during our tour of the medical warehouse, the secured area where sharps[21] were stored was left open, unlocked when not in active use, and available to incarcerated person porters.

21. *Sharps* is a medical term for devices with sharp points or edges that can puncture or cut the skin. Examples include needles, syringes, surgical blades, and lancets for checking fingerstick sugar levels.

According to the chief executive officer (CEO), the institution was not concerned about the medical supplies process. Health care managers and medical warehouse managers expressed no concerns about the medical supply chain or their communication process.

Infection Control and Sanitation

Staff appropriately cleaned, sanitized, and disinfected 14 of 15 clinics (MIT 5.101, 93.3%). In one clinic, cleaning logs were not maintained.

Staff in all clinics (MIT 5.102, 100%) properly sterilized or disinfected medical equipment. We found operating sinks and hand hygiene supplies in the examination rooms in all clinics (MIT 5.103, 100%).

We observed patient encounters in nine clinics. In four clinics, clinicians did not wash their hands before or after examining their patients, before applying gloves, and after performing blood draws (MIT 5.104, 55.6%). Health care staff in all clinics followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste (MIT 5.105, 100%).

Physical Infrastructure

At the time of the compliance inspection, CMF was renovating and adding clinic spaces for the pharmacy and for one medical clinic. These projects began February 2020, and health care managers estimated delays for completing these projects (from August 2020 to December 2020) due to COVID-19. Despite the projected delays, the CEO did not believe this would negatively impact the institution's ability to provide good patient care (MIT 5.999).

Recommendations

- Nursing leadership should consider performing random spot checks to ensure that staff follow equipment and medical supply management protocols.
- Medical leadership should remind staff to follow universal hand hygiene precautions. Implementing random spot checks could improve compliance.
- Nursing leadership should have each clinic nurse supervisor review the monthly EMRB logs to ensure that the EMRBs are regularly inventoried and sealed.

Compliance Testing Results

Table 11. Health Care Environment

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Infection control: Are clinical health care areas appropriately disinfected, cleaned, and sanitary? (5.101)	14	1	0	93.3%
Infection control: Do clinical health care areas ensure that reusable invasive and noninvasive medical equipment is properly sterilized or disinfected as warranted? (5.102)	13	0	2	100%
Infection control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? (5.103)	15	0	0	100%
Infection control: Does clinical health care staff adhere to universal hand hygiene precautions? (5.104)	5	4	6	55.6%
Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? (5.105)	15	0	0	100%
Warehouse, conex, and other nonclinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program? (5.106)	0	1	0	0
Clinical areas: Does each clinic follow adequate protocols for managing and storing bulk medical supplies? (5.107)	6	9	0	40.0%
Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies? (5.108)	9	6	0	60.0%
Clinical areas: Are the environments in the common clinic areas conducive to providing medical services? (5.109)	8	1	6	88.9%
Clinical areas: Are the environments in the clinic exam rooms conducive to providing medical services? (5.110)	13	0	2	100%
Clinical areas: Are emergency medical response bags and emergency crash carts inspected and inventoried within required time frames, and do they contain essential items? (5.111)	2	5	8	28.6%
Does the institution's health care management believe that all clinical areas have physical plant infrastructures that are sufficient to provide adequate health care services? (5.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
	Overall percentage (MIT 5): **69.7%**			

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Transfers

Overall Rating ***Inadequate***

Case Review Rating ***Adequate***

Compliance Score ***Inadequate*** **(62.6%)**

In this indicator, OIG inspectors examined the transfer process for patients who transferred into the institution, as well as for those who transferred to other institutions. For newly arrived patients, our inspectors assessed the quality of health screenings and the continuity of provider appointments, specialist referrals, diagnostic tests, and medications. For patients who transferred out of the institution, inspectors checked whether staff reviewed patient medical records and determined the patient's need for medical holds. They also assessed if staff transferred patients with their medical equipment and gave correct medications before patients left. In addition, our inspectors evaluated the ability of staff to communicate vital health transfer information, such as preexisting health conditions, pending appointments, tests, and specialty referrals; and inspectors confirmed if staff sent complete medication transfer packages to the receiving institution. For patients who returned from off-site hospitals or emergency rooms, inspectors reviewed whether staff appropriately implemented the recommended treatment plans, administered necessary medications, and scheduled appropriate follow-up appointments.

Results Overview

CMF's performance for this indicator was poor. Compliance testing scored low in specialty appointment continuity, medication continuity, and the initial health assessments of patients transferring in. Hospitalization was another area with poor performance in medication continuity, nursing assessments, order reconciliation, and the health information management of hospital records. Transfer-out performance was acceptable for both compliance testing and case review. Most of the case review deficiencies involved improper nursing assessments and health information management. Factoring both compliance testing and case review, for this indicator, CMF received a rating of ***inadequate***.

Case Review Results

OIG clinicians reviewed 30 events in 23 cases in which patients transferred into and out of the institution or returned from an off-site hospital or emergency room.[22] Of the 30 events, case reviewers identified 32 deficiencies, 12 of which were significant.[23] Of the 12 significant deficiencies, only two were related to transfers in and transfers out. Hospitalization deficiencies pertained mainly to health information management.

22. We reviewed cases 3, 9, 10 11, 14, 16, 18, 23, 24, 25, 26, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, and 77.

23. Deficiencies occurred in cases 3, 10, 14, 16, 18, 23, 24, 25, 26, 28, 31, 33, 34, 36, 38, and 77. Significant deficiencies occurred in cases 3, 14, 23, 33, 36, 38, and 77.

Transfers In

According to compliance testing, CMF performed poorly in managing patients transferring into the institution. Specialty services appointments for patients who arrived at CMF did not always occur within the required time frame (MIT 14.010, 60.0%). Appointments were two to 91 days late. Additionally, when patients transferred from one housing unit to another, 16 of 25 patients received medications without interruption (MIT 7.005, 64.0%). Only 28.6 percent (MIT 7.006) of the patients en route to another institution received their medications without interruption. Case review clinicians examined three cases of patients transferring to CMF from another institution and identified four deficiencies, one of which was significant.[24]

For patients with medications transferring into the institution, the medications were administered or delivered without interruption at a rate of 70.6 percent (MIT 6.003). Case review revealed one deficiency:

- In case 33, a patient transferred into CMF and received his keep-on-person medications five days after he arrived. These critical medications included a daily antiviral medication and diuretic blood pressure medication. This delay placed the patient at increased medical risk.

Although case review only identified one case in which the receiving and release (R&R) nurse did not complete an initial health screening, compliance testing identified that the R&R nurses did not complete an initial health screening in all but one case.[25] Compliance testing found poor performance (MIT 6.001, zero) due to incomplete medical information in the initial health screenings. Nurses did not obtain explanations for pertinent health-related questions, and in TB screenings, they did not ask patients whether they were experiencing fatigue.

R&R nurses performed well for MIT 6.002, scoring 100 percent. Nurses completed the assessment and disposition section of the initial health screening form for all 25 patients tested. Furthermore, CMF providers mostly evaluated new arrivals to the facility within the required time frame (MIT 1.002, 80.0%).

Transfers Out

CMF performed acceptably in transferring patients to other institutions. Our OIG clinicians reviewed three cases of patients transferring out of CMF and identified two deficiencies, one of which was significant.[26] The nurses usually completed the health care information form prior to the transfer, identified pending appointments, and ensured required

24. We reviewed the following transfer-in cases: 31, 32, and 33. Deficiencies occurred in cases 31 and 33. A significant deficiency occurred in case 33.

25. A nurse did not complete the initial health screening in case 31.

26. We reviewed the following transfer-out cases: 34, 35, and 36. Deficiencies occurred in cases 34 and 36. A significant deficiency occurred in case 36.

medications were included in the transfer packages. However, we identified one exception.

- In case 36, a nurse did not perform a face-to-face evaluation twenty-four hours prior to patient transfer, did not ensure the patient had his rescue inhaler, and failed to communicate pending referrals for the patient to see specialists in gastroenterology and endocrinology.

Our compliance findings showed that four of five patient transfer packages included required medications and transfer documents (MIT 6.101, 80.0%).

Hospitalizations

Patients returning from an off-site hospitalization or emergency room are at high-risk for lapses in quality care. These patients typically experience severe illness or injury. They require more care and place strain on the institution's resources. Because these patients have complex medical issues, the successful transfer of health information is necessary for quality care. Any transfer lapse can result in serious consequences for these patients.

CMF performed poorly with hospital returns. We reviewed 24 events in 17 cases for which patients were discharged from a hospitalization or returned from an emergency room visit.[27] We identified 26 deficiencies, 10 of which were significant.[28] Significant deficiencies included incomplete nursing assessments and late retrieval of hospital discharge documents and provider endorsements. Incomplete nursing assessments occurred in cases 3, 23, 26, and 28. TTA nurses did not perform assessments such as an abdominal assessment for a patient who returned with a diagnosis of pancreatitis, did not take the patient's blood pressure or assess pain levels, and did not obtain the weight of a patient who was treated for congestive heart failure.

- In case 23, a nurse did not complete a patient assessment when a patient returned from an emergency room visit where he was treated for hypoglycemia (low blood sugar).

CMF did not ensure medication continuity for patients returning from the hospital. When patients were discharged from the hospital, compliance testing showed one of 25 patients received hospital recommended medications within the required time frame (MIT 7.003, 4.0%). They included antibiotics, asthma, blood pressure, and diabetes medications. Case reviewers identified the following deficiencies:

- In case 23, a patient did not receive his antibiotic and insulin on the day he returned from the hospital. This was significant because the medications were necessary for proper healing.

27. We reviewed the following hospitalization cases: 3, 9, 10, 11, 14, 16, 18, 23, 24, 25, 26, 28, 29, 30, 37, 38, and 77.

28. Hospitalization deficiencies occurred in cases 3, 10, 14, 16, 18, 23, 24, 25, 26, 28, 38, and 77. Significant deficiencies occurred in cases 14, 23, 38, and 77.

- In case 38, a provider did not reconcile a patient's medications. As a result, the patient received a prolonged course of a high dosage of amiodarone, a heart medication, which has side effects of lung and thyroid toxicity.

Hospital discharge reports usually included key elements and the provider reviewed them within five calendar days (MIT 4.005, 72.0%). Our compliance results showed community hospital discharge documents scanned into patients' electronic health record within three days of discharge (MIT 4.003, 90.0%). However, our case reviewers identified late retrieval of hospital discharge documents and late provider signatures in eight cases.[29] Please refer to the **Health Information Management** indicator for further discussion. Provider follow-ups after a hospitalization or emergency room visit frequently occurred within the required time frame (MIT 1.007, 92.0%).

Clinician On-Site Inspection

The receiving and release (R&R) nurse was knowledgeable about transfer processes. The clinic had sufficient space, including an examination room, to interview and evaluate patients. An emergency response bag and an automated external defibrillator (AED) were available at the clinic. An average of 20 to 50 patients transfer in and out of CMF weekly. Additional nursing staff is available when needed to complete the transfer process. Due to the COVID-19 pandemic, CMF transfers patients in and out of CMF only when necessary. When there are no patients transferring in and out of the institution, the R&R nurse is redirected to assist in other nursing areas.

Recommendations

- Nursing leadership should determine the cause of challenges in the timely and uninterrupted provision of medications to newly arriving patients and hospital discharge patients, and should implement remedial measures as appropriate.
- The department should consider developing and implementing an electronic alert to ensure that receiving and release (R&R) nurses properly complete initial health screening questions and follow up as needed.
- Nursing leadership should develop and implement auditing measures to ensure staff complete thorough assessments for patients returning from hospitalizations.

29. The following hospitalization cases included health information management deficiencies for hospital documents: 3, 10, 14, 16, 18, 23, 28, 38, and 77.

Compliance Testing Results

Compliance On-Site Inspection

The R&R nurse prepared and verified the contents of transfer packets for patients transferring out of the institution. However, for one patient, the nurse did not physically verify if the patient was in possession of a rescue inhaler.

We also observed a face-to-face encounter wherein a patient refused to keep a rescue inhaler in his possession due to his fear of contracting COVID-19 if he used the inhaler during transport. The R&R nurse acknowledged the patient's refusal but did not educate the patient regarding how COVID-19 is transmitted and of the importance of having the rescue inhaler medication on person. Our compliance inspector intervened before the patient transferred out of the institution, and advised the patient to keep the rescue inhaler on person. The patient ultimately recognized the importance of the medication and kept it.

Table 12. Transfers

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
For endorsed patients received from another CDCR institution or COCF: Did nursing staff complete the initial health screening and answer all screening questions within the required time frame? (6.001) *	0	25	0	0
For endorsed patients received from another CDCR institution or COCF: When required, did the RN complete the assessment and disposition section of the initial 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? (6.002)	25	0	0	100%
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? (6.003) *	12	5	8	70.6%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? (6.101) *	4	1	5	80.0%
				Overall percentage (MIT 6): **62.6%**

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Table 13. Other Tests Related to Transfers

Compliance Questions	Scored Answer Yes	No	N/A	Yes %
For endorsed patients received from another CDCR institution: Based on the patient's clinical risk level during the initial health screening, was the patient seen by the clinician within the required time frame? (1.002) *	20	5	0	80.0%
Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment with a primary care provider within the required time frame? (1.007) *	23	2	0	92.0%
Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? (4.003) *	18	2	5	90.0%
For patients discharged from a community hospital: Did the preliminary or final hospital discharge report include key elements and did a provider review the report within five calendar days of discharge? (4.005) *	18	7	0	72.0%
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? (7.003) *	1	24	0	4.0%
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	16	9	0	64.0%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006) *	2	5	0	28.6%
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? (14.010) *	12	8	0	60.0%

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Medication Management

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
Inadequate
(61.6%)

In this indicator, OIG inspectors evaluated the institution's ability to administer prescription medications on time and without interruption. The inspectors examined this process from the time a provider prescribed medication until the nurse administered the medication to the patient. When rating this indicator, the OIG strongly considered the compliance test results, which tested medication processes to a much greater degree than case review testing. In addition to examining medication administration, our compliance inspectors also tested many other processes, including medication handling, storage, error reporting, and other pharmacy processes.

Results Overview

CMF performed poorly in this indicator. The overall compliance score was lower than in Cycle 5. Compliance scores were low for new medication prescriptions, chronic care medication continuity, hospital discharge medications, specialized medical housing medications, and layover medication continuity. Compliance scores for patients transferring into the institution, within the institution, and out of the institution were better. Case review clinicians examined 28 cases in which 19 had medication related deficiencies. Thirteen of these 28 cases had significant deficiencies. Case review clinicians also found gaps in chronic care medications and problems with the administration of direct observed therapy or nurse-administered medications. Both compliance and case review rated this indicator ***inadequate***.

Case Review Results

We reviewed 28 cases (146 events) related to medication management and found 52 medication deficiencies, 31 of which were significant.[30] Most of the deficiencies were delays in the delivery of chronic care medications and delays in medication administration.

New Medication Prescriptions

CMF performed poorly in managing new medication prescriptions. Compliance results showed that patients did not receive their newly prescribed medications timely. In reviewing the compliance findings, most of the medications were not available on the date the provider ordered (MIT 7.002, 24.0%). Most of the patients tested did not receive their medications because the medications were not available by the ordered administration date. Some patients refused medications and the nurse did not document a reason for the refusal. Case review identified the following deficiencies:

30. For medication management, we reviewed the following cases: 3, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 37, 38, 72, 74, 76, and 77. Deficiencies occurred in cases 11, 14, 16, 18, 19, 20, 21, 22, 23, 24, 25, 28, 29, 30, 33, 37, 38, 76, and 77. Significant deficiencies occurred in cases 14, 18, 19, 20, 21, 22, 23, 24, 30, 33,38, 76, and 77.

- In case 23, a patient did not receive a morning dosage of hydralazine, his newly ordered blood pressure medication, for two days. Also, the patient did not receive clindamycin, an antibiotic, for one day.
- In case 30, a patient did not receive his moxifloxacin eye drops for one day.

Chronic Care Medication Continuity

CMF had difficulty ensuring medication continuity for patients with chronic conditions. Compliance testing revealed patients did not receive their chronic medications timely (MIT 7.001, 17.4%). Most of the delays were related to policy compliance. Patients did not receive their keep-on-person (KOP) medications one business day prior to having their medication supply refilled. Our case reviewers also identified deficiencies in multiple cases.[31] Due to the institution's transition to the electronic health record system (EHRS), there were multiple cases where an electronic alert was triggered for the medication nurse to dispense medication to the patient, but the medication was not available.[32]

In addition, during case review, we identified instances in which patients did not receive medications because the medications were ordered as request refill.[33] The OIG has a concern about asthma inhalers being request-refill only. [34] Some patients may not realize they are running out of the medications needed to control asthma.

- In case 77, a patient did not receive his blood thinner medication for several days. The patient has a history of pulmonary embolism and this blood thinner is required to prevent blood clots from reoccurring.
- In case 38, a diabetic patient did not receive his chronic care medication, liraglutide.
- In case 24, during September 2019, a patient did not receive his cholesterol medication, atorvastatin.

Hospital Discharge Medications

CMF performed poorly in ensuring its patients received needed medications when they returned from an off-site hospital or emergency room. Compliance testing revealed a low score (MIT 7.003, 4.0%) for patients receiving their hospital discharge medications, as patients received those medications up to two days late. Case review found two deficiencies related to hospital discharge medications. Please see the **Transfers** indicator for further discussion.

31. Deficiencies related to chronic care medications occurred in cases: 16, 18, 19, 20, 21, 22, 23, 24, 25, 28, 29, 38, and 77.

32. Medications were not available in cases 18, 19, 23, 24, 25, 29, 37, 38, and 77.

33. When the medication is ordered as request refill, the medication is not automatically refilled unless the patient submits a request. Medications were not dispensed to patients because the patients did not request a refill in cases 19, 20, 22, 24, and 25.

34. Patients did not receive their asthma controller or rescue inhaler in cases 19, 20, and 25.

Specialized Medical Housing Medications

CMF did not ensure that patients received their needed medications when staff admitted them to specialized medical housing units. Compliance testing sampled 10 patients. Medications for seven patients were not available by the ordered administration date (MIT 13.004, 30.0%). Case review clinicians also found problems with medication administration in six of 11 specialized medical housing cases. Please refer to the **Specialized Medical Housing** indicator for further discussion.

Transfer Medications

CMF usually ensured patients transferring into the institution received their medications on time. Our case reviewers identified one deficiency in case 33. Compliance results showed some delays in medication administration (MIT 6.003, 70.6%). Patients mostly received their medications timely when they transferred from one unit to another (MIT 7.005, 64.0%), but nine of 25 patients did not receive their medications. Of the nine patients in this sample, eight refused their medications and the nurse did not document the reason for refusal. Compliance testing found medication continuity was lacking for patients en route to another institution (MIT 7.006, 28.6%). However, our case review clinicians only identified one case in which the patient transferred out of CMF without his medications.[35] CMF frequently ensured patients transferred out of CMF with required documents and medications (MIT 6.101, 80.0%).

Medication Administration

CMF nurses often administered TB medications as prescribed (MIT 9.001, 80.0%). In this test, we sampled five patients. While four patients received their medications as prescribed, one patient refused the medication and the nurses did not document a reason for the refusal. In addition, nurses did not monitor these five patients correctly (MIT 9.002, zero). They did not document patients' weight or address weight changes during the weekly monitoring.

Case reviewers identified problems with the administration of medications in the following cases:

- In case 38, a provider ordered a sliding scale of Lantus insulin. On multiple occasions, nurses administered the insulin without checking the patient's blood sugar level. On other occasions, nurses administered an incorrect dose of the insulin.
- In case 76, a provider ordered medication parameters prior to administering propranolol, a blood pressure medication. These parameters require the nurses to measure vital signs before giving the medication. Nurses did not always measure the patient's heart rate and blood pressure prior to administering

35. In case 36, a patient transferred out of CMF without all of his medications.

the propranolol. This medication can lower the heart rate and blood pressure.

Electronic Health Record System (EHRS)

Our OIG case review clinicians identified a glitch in the electronic health record system (EHRS) in case 14. A patient's medication administration record (MAR) was missing information from November 20, 2019, through January 28, 2020. When we asked what happened to the documentation during our on-site inspection, the pharmacist in charge (PIC) stated the patient was at another institution, Deuel Vocational Institution (DVI), during that time, even though there was no evidence of a physical transfer of the patient. Our review of records showed that CMF's correctional treatment center (CTC) providers continued to round and monitor the patient and documents indicated he was physically at CMF during that time. The EHRS "encounter," however, stated the patient was at DVI's CTC during that time. OIG reviewers had to enter the erroneous DVI encounter to observe the medications the patient received. Notwithstanding the error in the EHRS, the medical staff continued to provide medical care.

Clinician On-Site Inspection

We discussed our medication findings with the PIC and nursing supervisors. They acknowledged our findings and, in one case, reported the pharmacy technician had mistaken one medication for another medication that sounded similar. The PIC stated this technician had completed training to avoid this type of error.

CMF has multiple medication rooms throughout the facility. We interviewed medication nurses who were familiar with processes related to patient transfers, hospital returns, emergency response, keep-on-person medications, and medication noncompliance. They have a good rapport with custody staff.

Compliance Testing Results

Medication Practices and Storage Controls

The institution adequately stored and secured narcotic medications in nine of 11 clinic and medication line locations (MIT 7.101, 81.8%). In two locations, nurses could not describe the medication error reporting process.

CMF appropriately stored and secured nonnarcotic medications in all of the clinic and medication line locations (MIT 7.102, 100%).

Staff kept medications protected from physical, chemical, and temperature contamination in 11 of the 13 clinic and medication line locations (MIT 7.103, 84.6%). In one clinic, staff did not separate

storage of oral and topical medications. In another clinic, staff did not consistently record freezer and refrigerator temperatures.

Staff successfully stored valid, unexpired medications in 11 of the 13 applicable medication line locations (MIT 7.104, 84.6%). In two locations, nurses failed to initial or label the multi-use medication as required by CCHCS policy.

Nurses exercised proper hand hygiene and contamination control protocols in four of six locations (MIT 7.105, 66.7%). Some nurses neglected to wash or sanitize their hands when required, such as before putting on gloves, after touching a patient's skin, and before administering injection medications.

Staff in all medication preparation and administration areas demonstrated appropriate administrative controls and protocols (MIT 7.106, 100%).

Staff in five of six medication areas used appropriate administrative controls and protocols when distributing medications to their patients (MIT 7.107, 83.3%). OIG RN inspectors interviewed the nursing staff and assessed their knowledge on how to appropriately report medication errors according to policy expectations. A CMF nurse and supervisor interviewed failed to verbalize the process of reporting medication errors identified to the PIC and the chief nurse executive.

In addition, a nurse did not administer all the medications specified on two patients' corresponding medication administration record (MAR). The additional medications that should have been dispensed were not on the medication cart at the time of the medication cell pass, and the nurse explained to these patients she would go back and refill the missing medications. After the nurse's medication administration, she was asked by the OIG RN inspectors whether she completed task, and she responded, "Yes." This prompted the OIG RN inspectors to remind her that the missing medications from the medication cart needed to be restocked to deliver the medications to the two patients and complete the MAR instructions.

Pharmacy Protocols

CMF followed general security, organization, and cleanliness protocols in both pharmacies (MIT 7.108, 100%).

In its remote pharmacy, CMF properly stored nonrefrigerated medication. However, in its main pharmacy, we found medication not stored in its original labeled packaging. In addition, we found medications stored in a bin labeled with a different dosage from that noted on the individual bag's label containing the medication. As a result, CMF scored 50.0 percent on this test (MIT 7.109).

CMF properly stored refrigerated or frozen medications in both pharmacies (MIT 7.110, 100%).

The PIC did not adequately manage narcotic medications stored in CMF's main pharmacy. The pharmacy did not complete a monthly physical inventory of controlled substances in each automated dispensing cabinet (ADC) or Omnicell. In addition, the PIC did not correctly review monthly inventories of controlled substances in the institution's clinic and medication storage locations. Specifically, the PIC did not correctly complete several medication area inspection checklists (CDCR Form 7477) and neglected to record dates on several inventory records. These errors resulted in a score of 50.0 percent for this test (MIT 7.111).

We examined 25 medication error reports. The PIC timely or correctly processed only two of these 25 reports (MIT 7.112, 8.0%). In 23 reports, we found one or more of the following deficiencies:

- The PIC did not complete the follow-up review within three business days of the error's reported date; the review was completed between two and 101 days late.
- The PIC did not document the notification or notify the patient or prescribing physician of the medication error.
- The PIC did not document the medication error determinations or findings, or the recommended changes to correct the medication error.

Nonscored Tests

In addition to testing the institution's self-reported medication errors, our inspectors followed up on any significant medication errors found during compliance testing. We did not score this test; we provide these results for informational purposes only. At CMF, the OIG did not find any applicable medication errors (MIT 7.998).

The OIG interviewed patients in isolation units to determine whether they had immediate access to their prescribed asthma rescue inhalers or nitroglycerin medications. Ten of 11 applicable patients we interviewed indicated they had access to their rescue medications. One patient received a single order of nitroglycerin from an RN according to the chest pain protocol encounter form, which allowed the RN to administer the nitroglycerin medication to the patient. However, the RN did not close the encounter, and this nitroglycerin medication order was still active when this should have been a one-time order. In addition, the patient did not notify any staff and stated, "I don't want it," referring to the open order for nitroglycerin medication. We promptly notified CMF's chief executive officer of the concern, and health care management found the nitroglycerin order was from an unclosed RN protocol encounter. Subsequently, this medication order was discontinued by the provider. For another patient, the testing of rescue medication availability was not completed. We were not able to interview and confirm the availability of the medication for this patient because at that time we did not have personal protective equipment (PPE), and the patient was under quarantine due to exhibiting COVID-like symptoms (MIT 7.999).

Recommendations

- Pharmacy and medical leadership should consider changing the asthma controller inhalers from *request refill* to *automatic refill* with the 1:1 inhaler exchange.
- Pharmacy leadership should consider reviewing the causes of the untimely delivery of all prescribed medications.
- Nursing leadership should remind nursing staff to follow safe medication administration practices, including completely and thoroughly documenting all medications, specifically, insulin and hypertensive medications.
- Medical leadership should determine the cause of challenges related to medication continuity for chronic care, transfer-in, hospital discharge, and en-route patients and should implement remedial measures as appropriate.

Table 14. Medication Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
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? (7.001) *	4	19	2	17.4%
Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? (7.002)	6	19	0	24.0%
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? (7.003) *	1	24	0	4.0%
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? (7.004) *	N/A	N/A	N/A	N/A
Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? (7.005) *	16	9	0	64.0%
For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? (7.006) *	2	5	0	28.6%
All clinical and medication line storage areas for narcotic medications: Does the institution employ strong medication security controls over narcotic medications assigned to its storage areas? (7.101)	9	2	3	81.8%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution properly secure and store nonnarcotic medications in the assigned storage areas? (7.102)	13	0	1	100%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution keep nonnarcotic medication storage locations free of contamination in the assigned storage areas? (7.103)	11	2	1	84.6%
All clinical and medication line storage areas for nonnarcotic medications: Does the institution safely store nonnarcotic medications that have yet to expire in the assigned storage areas? (7.104)	11	2	1	84.6%
Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes? (7.105)	4	2	8	66.7%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *preparing* medications for patients? (7.106)	6	0	8	100%
Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when *administering* medications to patients? (7.107)	5	1	8	83.3%
Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and remote pharmacies? (7.108)	2	0	0	100%
Pharmacy: Does the institution's pharmacy properly store nonrefrigerated medications? (7.109)	1	1	0	50.0%
Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? (7.110)	2	0	0	100%
Pharmacy: Does the institution's pharmacy properly account for narcotic medications? (7.111)	1	1	0	50.0%
Pharmacy: Does the institution follow key medication error reporting protocols? (7.112)	2	23	0	8.0%
Pharmacy: For Information Purposes Only: During compliance testing, did the OIG find that medication errors were properly identified and reported by the institution? (7.998)	This is a nonscored test. Please see the indicator for discussion of this test.			
Pharmacy: For Information Purposes Only: Do patients in isolation housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications? (7.999)	This is a nonscored test. Please see the indicator for discussion of this test.			
				Overall percentage (MIT 7): **61.6%**

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Table 15. Other Tests Related to Medication Management

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
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? (6.003) *	12	5	8	70.6%
For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer-packet required documents? (6.101) *	4	1	5	80.0%
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001) *	4	1	0	80.0%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002) *	0	5	0	0
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.004) *	3	7	0	30.0%

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Overall Rating
Inadequate

Case Review Rating
(N/A)

Compliance Score
Inadequate
(56.2%)

Preventive Services

In this indicator, OIG compliance inspectors tested whether the institution offered or provided cancer screenings, tuberculosis (TB) screenings, influenza vaccines, and other immunizations. The OIG rated this indicator solely based on the compliance score, using the same scoring thresholds as in the Cycle 4 and Cycle 5 medical inspections. Our case review clinicians do not rate this indicator.

Recommendations

- Medical leadership should remind nursing staff to perform weekly monitoring of patients and to address the symptoms of patients taking TB medications.

Table 16. Preventive Services

	Scored Answer			
Compliance Questions	**Yes**	**No**	**N/A**	**Yes %**
Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? (9.001)	4	1	0	80.0%
Patients prescribed TB medication: Did the institution monitor the patient per policy for the most recent three months he or she was on the medication? (9.002)	0	5	0	0
Annual TB screening: Was the patient screened for TB within the last year? (9.003)	0	25	0	0
Were all patients offered an influenza vaccination for the most recent influenza season? (9.004)	25	0	0	100%
All patients from the age of 50 through the age of 75: Was the patient offered colorectal cancer screening? (9.005)	21	4	0	84.0%
Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy? (9.006)	N/A	N/A	N/A	N/A
Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy? (9.007)	N/A	N/A	N/A	N/A
Are required immunizations being offered for chronic care patients? (9.008)	11	4	10	73.3%
Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner? (9.009)	N/A	N/A	N/A	N/A
				Overall percentage (MIT 9): **56.2%**

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Nursing Performance

Overall Rating ***Inadequate***

Case Review Rating ***Inadequate***

Compliance Score **(N/A)**

In this indicator, the OIG clinicians evaluated the quality of care delivered by the institution's nurses, including registered nurses (RNs), licensed vocational nurses (LVNs), psychiatric technicians (PTs), and certified nursing assistants (CNAs). Our clinicians evaluated nurses' ability to make timely and appropriate assessments and interventions. We also evaluated the institution's nurses' documentation for accuracy and thoroughness. Clinicians reviewed nursing performance in many clinical settings and processes, including sick call, outpatient care, care coordination and management, emergency services, specialized medical housing, hospitalizations, transfers, specialty services, and medication management. The OIG assessed nursing care through case review only and performed no compliance testing for this indicator.

When summarizing overall nursing performance, our clinicians understand that nurses perform numerous aspects of medical care. As such, specific nursing quality issues are discussed in other indicators, such as **Emergency Services**, **Specialty Services**, and S**pecialized Medical Housing**.

Results Overview

Nursing care at CMF was appropriate and timely some of the time. Similar to its performance in Cycle 5, CMF continued to show areas wherein improvement was needed, such as assessment, intervention, appropriate triage of sick call requests, wound care, documentation, completion of orders, and communication with providers concerning stat laboratory results and changes in condition, as discussed in further detail in the subcategories below. The number of overall nursing deficiencies was slightly lower, but the number of significant deficiencies remained the same. Nursing leadership has initiated quality improvement projects, which are still ongoing. Considering all these factors, the OIG rated this indicator ***inadequate***.

Case Review Results

We reviewed 260 nursing encounters in 63 cases. Of the nursing encounters we reviewed, 105 were in the outpatient setting. We identified 167 nursing performance deficiencies, 43 of which were significant.[36] These deficiencies could potentially cause increased risk of harm to the patients.

Nursing Assessment and Intervention

CMF nurses provided timely and appropriate care some of the time. Adequate nursing care involves complete and thorough nursing

36. Deficiencies were identified in cases 3, 4, 5, 6, 7, 8, 9, 11, 14, 18, 19, 20, 21, 22, 23, 24, 25, 26, 28, 29, 31, 33, 34, 36, 37, 38, 39, 40, 41, 43, 44, 46, 47, 48, 49, 50, 51, 52, 53, 54, 58, 59, 60, 61, 62, 64, 65, 66, 68, 69, 72, 74, 76, and 77. Significant deficiencies were identified in cases 3, 11, 20, 21, 22, 23, 25, 36, 38, 41, 46, 47, 48, 50, 51, 52, 61, 74, 76, and 77.

assessments in order to provide appropriate and timely interventions; however, we found that nursing assessment was an area in need of improvement. Assessments were often incomplete or, in some cases, nonexistent, in both outpatient and inpatient settings, placing patients at risk of harm. As a result of these incomplete or nonexistent assessments, interventions were also improper or incomplete. Below are some examples we identified during our case review:

- In case 20, a provider ordered an RN visit for reassessment of an asthmatic patient who had a low asthma control test (ACT) score at his provider's appointment. At the RN visit, the nurse did not obtain vital signs to include oxygen saturation and did not auscultate lung sounds.
- In case 23, a patient who was housed in specialized medical housing complained of pain and swelling in his right forearm. The arm was tender to touch and had two boils. The nurse did not obtain vital signs, assess pain levels, or notify the provider. Later in the review period, the patient was sent to the hospital for altered mental status. He was treated for hypoglycemia and later discharged back to the institution. The nurse did not assess the patient upon his return.
- In case 46, an elderly patient with a history of benign prostatic hypertrophy (BPH) submitted a sick call request due to blood in his urine. The clinic nurse did not obtain the patient's blood pressure, did not document the oxygen saturation reading, and failed to obtain a urine sample for testing. The nurse did not notify the provider or schedule a follow-up appointment with the patient's primary care physician.
- In case 47, a patient submitted a sick call request due to right leg, knee, and hip pain. Later, the patient submitted a sick call for right ankle pain. In both instances, the nurse inappropriately triaged the patient as asymptomatic, which caused evaluations to be delayed. In addition, the nurse did not perform complete assessments of the patient's painful joints.
- In case 52, a patient submitted a sick call request with symptoms of incontinence of the bowel and bladder. The nurse inappropriately triaged the patient and ordered an asymptomatic appointment, even though the patient was symptomatic; the patient was evaluated four days later. The nurse noted the patient has multiple sclerosis (MS) and recently started taking metformin. The nurse documented that the metformin was the reason for the incontinence. The nurse did not weigh the patient, obtain vital signs, assess the patient's pain level, or perform any type of gastrointestinal (GI) or gastrourinary (GU) assessment. In addition, the RN did not communicate the new symptom of incontinence to the provider.

Nursing Documentation

CMF nurses did not always document their care thoroughly and consistently. We identified poor documentation for wound care, with

the exception noted in case 72. Both inpatient and outpatient nurses frequently did not document all vital signs and often did not document discharge instructions. We also identified inconsistent documentation of skin assessments occurred from shift to shift in specialized housing facilities. In the TTA, nurses failed to document emergency response times and, when documenting post emergency events, did not accurately record the time the patient care occurred. While these deficiencies did not affect patient care, this is an area where improvement is needed.

Nursing Sick Call

Our clinicians reviewed 79 sick call requests. We identified 40 deficiencies, 15 of which were significant.[37] Of the 15 significant deficiencies, nine were related to the improper triage of sick call requests.[38] Below are some examples identified during case review:

- In case 3, an elderly patient with multiple medical problems completed a sick call request with a complaint of lesions on both arms. The clinic nurse incorrectly triaged the sick call as an asymptomatic RN appointment and scheduled the patient within 14 days instead of within one business day.
- In case 38, a diabetic patient completed a sick call request with complaints of a left foot sore and painful testicles, which the nurse should have triaged for a same-day RN appointment. The clinic nurse did not evaluate the patient until the next day. This patient placed another sick call request two months later with a complaint of a sore on the left foot. He received a face-to-face RN evaluation three days later instead of the same day.
- In case 51, a patient submitted a sick call request to see a specialist regarding intense pain in the hip, back, and groin. The clinic nurse placed an order for an RN follow-up appointment within seven days instead of within one business day for the symptoms.
- In case 61, a patient submitted a sick call request with a complaint of increased shoulder pain. The clinic RN incorrectly triaged the sick call and ordered an asymptomatic RN visit. The patient was seen 12 days later.

OIG clinicians also identified that many face-to-face RN evaluations had incomplete assessments and no notification to the provider. This is further discussed in the "Nursing Assessment and Intervention" section above. We also identified a pattern in which staff did not provide education or discharge instructions to the patients.

37. Deficiencies were identified in cases 3, 18, 19, 21, 22, 24, 28, 29, 37, 38, 39, 40, 41, 43, 44, 46, 47, 48, 49, 50, 51, 52, 53, 54, 58, 59, 60, 61, 62, 64, 65, 66, 68, and 69. Significant deficiencies were identified in cases 3, 21, 22, 38, 41, 46, 47, 48, 50, 51, 52, and 61.

38. Improper triage of sick call requests was identified in cases 3, 38, 41, 47, 50, 52, and 61.

Care Coordinator

At CMF, the primary clinic nurse serves as the care manager for the specific patient population covered by the clinic. The clinic nurse not only triages sick call requests and evaluates patients at RN appointments, but also is responsible for each patient's chronic care management, medication compliance, wound care, completion of providers' treatment plans, and patient education. This has not changed since Cycle 5. We have noted that other institutions designate a position for an RN care management coordinator.

Wound Care

We reviewed five cases in which wound care was provided for patients.[39] Patients in all except one of the cases were housed in specialized medical housing. We recognized this area as an opportunity for performance improvement and discuss it in more detail in the **Specialized Medical Housing** indicator. We identified good care and documentation in one case, listed below:

- In case 72, a patient underwent emergency surgery with extensive removal of infected tissue. He was admitted to the CTC and placed on a wound VAC.[40] The nurses completed daily wound care and documented the care in detail, using pictures and measuring devices to note improvement.

Emergency Services

First responders and TTA nurses provided adequate care responding to emergencies within the institution. We identified room for improvement in documenting emergency responses, making thorough initial assessments, and making thorough follow-up assessments after treatment. These deficiencies and our recommendations are more thoroughly discussed in the **Emergency Services** indicator.

Hospital Returns

We reviewed 17 out-to-medical hospital returns for patients who were discharged from the hospital or returned from an emergency room visit.[41] We identified 10 deficiencies in the quality of nursing care. Only one deficiency was categorized as significant.[42] Some of the deficiencies included incomplete assessments, lack of order reconciliation, and lack

39. Wound care was provided for patients in cases 11, 23, 29, 72, and 76.

40. A wound VAC is a vacuum assisted closure device used to decreased air pressure around a wound to assist in healing.

41. We reviewed patients returning from hospitalizations or emergency visits in cases 3, 9, 10, 11, 14, 16, 18, 23, 24, 25, 26, 28, 29, 30, 37, and 77.

42. Deficiencies related to the quality of nursing care for hospitalizations or emergency visits were found in cases 3, 18, 23, 24, 25, 26, and 38. One significant deficiency was identified in case 23.

of medication continuity. Please refer to the "Hospitalizations" subheading under the **Transfers** indicator for further details.

Transfers

We reviewed six cases that involved transfer-in and transfer-out processes. We identified four deficiencies that were directly related to the quality of nursing performance. Only one of the deficiencies was cited as significant.[43] While the receiving and release (R&R) nurses evaluated newly arrived patients in a timely manner, they did not fully complete the initial health screening, did not refer a symptomatic patient appropriately, and did not provide education to patients. In one case, when a patient transferred to another institution, R&R nurses did not communicate specialty appointments, did not complete a face-to-face evaluation 24 hours prior to transfer, and did not confirm a patient had his rescue inhaler on his person prior to leaving the facility. For additional information, please refer to the **Transfers** indicator.

Specialized Medical Housing

Nursing performance in the CTC and outpatient housing unit (OHU) was inadequate. We identified 93 deficiencies in specialized medical housing, 63 of which were related to nursing performance. Forty of those deficiencies were cited as significant and could have led to patient harm. Examples include failure to complete wound care, failure to follow medical orders, and incomplete or inaccurate assessments and documentation. Nurses did not always communicate vital information with the provider, including stat laboratory results and changes in condition. We found the care provided in the hospice unit to be proficient, but this did not change the overall rating from inadequate. For more details, please refer to the **Specialized Medical Housing** indicator.

Specialty Services

We reviewed 37 nursing encounters in 12 cases where patients returned to the institution after specialty procedures and consultations, even when patients refused these appointments.[44] We noted 14 deficiencies, including one that was significant.[45] Most deficiencies were related to nurses' failure to document treatment or document specialty consultation information when patients returned from off-site specialty appointments as well as their failure to document educating patients on informed refusals of specialty services. Please refer to the **Specialty Services** indicator for additional details.

43. The process of transferring in and out was reviewed in cases 31, 32, 33, 34, 35, and 36. Deficiencies were identified in cases 31, 33, 34, and 36. The only major deficiency was identified in case 36.

44. Nursing encounters for specialty services were reviewed in cases 9, 16, 23, 25, 28, 29, 37, 38, 72, 74, 76, and 77.

45. Deficiencies in the quality of nursing performance occurred in cases 23, 25, 37, 38, 72, 74, and 77. The only significant deficiency occurred in case 25.

Medication Management

OIG clinicians examined 146 events in 28 cases involving medication management and administration.[46] We identified 52 deficiencies, but only four were related to the quality of nursing care. Of the four identified, two were deemed significant.[47] Nurses generally administered medications properly, but in the following two examples, they did not:

- In case 23, a nurse did not notify a provider on five different days a diabetic patient had low blood sugar. On a separate day, nursing staff did not notify the provider that the patient's blood sugar remained low throughout the day even though the patient was given oral glucose and meals.
- In case 76, throughout the two-month review period, nursing staff failed multiple times to notify a provider as ordered when a patient's blood sugar level was over 500.

Clinician On-Site Inspection

OIG clinicians attended huddles in the clinics and inpatient housing units. The staff appeared well organized and discussed all aspects of care concerning the patient population. We also attended the daily provider meeting, which was detailed and informative.

Upon entering the administration building, there was written notification of the number of patients and staff who were positive with COVID-19 and where the positive COVID-19 patients were housed. All staff we observed were screened for symptoms of COVID-19 and high temperatures prior to entering the facility. In Clinics 1 through 7, patients were triaged for symptoms of influenza-like illness (ILI), which included being checked for a high temperature, before entering the clinic. Any patient who appeared symptomatic was redirected to the ILI clinic, which was established in March in a separate building where either the public health nurse (PHN) or the infection control nurse (ICN) performed rapid COVID-19 testing and arranged quarantine or isolation housing. Additional housing tents had been obtained and set up in the main yard to assist with social distancing for the patient population. While it was evident the pandemic had affected the operation of medical services, the institution had taken steps to implement a process to isolate and protect the patient population from the disease.

Our OIG clinician inspectors were able to tour areas that included the CTC, OHU, hospice unit, clinics, nursing education, specialty services, TTA, R&R, public health, and medication pill line. We interviewed staff, and found them knowledgeable regarding policies and procedures. They expressed satisfaction with nursing leadership and with the support they receive from supervisors.

46. Medication management events were reviewed in cases 3, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 20, 21, 22,23, 24, 25, 26, 27, 28, 29, 30, 37, 38, 72, 74, 76, and 77.

47. Deficiencies related to the quality of nursing performance were identified in cases 23 and 76, with a significant deficiency identified in each case.

We met with the nursing education department and found there had been changes in staff within the past six months, along with additional open positions. Nurse instructors appeared enthusiastic and provided details of annual and special trainings currently being taught.

There were several completed and ongoing projects in place to improve the delivery and quality of patient care in both the outpatient and inpatient settings, several of which are discussed in the individual indicators.

Recommendations

- Nursing leadership should consider incorporating camera and measurement tools to document wound care and other significant physical findings.
- Nursing leadership should determine the causes that prevent outpatient and specialized medical housing nurses from performing complete assessments and proper wound care, notifying the provider of any abnormal changes in patient condition, completing proper triage and scheduling of symptomatic sick call requests, providing patient discharge instructions, and accurately documenting care.

Overall Rating
Adequate

Case Review Rating
Adequate

Compliance Score
(N/A)

Provider Performance

In this indicator, OIG case review clinicians evaluated the quality of care the institution's providers (physicians, physician assistants, and nurse practitioners) delivered. Our clinicians assessed the institution's providers' ability to evaluate, diagnose, and manage their patients properly. We examined provider performance across several clinical settings and programs, including sick call, emergency services, outpatient care, chronic care, specialty services, intake, transfers, hospitalizations, and specialized medical housing. The OIG assessed provider care through case review only and performed no compliance testing for this indicator.

Results Overview

Overall, CMF providers delivered good care. In Cycle 6, providers' performance improved from Cycle 5. Providers showed good assessment and diagnostic skills, generally ordered proper follow-ups, performed well in caring for emergent and urgent patients, and appropriately referred patients to specialists. Areas with room for improvement included the thorough review of records, the recognition of elevated blood pressure, the performance of relevant examinations related to the reason for the visit, the accuracy of documentation, and the review of off-site reports.

Several providers did not endorse off-site reports and diagnostics within policy time frames. Occasionally, these led to minor delays in care, except for the examples discussed later in this indicator. Medical leadership appeared to be aware that a few providers were not performing well and indicated they were working with these providers to improve their performance.

In Cycle 5, we noted one provider who delivered poor care. This provider was removed from his clinic and his work was monitored closely. His personnel file included periodic performance evaluations. This provider showed improved clinical assessments and reduced opioid prescriptions. Medical leadership demonstrated a willingness to help such providers improve their care. The OIG rated this indicator as ***adequate***.

Case Review Results

In our inspection, we reviewed 301 provider encounters and found a total of 62 deficiencies. Of these, 34 were significant.[48] In addition, OIG clinicians examined the quality of care in 25 comprehensive case reviews. Of these 25 cases, 22 were rated ***adequate*** and three ***inadequate***.

48. We identified significant deficiencies in cases 3, 6, 11, 15, 19, 20, 21, 23, 24, 27, 28, 29, 37, 38, 41, and 76. We identified minor deficiencies in cases 3, 13, 19, 22, 23, 24, 25, 28, 29, 30, 33, 38, 72, 76, and 77.

Assessment and Decision-Making

Generally, providers made good assessments and sound decisions; however, case reviewers identified instances of superficial assessments and decisions.[49] Overall, history-taking and differential diagnoses were acceptable. Providers generally ordered diagnostic tests and ordered specialist care appropriately. Physical examinations needed improvement, as noted in the following examples.

- On multiple occasions in case 3, a provider did not properly examine a patient according to his complaint or reason for visit. The provider did not examine the patient's abdomen when the patient had abdominal pain, or his chest when he had chest pain.
- In case 11, a correctional treatment center provider did not justify why a patient was on chronic opioids. On two occasions, nurses documented that the patient tried to use the opioid medications for secondary, nonmedical purposes.

Review of Records

CMF providers did not always review medical records carefully.[50] They did not always review hospital discharge reports completely to identify abnormal diagnostic results. They did not always review patients' charts thoroughly.

- In case 3, a provider did not review the Emergency Department report carefully to identify the abdominal computed tomography (CT) abnormalities that required follow-up.
- In case 19, a provider erroneously reviewed that a patient was a new arrival and had a positive viral load for Hepatitis C. However, the patient had just completed treatment for Hepatitis C and had undetected viral loads.
- In case 20, a patient had poorly controlled, severe, and persistent asthma and the medical administration record (MAR) indicated that the patient did not refill his asthma inhaler. A provider did not review the MAR thoroughly and should have discussed inhaler usage with the patient.
- In case 28, a provider did not review the CTC discharge summary properly to identify the abnormal chest CT result and follow up with the patient regarding the CT.
- In case 38, a provider did not reconcile a patient's medication properly upon the patient's return from the hospital. This resulted in the patient receiving a prolonged amiodarone loading period, which placed the patient at increased risk of lung and thyroid toxicity or death.

49. Significant decision-making deficiencies occurred in cases 3, 6, 11, 24, 29, 37, and 38. Minor decision-making deficiencies occurred in cases 23 and 29.

50. Significant deficiencies were identified in cases 3, 19, 20, 28, 38, and 76. Minor deficiencies were identified in cases 13, 24, and 25.

Emergency Care

CMF providers appropriately managed patients in the TTA with urgent or emergent conditions. In the cases we reviewed, TTA providers thoroughly documented their thought processes to explain the rationale for their decision-making. However, the provider on-call did not always document a progress note when consulted by the nurse. Please refer to the **Emergency Services** indicator for more information.

Chronic Care

In most instances, CMF providers appropriately managed their patients' chronic health conditions. Providers performed well in managing chronic medical conditions such as diabetes, asthma, hepatitis C infection, and cardiovascular disease. However, we identified a pattern where providers ignored elevated blood pressure in cases 19, 23, 29, and 38.

CMF has an effective coumadin (blood thinning medication) clinic to manage patients on anticoagulants. A clinical pharmacist appropriately monitored international normalized ratio, or INR (a blood test for monitoring the effects of coumadin) levels and adjusted oral anticoagulants. We did not find any deficiencies related to anticoagulation care.

Specialty Services

CMF providers appropriately referred patients for specialty consultation when needed. When specialists made recommendations, providers followed those recommendations appropriately. A few providers had difficulty reviewing specialty reports timely.[51] We discuss providers' specialty performance further in the **Specialty Services** indicator.

- In case 38, a provider did not review a cardiologist's consultation report timely or carefully to identify that the specialist wanted to increase lisinopril, an antihypertensive medication that has beneficial heart and kidney effects. As a result, the patient continued to take a lower dose of the medication despite significantly elevated blood pressures.

Documentation Quality

CMF providers documented patient care accurately with few exceptions.[52] Specialized medical housing providers entered few cloned notes, as evidenced by the providers documenting elevated blood pressures as under control. This is discussed in more detail in the **Specialized Medical Housing** indicator.

- In case 13, a provider erroneously documented that a patient was on warfarin for pulmonary embolism.

51. We found either late or no endorsements of specialty reports in cases 9, 13, 23, 29, 30, 38, and 77.

52. Documentation deficiencies were found in cases 13, 19, 23, 24, and 76.

- In case 23, a provider repeatedly documented that a patient's blood pressures was at goal levels, even though vital signs showed otherwise. This was due to the provider cloning the assessment and treatment plan reflected in the progress notes.

Provider Continuity

Generally, CMF offered good provider continuity. Providers were assigned to specified clinics and specialized medical housing units to ensure continuity of care. CMF did not have any provider shortages or vacancies.

Clinician On-Site Inspection

We attended the morning provider meeting, which included the chief medical executive (CME) and two chief physicians and surgeons (CP&S). During the provider meeting, the physician on-call discussed the calls received during off-hours and described appropriate actions for each patient. We also attended the socially distanced morning huddle, run by an RN. During the morning huddle, the RN discussed the patients who were active and needed medical attention overnight, the patients who were going off-site, the patients who were to be seen that day, and the medications that were expected to expire.

The providers we interviewed unanimously praised their medical leadership. Several providers credited their CME as the only reason they are and continue to be in state service. Generally, they also stated that the two CP&Ss were fair, approachable, and supportive. The COVID-19 pandemic initially affected morale, but the support of medical leadership eventually made providers feel at ease. Providers generally have a good relationship with nurses, ancillary staff, and custody staff.

We discussed provider matters with the CME. She reported that CMF did not have any problems filling vacancies during the last two hiring cycles. She did state that several providers were getting help or receiving more frequent monitoring. For example, one provider was removed from his clinic due to concern about his care; consequently, he received more frequent review of his work. Two other providers were being trained by the CP&S to improve documentation and manage their electronic inboxes.

Recommendations

- Medical leadership should ascertain causative factors in the untimely provider review of their electronic inboxes and report endorsement. Medical leadership should implement remedial measures as appropriate.
- Medical leadership should consider more frequent review of provider documentation to ensure that providers thoroughly review vitals, laboratory results, and pending appointments.

Overall Rating
Inadequate

Case Review Rating
Inadequate

Compliance Score
Inadequate
(66.0%)

Specialized Medical Housing

In this indicator, OIG inspectors evaluated the quality of care in the specialized medical housing units. We evaluated the performance of the medical staff in assessing, monitoring, and intervening for medically complex patients requiring close medical supervision. Our inspectors also evaluated the timeliness and quality of provider and nursing intake assessments and care plans. We considered staff members' performance in responding promptly when patients' conditions deteriorated and looked for good communication when staff consulted with one another while providing continuity of care. At the time of our inspection, the CMF specialized medical housing included an outpatient housing unit (OHU), a correctional treatment center (CTC), and hospice.

Results Overview

CMF performed poorly in this indicator. We identified many of the same deficiencies discussed in the Cycle 5 report, including the quality of nursing care in the OHU and the CTC. However, we found few and minor deficiencies for patients treated in the hospice unit. While providers and nurses timely completed admission assessments, medical histories, and physical examinations, daily nursing assessments were often incomplete and inaccurate. Nursing staff frequently did not follow provider orders and did not consistently communicate changes in patient conditions, such as abnormal vital signs, blood glucose levels, and stat laboratory results, to the provider and to other health care staff. The nurses provided sporadic wound care, often with poor documentation. While providers documented most of the issues the patients had, they sometimes overlooked important details. Mainly due to the continued problematic quality of nursing performance, and to the high number of significant deficiencies that could increase the risk of harm to the patients, the OIG rated this indicator ***inadequate***.

Case Review Results

We reviewed a total of 11 cases involving patients housed in specialized medical housing units. One patient was housed in the hospice unit, six patients were housed in the CTC, and four patients were housed in OHU.[53] Two patients in the CTC were later transferred to the hospice unit prior to their demise. We reviewed a total of 269 events, which included 95 provider encounters and 95 nursing encounters. Due to the volume of care that occurs in specialized medical housing units, each provider and nursing event represents up to one month of provider care and two weeks of nursing care. We identified 94 deficiencies, 40 of which were significant.[54] We identified that 63 of the overall deficiencies

53. In case 10, the patient was housed in the hospice unit; in cases 9, 11, 14, 28, 30, and 72, patients were housed in the CTC; and in cases 23, 74, 76, and 77, patients were housed in the OHU. Patients in cases 9 and 11 were later transferred to the hospice unit.

54. Deficiencies occurred in cases 9, 11, 14, 23, 28, 30, 72, 74, 76, and 77. Significant deficiencies occurred in cases 11, 14, 23, 30, 74, 76, and 77.

and 23 of the significant deficiencies were related to the quality of nursing performance.

Provider Performance

Providers performed well with the quality and timeliness of admission for health and physical examinations; compliance testing was excellent (MIT 13.002, 100%), and case review only found one deficiency in the quality of the patient health history and physical. Providers generally performed rounds on patients within policy time frames, except in cases 14 and 30, where there were intervals between CTC rounds that were greater than seven days.

Most providers sufficiently documented patient care with thorough assessments and plans. However, the quality of documentation varied, depending on the provider. Some providers did not document pertinent physical findings clearly. Cloned elements of the documentation called into question whether providers examined the patients.

- In case 23, a provider evaluated a patient for follow-up and did not document his examination of the patient's wound. The provider also cloned elements of the assessments portion of the progress notes; as a result, the provider overlooked the patient's elevated blood pressure several times. Furthermore, when the patient was discharged from the hospital with a fluid overload, multiple providers did not appropriately manage the patient because they did not order fluid restriction, did not order more frequent weight checks, or did not adjust the medication.
- In case 11, a patient at the CTC had a skin ulcer on his left ankle; however, documentation of the ulcer was inconsistent. An initial provider identified the ulcer, while a subsequent provider noted no open wounds, abrasions, or ulcers. The second provider identified the ulcer several days later while examining the patient.

Nursing Performance

The OIG clinicians' findings concurred with compliance testing results that initial nursing assessments upon a patient's admission into the institution were completed timely and accurately in both the CTC and OHU (MIT 13.001, 100%) and both units maintained operational call systems (MIT 13.101, 100%). However, we found that additional nursing care provided in both units was problematic. We identified patterns of incomplete or inaccurate assessments, inconsistent wound care, incomplete documentation, and poor communication with the provider. We determined that six of the 23 significant nursing deficiencies occurred in the CTC and 17 occurred in the OHU.[55]

55. All six major deficiencies that occurred in the CTC occurred in case 11. Of the 16 major deficiencies that occurred in the OHU, 11 occurred in case 23, one in case 74, two in case 76, and two in case 77.

While nursing staff completed assessments every shift at the CTC, the assessments were not always accurate or complete, as noted in the example below:

- In case 11, a patient had a pressure wound on his left foot and intermittent bed sores to bilateral hips. Nursing documentation of the patient's skin integrity over a four-month period was inconsistent from shift to shift, with some nurses documenting intact skin, others noting localized skin abnormality, and others documenting open sores. The nurses also rarely performed musculoskeletal assessments for this elderly patient who had limited mobility.

Failure to follow providers' orders was also identified. Staff did not always obtain vital signs or perform wound care as ordered. When a new wound was identified, nurses failed to notify the provider and obtain an order for wound care. This was a constant occurrence for the patient in case 11 described above.

Another example is listed below:

- In case 9, a patient was diagnosed with metastatic colon cancer after undergoing an abdominal surgery that included a colostomy. The provider ordered documentation of the colostomy bag outputs every shift. This did not occur.

OIG clinicians noted that OHU nurses had lapses in documentation, assessment, wound care, and communication with both the provider and other staff. The cases below exemplify poor communication that placed the patient at risk for increased harm:

- In case 23, an OHU nurse did not communicate a patient's positive orthostatic vital signs to the medication nurse.[56] The medication nurse administered metoprolol, a medication that lowers blood pressure. Approximately an hour later, the patient's blood pressure was even lower.
- Also in case 23, a nurse did not report the patient's abnormal stat laboratory results to the provider. Because white blood cell count and kidney laboratory levels were elevated, the diabetic patient with chronic kidney disease was at risk of infection and kidney issues.
- In case 76, nurses did not always notify the provider regarding abnormally elevated blood sugars.

We identified two cases for which there were marked changes in condition and the patients were never assessed, which increased the risk of harm to the patients. Below are examples from case review:

- In case 74, a patient developed an abscess on his left thigh and had an abnormal elevated temperature of 102.8 degrees F. There was no assessment of the patient with this change in condition.

56. *Orthostatic vital signs* means that when the patient's vital signs are checked in different positions such as lying, sitting, and standings, there are significant blood pressure or pulse changes.

- In case 23, a patient developed a fever and had multiple abnormal elevated temperatures. However, nurses did not perform a nursing assessment or notify the provider.

Nursing care provided to patients in the hospice unit was good. Nurses thoroughly assessed patients and documented patient care. We identified minor documentation errors only, which had no impact on patient care.

Medication Administration

Compliance testing showed that CMF scored poorly in delivering medication to newly admitted patients to the specialized medical housing unit within the required time frames (MIT 13.004, 30.0%). While OIG clinicians did not identify a pattern of new patients missing prescribed medications, we identified several instances where patients missed critical medications, which could directly affect patient care. This occurred in cases 11, 23, 76, and in the following examples:

- In case 30, a CTC patient had a stroke and later developed a corneal abrasion due to his inability to completely close his right eye. He was seen by the ophthalmologist multiple times and was prescribed an antibiotic eye drop. The prescription expired and was not refilled until it was renewed by the provider. As a result, the patient did not receive his antibiotic eye drops for an entire day.
- In case 77, a patient housed in the OHU did not receive his enoxaparin[57] for four days because the medication was unavailable or was not found. Because the patient has a history of pulmonary embolism, this blood thinner is required to prevent a blood clot from reoccurring.

Clinician On-Site Inspection

The OIG clinicians' inspection included the CTC, OHU, and hospice unit. The CTC can house up to 28 medical patients and is located in G Building, which has a 47-bed capacity. G Building also houses the OHU. Both the CTC and the OHU have a negative pressure room. There is a separate hospice unit.

The CTC daily huddle was organized and all pertinent patient information was exchanged between medical and nursing staff. At the time of our on-site visit, the CTC had only two available beds. The CTC shift lead produced a list of assignments and duties and advised that wound care and additional assignments are shared among shifts. Nurses reported that assessments are completed on every patient each shift and that the patients are weighed weekly.

Staffing in the CTC included four RNs and three licensed vocational nurses (LVNs) for second and third watch and three RNs and one LVN for first watch. A designated provider is staffed during daytime hours

57. Enoxaparin is a blood-thinning medication.

Monday through Friday and a provider on-call is staffed after hours, on weekends, and on holidays.

In the OHU huddle, nursing and medical staff discussed all patients. The medical assistant (MA) utilized an Excel spreadsheet to schedule patients for the provider. The patients were seen by the provider either every two weeks or monthly, depending on their medical conditions. On the day of our on-site visit, the OHU housed 39 patients. The nursing staff advised they normally average between 42 and 45 patients. Nursing staff advised they perform assessments when a patient's condition changes. Patients are weighed monthly. Wound care is completed by the RNs, who utilize an ad-hoc form or progress note for documentation. Both units had access to a digital camera.

Staffing in the OHU included two RNs, one MA, and either an LVN or certified nursing assistant (CNA) for second watch; two LVNs and a CNA for third watch; and two LVNs for first watch. There is also a designated provider for daytime hours during the week. Staff contact the physician on-call for after-hours concerns.

The tour of the hospice unit included a visit to a serene, covered garden area available for the patients and visiting families.

Recommendations

- Nursing leadership for specialized medical housing should determine the causes that prevent outpatient nurses from performing complete assessments and proper wound care, notifying providers for any abnormal changes in patient condition, and documenting care accurately.
- Nursing leadership should review the root cause of challenges to ensure patients who are admitted into the CTC and the OHU receive their medications timely upon admission and should implement remedial measures as appropriate.
- Medical leadership should review the factors that may preclude specialized medical housing providers from documenting all pertinent physical examination findings.

Compliance Testing Results

Table 17. Specialized Medical Housing

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For OHU, CTC, and SNF: Prior to 4/2019: 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? Effective 4/2019: Did the registered nurse complete an initial assessment of the patient at the time of admission? (13.001) *‡	10	0	0	100%
For CTC and SNF only (effective 4/2019, include OHU): Was a written history and physical examination completed within the required time frame? (13.002) *	10	0	0	100%
For OHU, CTC, SNF, and Hospice (applicable only for samples prior to 4/2019): Did the primary care provider complete the Subjective, Objective, Assessment, and Plan notes on the patient at the minimum intervals required for the type of facility where the patient was treated? (13.003) *,†	0	0	10	N/A
Upon the patient's admission to specialized medical housing: Were all medications ordered, made available, and administered to the patient within required time frames? (13.004) *	3	7	0	30.0%
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? (13.101) *	3	0	1	100%
For specialized health care housing (CTC, SNF, Hospice, OHU): Do health care staff perform patient safety checks according to institution's local operating procedure or within the required time frames? (13.102) *	0	1	3	0
				Overall percentage (MIT 13): **66.0%**

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

† CCHCS changed its policies and removed mandatory minimum rounding intervals for patients located in specialized medical housing. After April 2, 2019, MIT 13.003 only applied to CTCs that still have state-mandated rounding intervals. OIG case reviewers continued to test the clinical appropriateness of provider follow-ups within specialized medical housing units through case reviews.

Source: The Office of the Inspector General medical inspection results.

Overall Rating
Inadequate

Case Review Rating
Adequate

Compliance Score
Inadequate
(68.5%)

Specialty Services

In this indicator, OIG inspectors evaluated the quality of specialty services. The OIG clinicians focused on the institution's ability to provide needed specialty care. Our clinicians also examined specialty appointment scheduling, providers' specialty referrals, and medical staff's retrieval, review, and implementation of any specialty recommendations.

Results Overview

In this indicator, case review analysis and compliance testing revealed different ratings. Case review found that CMF provided satisfactory specialty access for its patients. Providers requested specialty services appropriately with proper priorities. They generally followed recommendations, with only a few exceptions. However, health information management of the reports was poor. The institution had difficulty retrieving reports and obtaining the provider's endorsement within policy time frames. The case review team concluded that deficiencies in health information management did not ultimately affect care in the cases they reviewed because the triage and treatment area RNs generally documented recommendations and made them available to the provider.

Compliance testing showed poor performance in access to specialists, retrieval of reports, and health information management; all areas of specialty services had poor performance. Considering both compliance and case review, CMF received an ***inadequate*** rating for this indicator.

Case Review Results

Our clinicians reviewed 234 events related to specialty services, including 137 specialty consultations and procedures, and found 59 deficiencies, 25 of which were significant.[58] Most of the deficiencies pertained to the health information management of specialty reports. CMF had difficulty retrieving and ensuring providers endorsed specialty reports. Although the large number of these deficiencies could have impacted patient care, CMF compensated by having the TTA RN summarize recommendations from the specialist and make the summary available to providers.

Access to Specialty Services

Case review clinicians found that specialty services were generally provided within requested time frames, with only a few exceptions. One delay was due to an outside specialist scheduling a patient according to his own schedule, and the institution was not penalized. There was another minor delay with an otolaryngologist consultation in case 27.

58. We identified deficiencies in cases 9, 12, 13, 15, 16, 17, 19, 22, 23, 24, 25, 27, 28, 29, 30, 37, 38, 72, 74, 76, and 77. Cases 9, 13, 15, 16, 17, 22, 23, 25, 27, 28, 30, and 38 had significant deficiencies.

Compliance testing showed good results in routine (MIT 14.007, 86.7%) and high-priority (MIT 14.001, 80.0%) specialty access, but poor results in medium-priority specialty access (MIT 14.004, 60.0%) and transfer continuity (MIT 14.010, 60.0%).

Compliance testing found problems with the continuation of previously approved specialty referrals. This was not applicable to the case review team, as the patients in the cases we reviewed did not have any pending specialty referrals upon transferring into CMF.

Provider Performance

CMF providers performed well in recognizing the need for specialty services. They requested the proper priority appointments. However, there were a few instances where providers did not review specialty reports properly to follow specialists' recommendations. This occurred in case 23 and in the following:

- In case 38, a cardiologist recommended increasing the dosage of lisinopril, a blood pressure medication, for a patient with uncontrolled blood pressure. Instead, the provider reduced the dosage of this medication from 20 mg twice daily to 5 mg daily. This significantly increased the risk of harm to the patient.
- In case 27, an otolaryngologist recommended a magnetic resonance imaging (MRI) of a patient's cerebellum and internal auditory canals to complete an evaluation for dizziness. The provider did not follow this recommendation.
- Case review clinicians found two instances where provider follow-ups after a specialty consultation were not scheduled. We found the deficiencies in case 38. Compliance testing found poor follow-up after specialty services (MIT 1.008, 73.8%).

Nursing Performance

CMF nurses performed well with patients returning from specialty appointments. We reviewed 37 nursing encounters related to specialty services and did not identify any significant deficiencies. The nurses often performed complete assessments, reviewed specialty reports, communicated pertinent findings to the provider, and scheduled timely provider follow-ups. However, we identified a pattern: Nurses did not always provide patient education for these encounters.

Health Information Management

Case review clinicians found problems with the processing of specialty reports. Health information management deficiencies comprised 22 of the 25 deficiencies in this indicator and 39 of the 59 total deficiencies found during the Cycle 6 review period. CMF had difficulty obtaining

specialty reports within policy time frames.[59] It also had difficulty ensuring provider endorsement.[60] A few providers were responsible for not acknowledging their review of the records. We observed that the TTA RN generally summarized specialists' recommendations to the providers. This prevented any major consequences in the cases we observed; however, health information processing could be improved to reduce the risk of missed recommendations. Compliance testing also found poor management of specialty reports. We found less than timely scanning of specialty reports into the electronic health record system (EHRS) (MIT 4.002, 70.0%). Providers did not review specialty reports within policy time frames for routine-priority (MIT 14.008, 35.7%), medium-priority (MIT 14.005, 26.7%), and high-priority appointments (MIT 14.002, 46.7%).

Clinician On-Site Inspection

We discussed specialty referral management with CMF managers, supervisors, providers, and utilization nursing staff. Providers reported no trouble obtaining specialty referrals for patients who needed them. CMF has an accountability log, tracked by HIM staff, to note all off-site encounters. When HIM retrieves reports from the off-site encounter, radiology reports are sent to the radiology department for scanning into the radiology information system/picture archiving and communication system (RIS/PACS), and the off-site nurse is responsible for obtaining the provider's endorsement of the off-site specialty reports. On-site specialists provide written documentation of their findings and recommendations on the day of the encounter. The support staff (LVNs) review all specialty provider reports, notify the primary care physician or physician on-call of any immediate requirements, and perform any telephone orders. The support staff then forward all written documentation for scanning into the EHRS.

Recommendations

- Medical leadership should review the causes in the untimely retrieval of specialty reports and untimely provider review of the specialty reports; medical leadership should implement remedial measures as appropriate.

59. Deficiencies related to the retrieval of specialty records were identified in cases 9, 12, 13, 15, 17, 19, 23, 24, 28, 29, and 38.

60. Deficiencies related to late or missing endorsement of specialty records were identified in cases 9, 13, 23, 29, 30, 38, and 77.

Compliance Testing Results

Table 18. Specialty Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
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? (14.001) *	12	3	0	80.0%
Did the institution receive and did the primary care provider review the high-priority specialty service consultant report within the required time frame? (14.002) *	7	8	0	46.7%
Did the patient receive the subsequent follow-up to the high-priority specialty service appointment as ordered by the primary care provider? (14.003) *	5	2	8	71.4%
Did the patient receive the medium-priority specialty service within 15-45 calendar days of the primary care provider order or Physician Request for Service? (14.004) *	9	6	0	60.0%
Did the institution receive and did the primary care provider review the medium-priority specialty service consultant report within the required time frame? (14.005) *	4	11	0	26.7%
Did the patient receive the subsequent follow-up to the medium-priority specialty service appointment as ordered by the primary care provider? (14.006) *	3	2	10	60.0%
Did the patient receive the routine-priority specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? (14.007) *	13	2	0	86.7%
Did the institution receive and did the primary care provider review the routine-priority specialty service consultant report within the required time frame? (14.008) *	5	9	1	35.7%
Did the patient receive the subsequent follow-up to the routine-priority specialty service appointment as ordered by the primary care provider? (14.009) *	9	0	6	100%
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? (14.010) *	12	8	0	60.0%
Did the institution deny the primary care provider's request for specialty services within required time frames? (14.011)	20	0	0	100%
Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? (14.012)	19	1	0	95.0%
				Overall percentage (MIT 14): **68.5%**

* The OIG clinicians considered these compliance tests along with their case review findings when determining the quality rating for this indicator.

Source: The Office of the Inspector General medical inspection results.

Table 19. Other Tests Related to Specialty Services

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
Specialty service follow-up appointments: Did the clinician follow-up visits occur within required time frames? (1.008) *, †	31	11	3	73.8%
Are specialty documents scanned into the patient's electronic health record within five calendar days of the encounter date? (4.002) *	21	9	15	70.0%

* The OIG clinicians considered these compliance tests along with their own case review findings when determining the quality rating for this indicator.

† CCHCS changed its specialty policies in April 2019, removing the requirement for primary care physician follow-up visits following most specialty services. As a result, we test 1.008 only for high-priority specialty services or when the staff orders PCP or PC RN follow-ups. The OIG continues to test the clinical appropriateness of specialty follow-ups through its case review testing.

Source: The Office of the Inspector General medical inspection results.

Administrative Operations

Overall Rating ***Adequate***

Case Review Rating **(N/A)**

Compliance Score ***Adequate*** **(79.4%)**

In this indicator, OIG compliance inspectors evaluated health care administrative processes. Our inspectors examined the timeliness of the medical grievance process and checked whether the institution followed reporting requirements for adverse or sentinel events and patient deaths. Inspectors checked whether the Emergency Medical Response Review Committee (EMRRC) met and reviewed incident packages. We investigated and determined if the institution conducted the required emergency response drills. Inspectors also assessed whether the Quality Management Committee (QMC) met regularly and addressed program performance adequately. In addition, the inspectors examined if the institution provided training and job performance reviews for its employees. They checked whether staff possessed current, valid professional licenses, certifications, and credentials. The OIG rated this indicator solely based on the compliance score, using the same scoring thresholds as in the Cycle 4 and Cycle 5 medical inspections. Our case review clinicians do not rate this indicator.

Because none of the tests in this indicator affected clinical patient care directly (it is a secondary indicator), the OIG did not consider this indicator's rating when determining the institution's overall quality rating.

Nonscored Results

We obtained CCHCS Death Review Committee (DRC) reporting records. After a patient dies, the DRC must complete a death review summary report within 60 calendar days for unexpected deaths and within 30 calendar days for expected deaths. When the DRC completes the death review summary report, it must submit the report to the institution's CEO within seven calendar days of completion. At CMF, 10 expected (Level 2) deaths occurred during the inspection review period. We found the DRC did not complete any death reviews promptly; the DRC finished 10 reports between 34 to 59 days late and submitted them to the institution's CEO between 28 to 52 days late (MIT 15.998).

Recommendations

- The EMRRC should ensure the checklist form in the incident package is fully completed.
- Medical leadership should ensure that clinical competency evaluations and performance appraisals are completed timely.

Table 20. Administrative Operations

Compliance Questions	Scored Answer			
	Yes	No	N/A	Yes %
For health care incidents requiring root cause analysis (RCA): Did the institution meet RCA reporting requirements? (15.001)	N/A	N/A	N/A	N/A
Did the institution's Quality Management Committee (QMC) meet monthly? (15.002)	4	2	0	66.7%
For Emergency Medical Response Review Committee (EMRRC) reviewed cases: Did the EMRRC review the cases timely, and did the incident packages the committee reviewed include the required documents? (15.003)	3	9	0	25.0%
For institutions with licensed care facilities: Did the Local Governing Body (LGB) or its equivalent, meet quarterly and discuss local operating procedures and any applicable policies? (15.004)	4	0	0	100%
Did the institution conduct medical emergency response drills during each watch of the most recent quarter, and did health care and custody staff participate in those drills? (15.101)	2	1	0	66.7%
Did the responses to medical grievances address all of the inmates' grieved issues? (15.102)	10	0	0	100%
Did the medical staff review and submit initial inmate death reports to the CCHCS Death Review Unit on time? (15.103)	9	1	0	90.0%
Did nurse managers ensure the clinical competency of nurses who administer medications? (15.104)	8	2	0	80.0%
Did physician managers complete provider clinical performance appraisals timely? (15.105)	4	15	0	21.1%
Did the providers maintain valid state medical licenses? (15.106)	25	0	0	100%
Did the staff maintain valid Cardiopulmonary Resuscitation (CPR), Basic Life Support (BLS), and Advanced Cardiac Life Support (ACLS) certifications? (15.107)	2	0	1	100%
Did the nurses and the pharmacist-in-charge (PIC) maintain valid professional licenses and certifications, and did the pharmacy maintain a valid correctional pharmacy license? (15.108)	5	1	1	83.3%
Did the pharmacy and the providers maintain valid Drug Enforcement Agency (DEA) registration certificates? (15.109)	2	0	0	100%
Did nurse managers ensure their newly hired nurses received the required onboarding and clinical competency training? (15.110)	1	0	0	100%
Did the CCHCS Death Review Committee process death review reports timely? (15.998)	This is a nonscored test. Please refer to the discussion in this indicator.			
What was the institution's health care staffing at the time of the OIG medical inspection? (15.999)	This is a nonscored test. Please refer to Table 4 for CCHCS-provided staffing information.			
	Overall percentage (MIT 15): **79.4%**			

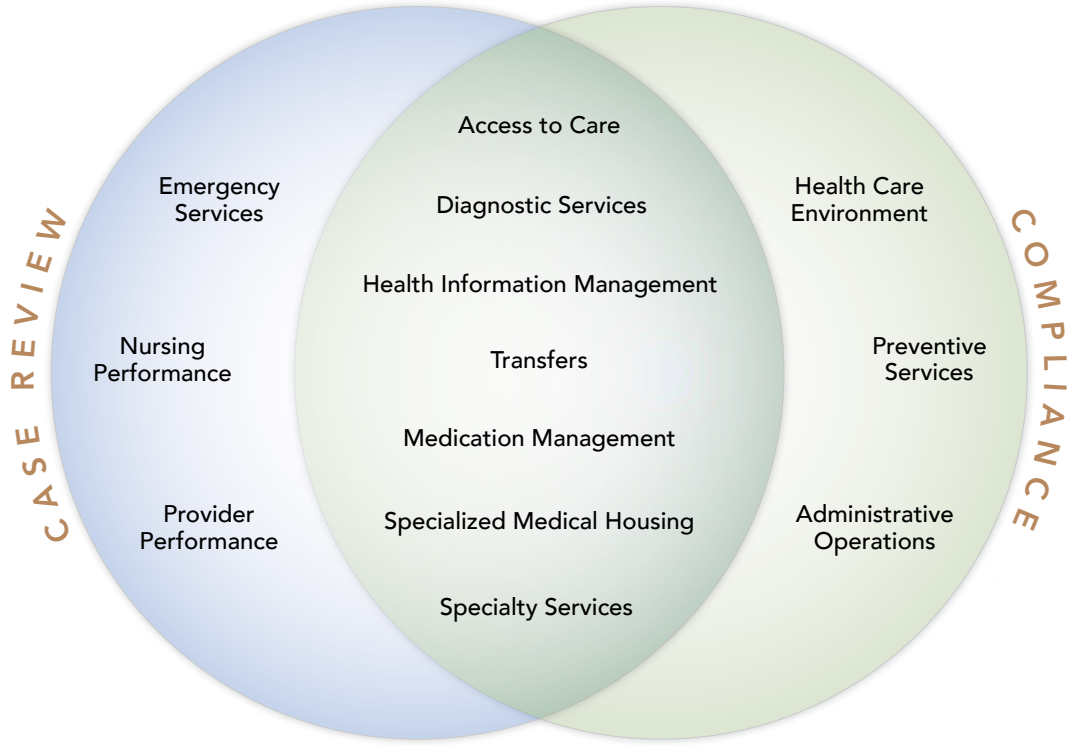
Source: The Office of the Inspector General medical inspection results.

Appendix A: Methodology

In designing the medical inspection program, the OIG met with stakeholders to review CCHCS policies and procedures, relevant court orders, and guidance developed by the American Correctional Association. We 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, the department, the Office of the Attorney General, and the Prison Law Office to discuss the nature and scope of our inspection program. With input from these stakeholders, the OIG developed a medical inspection program that evaluates the delivery of medical care 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.

We rate each of the quality indicators applicable to the institution under inspection based on case reviews conducted by our clinicians or compliance tests conducted by our registered nurses. Figure A–1 below depicts the intersection of case review and compliance.

Figure A–1. Inspection Indicator Review Distribution for CMF



Source: The Office of the Inspector General medical inspection results.

Case Reviews

The OIG added case reviews to the Cycle 4 medical inspections at the recommendation of its stakeholders, which continues in the Cycle 6 medical inspections. Below, Table A–1 provides important definitions that describe this process.

Table A–1. Case Review Definitions

Case, Sample, or Patient	The medical care provided to one patient over a specific period, which can comprise detailed or focused case reviews.
Comprehensive Case Review	A review that includes all aspects of one patient's medical care assessed over a six-month period. This review allows the OIG clinicians to examine many areas of health care delivery, such as access to care, diagnostic services, health information management, and specialty services.
Focused Case Review	A review that focuses on one specific aspect of medical care. This review tends to concentrate on a singular facet of patient care, such as the sick call process or the institution's emergency medical response.
Event	A direct or indirect interaction between the patient and the health care system. Examples of direct interactions include provider encounters and nurse encounters. An example of an indirect interaction includes a provider reviewing a diagnostic test and placing additional orders.
Case Review Deficiency	A medical error in procedure or in clinical judgment. Both procedural and clinical judgment errors can result in policy noncompliance, elevated risk of patient harm, or both.
Adverse Event	An event that caused harm to the patient.

The OIG eliminates case review selection bias by sampling using a rigid methodology. No case reviewer selects the samples he or she reviews. Because the case reviewers are excluded from sample selection, there is no possibility of selection bias. Instead, nonclinician analysts use a standardized sampling methodology to select most of the case review samples. A randomizer is used when applicable.

For most basic institutions, the OIG samples 20 comprehensive physician review cases. For institutions with larger high-risk populations, 25 cases are sampled. For the California Health Care Facility, 30 cases are sampled.

Case Review Sampling Methodology

We obtain a substantial amount of health care data from the inspected institution and from CCHCS. Our analysts then apply filters to identify clinically complex patients with the highest need for medical services. These filters include patients classified by CCHCS with high medical risk, patients requiring hospitalization or emergency medical services, patients arriving from a county jail, patients transferring to and from other departmental institutions, patients with uncontrolled diabetes or uncontrolled anticoagulation levels, patients requiring specialty services or who died or experienced a sentinel event (unexpected occurrences resulting in high risk of, or actual, death or serious injury), patients requiring specialized medical housing placement, patients requesting medical care through the sick call process, and patients requiring prenatal or postpartum care.

After applying filters, analysts follow a standardized protocol and select samples for clinicians to review. Samples are obtained per the case review methodology shared with stakeholders in prior cycles. Our physician and nurse reviewers test the samples by performing comprehensive or focused case reviews.

Case Review Testing Methodology

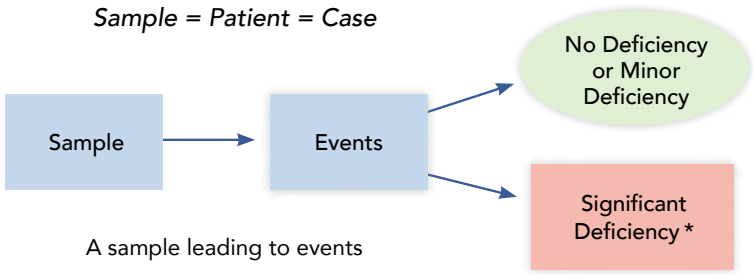
An OIG physician, a nurse consultant, or both review each case. As the clinicians review medical records, they record pertinent interactions between the patient and the health care system. We refer to these interactions as case review ***events***. Our clinicians also record medical errors, which we refer to as case review ***deficiencies***.

Deficiencies can be minor or significant, depending on the severity of the deficiency. If a deficiency caused serious patient harm, we classify the error as an ***adverse event***. On the next page, Figure A–2 depicts the scenarios that can lead to these different events.

After the clinician inspectors review all the cases, they analyze the deficiencies, then summarize their findings in one or more of the health care indicators in this report.

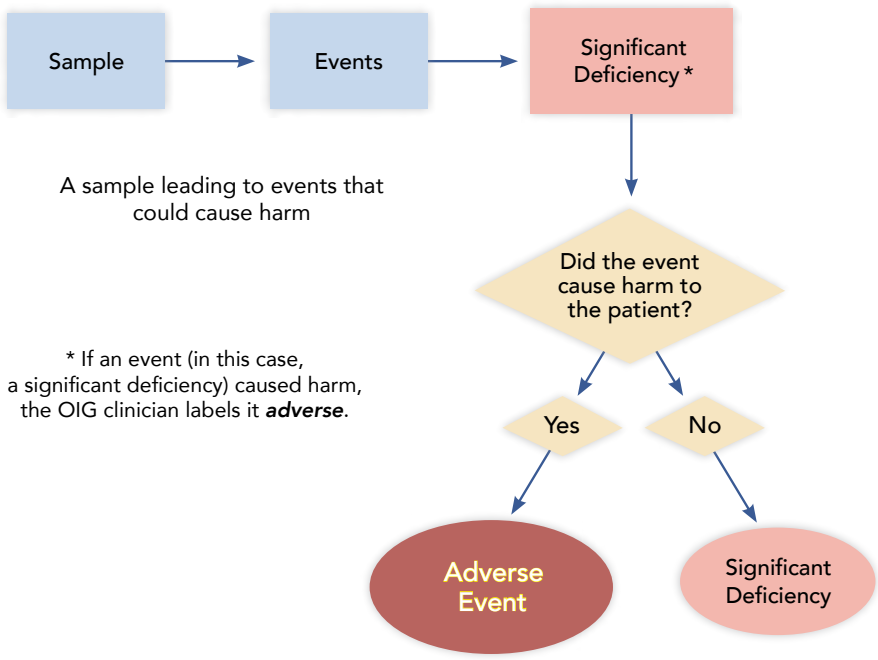
Figure A–2. Case Review Testing

The OIG clinicians examine the chosen samples, performing either a ***comprehensive case review*** or a ***focused case review***, to determine the events that occurred.



Deficiencies

Not all events lead to deficiencies (medical errors); however, if errors did occur, then the OIG clinicians determine whether any were ***adverse***.



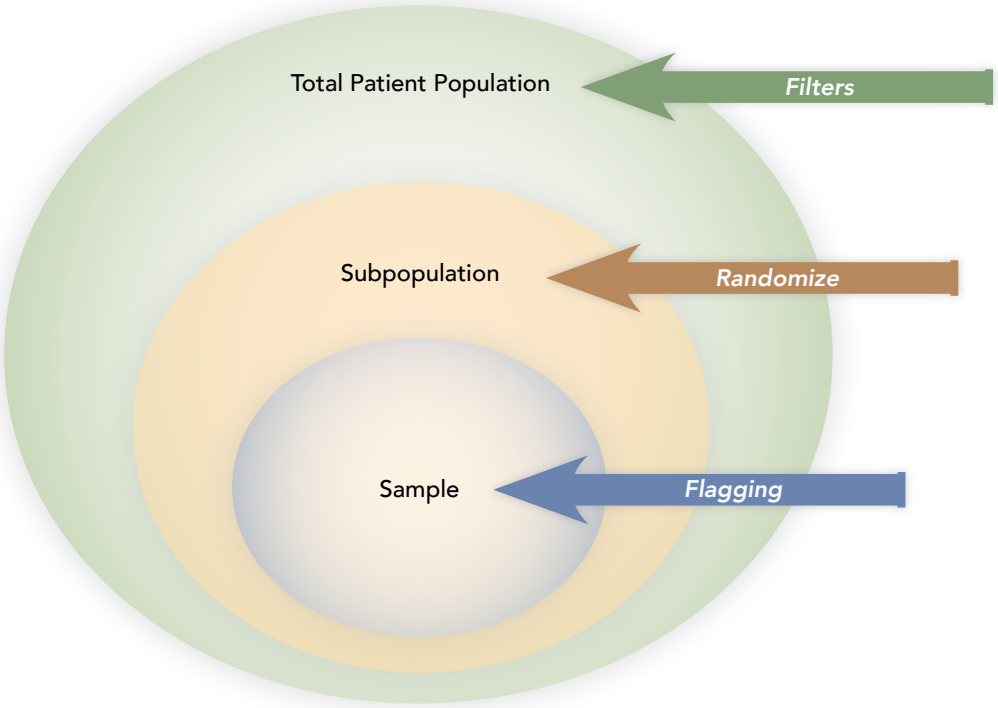
Source: The Office of the Inspector General medical inspection analysis.

Compliance Testing

Compliance Sampling Methodology

Our analysts identify samples for both our case review inspectors and compliance inspectors. Analysts follow a detailed selection methodology. For most compliance questions, we use sample sizes of approximately 25 to 30. Figure A–3 below depicts the relationships and activities of this process.

Figure A–3. Compliance Sampling Methodology



Source: The Office of the Inspector General medical inspection analysis.

Compliance Testing Methodology

Our inspectors answer a set of predefined medical inspection tool (MIT) questions to determine the institution's compliance with CCHCS policies and procedures. Our nurse inspectors assign a ***Yes*** or a ***No*** answer to each scored question.

OIG headquarters nurse inspectors review medical records to obtain information, allowing them to answer most of the MIT questions. Our regional nurses visit and inspect each institution. They interview health care staff, observe medical processes, test the facilities and clinics, review employee records, logs, medical grievances, death reports, and other documents, and also obtain information regarding plant infrastructure and local operating procedures.

Scoring Methodology

Our compliance team calculates the percentage of all ***Yes*** answers for each of the questions applicable to a particular indicator, then averages the scores. The OIG continues to rate these indicators based on the average compliance score using the following descriptors: ***proficient*** (85.0 percent or greater), ***adequate*** (between 84.9 percent and 75.0 percent), or ***inadequate*** (less than 75.0 percent).

Indicator Ratings and the Overall Medical Quality Rating

To reach an overall quality rating, our inspectors collaborate and examine all the inspection findings. We consider the case review and the compliance testing results for each indicator. After considering all the findings, our inspectors reach consensus on an overall rating for the institution.

Appendix B: Case Review Data

Table B–1. Case Review Sample Sets

Sample Set	Total
Anticoagulation	3
CTC/OHU	4
Death Review/Sentinel Events	3
Diabetes	3
Emergency Services – CPR	5
Emergency Services – Non-CPR	3
High Risk	5
Hospitalization	4
Intrasystem Transfers In	3
Intrasystem Transfers Out	3
RN Sick Call	32
Specialty Services	4
	72

Table B–2. Case Review Chronic Care Diagnoses

Diagnosis	Total
Anemia	9
Anticoagulation	4
Arthritis/Degenerative Joint Disease	4
Asthma	14
COPD	13
Cancer	2
Cardiovascular Disease	11
Chronic Kidney Disease	4
Chronic Pain	30
Cirrhosis/End-Stage Liver Disease	11
Coccidioidomycosis	2
Deep Venous Thrombosis/Pulmonary Embolism	1
Diabetes	23
Gastroesophageal Reflux Disease	15
Gastrointestinal Bleed	1
HIV	3
Hepatitis C	28
Hyperlipidemia	21
Hypertension	36
Mental Health	26
Migraine Headaches	3
Seizure Disorder	7
Sleep Apnea	4
Thyroid Disease	3
	275

Table B–3. Case Review Events by Program

Diagnosis	Total
Diagnostic Services	243
Emergency Care	88
Hospitalization	38
Intrasystem Transfers In	3
Intrasystem Transfers Out	3
Not Specified	2
Outpatient Care	409
Specialized Medical Housing	269
Specialty Services	234
	1,289

Table B–4. Case Review Sample Summary

MD Reviews Detailed	25
MD Reviews Focused	2
RN Reviews Detailed	14
RN Reviews Focused	45
Total Reviews	86
Total Unique Cases	72
Overlapping Reviews (MD & RN)	14

Appendix C: Compliance Sampling Methodology

California Medical Facility

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Access to Care				
MIT 1.001	Chronic Care Patients	25	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • Randomize
MIT 1.002	Nursing Referrals	25	OIG Q: 6.001	• See Transfers
MITs 1.003–006	Nursing Sick Call (6 per clinic)	40	MedSATS	• Clinic (each clinic tested) • Appointment date (2–9 months) • Randomize
MIT 1.007	Returns From Community Hospital	25	OIG Q: 4.005	• See **Health Information Management** (Medical Records) (returns from community hospital)
MIT 1.008	Specialty Services Follow-Up	45	OIG Q: 14.001, 14.004 & 14.007	• See Specialty Services
MIT 1.101	Availability of Health Care Services Request Forms	6	OIG on-site review	• Randomly select one housing unit from each yard
Diagnostic Services				
MITs 2.001–003	Radiology	10	Radiology Logs	• Appointment date (90 days–9 months) • Randomize • Abnormal
MITs 2.004–006	Laboratory	10	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.007–009	Laboratory STAT	10	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • Randomize • Abnormal
MITs 2.010–012	Pathology	10	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Health Information Management (Medical Records)				
MIT 4.001	Health Care Services Request Forms	20	OIG Qs: 1.004	• Nondictated documents • First 20 IPs for MIT 1.004
MIT 4.002	Specialty Documents	30	OIG Qs: 14.002, 14.005 & 14.008	• Specialty documents • First 10 IPs for each question
MIT 4.003	Hospital Discharge Documents	20	OIG Q: 4.005	• Community hospital discharge documents • First 20 IPs selected
MIT 4.004	Scanning Accuracy	24	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.005	Returns From Community Hospital	25	CADDIS off-site Admissions	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • Randomize
Health Care Environment				
MITs 5.101–105 MITs 5.107–111	Clinical Areas	15	OIG inspector on-site review	• Identify and inspect all on-site clinical areas.
Transfers				
MITs 6.001–003	Intrasystem Transfers	25	SOMS	• Arrival date (3–9 months) • Arrived from (another departmental facility) • Rx count • Randomize
MIT 6.101	Transfers Out	10	OIG inspector on-site review	• R&R IP transfers with medication

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Pharmacy and Medication Management				
MIT 7.001	Chronic Care Medication	25	OIG Q: 1.001	See **Access to Care** • At least one condition per patient—any risk level • Randomize
MIT 7.002	New Medication Orders	25	Master Registry	• Rx count • Randomize • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns From Community Hospital	25	OIG Q: 4.005	• See **Health Information Management** (Medical Records) (returns from community hospital)
MIT 7.004	RC Arrivals—Medication Orders	N/A at this institution	OIG Q: 12.001	• See **Reception Center**
MIT 7.005	Intrafacility Moves	25	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • Randomize
MIT 7.006	En Route	7	SOMS	• Date of transfer (2–8 months) • Sending institution (another departmental facility) • Randomize • NA/DOT meds
MITs 7.101–103	Medication Storage Areas	Varies by test	OIG inspector on-site review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–107	Medication Preparation and Administration Areas	Varies by test	OIG inspector on-site review	• Identify and inspect on-site clinical areas that prepare and administer medications
MITs 7.108–111	Pharmacy	2	OIG inspector on-site review	• Identify & inspect all on-site pharmacies
MIT 7.112	Medication Error Reporting	25	Medication error reports	• All medication error reports with Level 4 or higher • Select total of 25 medication error reports (recent 12 months)
MIT 7.999	Isolation Unit KOP Medications	12	On-site active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in isolation units

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Prenatal and Postpartum Care				
MITs 8.001–007	Recent Deliveries	N/A at this institution	OB Roster	• Delivery date (2–12 months) • Most recent deliveries (within date range)
	Pregnant Arrivals	N/A at this institution	OB Roster	• Arrival date (2–12 months) • Earliest arrivals (within date range)
Preventive Services				
MITs 9.001–002	TB Medications	5	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • Randomize
MIT 9.003	TB Evaluation, Annual Screening	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Birth month • Randomize
MIT 9.004	Influenza Vaccinations	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Randomize • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening	25	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • Randomize
MIT 9.006	Mammogram	N/A at this institution	SOMS	• Arrival date (at least 2 yrs. prior to inspection) • Date of birth (age 52–74) • Randomize
MIT 9.007	Pap Smear	N/A at this institution	SOMS	• Arrival date (at least three yrs. prior to inspection) • Date of birth (age 24–53) • Randomize
MIT 9.008	Chronic Care Vaccinations	25	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • Randomize • Condition must require vaccination(s)
MIT 9.009	Valley Fever (number will vary)	N/A at this institution	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • All

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Reception Center				
MITs 12.001–008	RC	N/A at this institution	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • Randomize
Specialized Medical Housing				
MITs 13.001–004	Specialized Health Care Housing Unit	10	CADDIS	• Admit date (2–8 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • Rx count • Randomize
MIT 13.101	Call Buttons	All	OIG inspector on-site review	• Specialized Health Care Housing • Review by location
Specialty Services				
MITs 14.001–003	High-Priority Initial and Follow-Up RFS	15	MedSATS	• Approval date (3–9 months) • Remove consult to gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, or podiatry • Randomize
MITs 14.004–006	Medium-Priority Initial and Follow-Up RFS	15	MedSATS	• Approval date (3–9 months) • Remove consult to gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, or podiatry • Randomize
MITs 14.007–009	Routine-Priority Initial and Follow-Up RFS	15	MedSATS	• Approval date (3–9 months) • Remove consult to gynecology, consult to public health/Specialty RN, dialysis, ECG 12-Lead (EKG), mammogram, occupational therapy, ophthalmology, optometry, oral surgery, physical therapy, or podiatry • Randomize
MIT 14.010	Specialty Services Arrivals	20	MedSATS	• Arrived from (other departmental institution) • Date of transfer (3–9 months) • Randomize
MITs 14.011–012	Denials	20	InterQual	• Review date (3–9 months) • Randomize
		N/A	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • Randomize

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations				
MIT 15.001	Adverse/sentinel events	N/A at this institution	Adverse/sentinel events (ASE) report	• Adverse/Sentinel events (2–8 months)
MIT 15.002	QMC Meetings	6	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.003	EMRRC	12	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.004	LGB	4	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills	3	On-site summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	Institutional Level Medical Grievances	10	On-site list of grievances/closed grievance files	• Medical grievances closed (6 months)
MIT 15.103	Death Reports	10	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.104	Nursing Staff Validations	10	On-site nursing education files	• On duty one or more years • Nurse administers medications • Randomize
MIT 15.105	Provider Annual Evaluation Packets	19	On-site provider evaluation files	• All required performance evaluation documents
MIT 15.106	Provider Licenses	25	Current provider listing (at start of inspection)	• Review all
MIT 15.107	Medical Emergency Response Certifications	All	On-site certification tracking logs	• All staff ◦ Providers (ACLS) ◦ Nursing (BLS/CPR) • Custody (CPR/BLS)
MIT 15.108	Nursing Staff and Pharmacist in Charge Professional Licenses and Certifications	All	On-site tracking system, logs, or employee files	• All required licenses and certifications

Quality Indicator	Sample Category	No. of Samples	Data Source	Filters
Administrative Operations				
MIT 15.109	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations	All	On-site listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 15.110	Nursing Staff New Employee Orientations	All	Nursing staff training logs	• New employees (hired within last 12 months)
MIT 15.998	Death Review Committee	10	OIG summary log: deaths	• Between 35 business days & 12 months prior • Health Care Services death reviews

California Correctional Health Care Services' Response

April 9, 2021

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

Dear Mr. Wesley:

The Office of the Receiver has reviewed the draft report of the Office of the Inspector General (OIG) Medical Inspection Results for California Medical Facility (CMF) conducted from September 2019 to February 2020. California Correctional Health Care Services (CCHCS) acknowledges the OIG findings.

Thank you for preparing the report. Your efforts have advanced our mutual objective of ensuring transparency and accountability in CCHCS operations. If you have any questions or concerns, please contact me at (916) 691-3284.

Sincerely,

Amanda Oltean

Digitally signed by Amanda Oltean
Date: 2021.04.09 09:49:21 -07'00'

Amanda Oltean
Associate Director (A)
Risk Management Branch
California Correctional Health Care Services

cc: Clark Kelso, Receiver
Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Richard Kirkland, Chief Deputy Receiver
Katherine Tebrock, Chief Assistant Inspector General, OIG
Doreen Pagaran, R.N., Nurse Consultant Program Review, OIG
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Regional Health Care Executive, Region I, CCHCS
Regional Deputy Medical Executive, Region I, CCHCS
Regional Nursing Executive, Region I, CCHCS
Chief Executive Officer, CMF
Misty Polasik, Staff Services Manager I, OIG

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

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Cycle 6
Medical Inspection Report

for

California Medical Facility

OFFICE *of the*
INSPECTOR GENERAL

Roy W. Wesley
Inspector General

Bryan B. Beyer
Chief Deputy Inspector General

STATE *of* CALIFORNIA
May 2021

OIG