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California Institution for Women Medical Inspection Results Cycle 5



August 2018

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

Office of the Inspector General CALIFORNIA INSTITUTION FOR WOMEN Medical Inspection Results Cycle 5

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FOREWORD

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

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

In Cycle 5, for the first time, the OIG will be inspecting institutions delegated back to CDCR from the Receivership. There is no difference in the standards used for assessment of a delegated institution versus an institution not yet delegated. The Receiver delegated the California Institution for Women back to CDCR in March 2017.

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

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EXECUTIVE SUMMARY

The OIG completed the Cycle 5 medical inspection of the California Institution for Women (CIW) in August 2018. The vast majority of our inspection findings were based on CIW’s health care delivery between November 2016 and November 2017. Our policy compliance inspectors performed an onsite inspection in October 2017. After reviewing the institution’s health care delivery, our case review clinicians performed an onsite inspection in January 2018.

OVERALL RATING:
Adequate

Our clinician team, consisting of expert physicians and nurse consultants, reviewed cases (patient medical records) and interpreted our policy compliance results to determine the quality of health care the institution provided. Our compliance team, consisting of registered nurses, monitored the institution’s compliance with its medical policies by answering a predetermined set of policy compliance questions.

Our clinician team reviewed 63 cases that contained 1,649 patient-related events. Our compliance team tested 94 policy questions by observing CIW’s processes and examining 414 patient records and 1,259 data points. We distilled the results from both the case review and compliance testing into 14 health care indicators, and have listed the individual indicators and ratings applicable for this institution in the *CIW Executive Summary Table* on the following page. Our experts made a considered and measured opinion that the overall quality of health care at CIW was *adequate*.

CIW Executive Summary Table

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

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

Expert Clinician Case Review Results

The clinicians' case reviews sampled patients with high medical needs and included a review of 1,649 patient care events.¹ The vast majority of our case review covered the period between November 2016 and November 2017. As depicted on the executive summary table on page *iv*, of the 14 indicators applicable to CIW, 11 were evaluated by clinician case review; 4 were *proficient*, 5 were *adequate*, and 2 were *inadequate*. When determining the overall adequacy of care, the OIG paid particular attention to the clinical nursing and provider quality indicators, as adequate health care staff can sometimes overcome suboptimal compliance or performance with processes and programs. However, the opposite is not true; inadequate health care staff cannot provide adequate care, even though the established processes and programs onsite may be adequate. The OIG clinicians identify inadequate medical care based on the risk of significant harm to the patient, not the actual outcome.

For Cycle 5, CIW continued to provide adequate medical care. However, compared to Cycle 4, overall medical performance has declined. While still performing at acceptable levels, CIW provider and nursing errors were more noticeable in this cycle than in Cycle 4. While this aspect was most pronounced in two health care indicators in which the ratings were determined to be no longer *adequate* for Cycle 5 (*Pharmacy and Medication Management* and *Specialized Medical Housing*), the OIG case review clinicians detected this performance decline in several areas that remain *adequate*, including the *Quality of Provider Performance* and *Quality of Nursing Performance* indicators.

Program Strengths — Clinical

- As the OIG noted in Cycle 4, CIW continued to provide excellent access to care, reflected in that indicator's rating. The institution's medical staff expressed commitment to provide their patients with appropriate health care access.
- Medical staff delivered excellent prenatal medical care. With a dedicated obstetric specialist on staff and excellent access to offsite high-risk pregnancy specialists, CIW provided timely laboratory tests, vaccinations, appointments, and consultations.
- Nurses proactively reviewed patient records for patients who were transferred into the institution. They notified providers and the pharmacy ahead of time to ensure that CIW was well-prepared to meet the needs of arriving patients.
- CIW specialty nurses prepared and educated their patients extensively for upcoming specialty appointments. This practice resulted in improved patient compliance with specialty care.

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

Program Weaknesses — Clinical

- Medical staff had difficulty providing consistent medication administration and did not maintain medication continuity for patients returning from an outside hospital.
- CIW's provider and nursing performance were insufficient in the specialized medical housing units. Providers sometimes failed to diagnose medical conditions correctly or intervene appropriately. Nurses often failed to recognize their patients' dangerous medical conditions or notify the provider when they occurred.

Compliance Testing Results

Of the 14 health care indicators applicable to CIW, compliance inspectors evaluated 11.² Of these, five were *proficient*, two were *adequate*, and four were *inadequate*. The vast majority of our compliance testing was of medical care that occurred between January 2017 and October 2017. There were 94 individual compliance questions within those 11 indicators, generating 1,259 data points, which tested CIW's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.³ *Appendix A — Compliance Test Results* provides details for the 94 questions.

Program Strengths — Compliance

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

- The institution provided timely provider appointments to pregnant patients. Patients received their prenatal vitamins and daily nutritional supplements within the required time frame, and staff also properly assigned pregnant patients to appropriate housing and accommodations.
- CIW staff did an excellent job of offering immunizations to patients and providing them with preventive services such as mammograms, Pap smears, and colorectal cancer screenings.
- Patients at CIW received their high-priority and routine specialty service appointments within required time frames. CIW providers timely received and reviewed specialty service appointment reports. For specialty services the institution denied, its staff followed departmental policy for processing denied requests.

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

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

- Nursing staff at CIW received and reviewed health care services request forms and conducted face-to-face encounters within required time frames.

Program Weaknesses — Compliance

The following listing identifies some of the weaknesses CIW's compliance scores demonstrate in response to individual questions in all health care indicators:

- CIW providers did not always communicate results of radiology, laboratory, and pathology reports to patients within required time frames.
- OIG inspectors found medical supplies stored past manufacturers' guidelines in the institution's medical warehouse.
- Several medical clinics did not follow proper CCHCS policy and procedures for inventorying emergency medical response bags (EMRBs) and medical crash carts within the time frame required.
- Patients recently discharged from a community hospital did not timely receive their medications upon returning to the institution. Furthermore, patients did not consistently receive their ordered chronic care medications timely.

Recommendations

The OIG recommends the following:

- The pharmacist in charge (PIC) and the chief nurse executive (CNE) should implement quality improvement processes to improve the medication administration of newly prescribed medications and to improve the medication continuity for chronic care patients and patients returning from an outside hospital or emergency department. We found significant problems in these medication delivery areas during this inspection.
- The CEO should expand the institution's quality improvement efforts to include both nursing and medical provider care in the psychiatric inpatient program (PIP) and the outpatient housing unit (OHU). Because of the problems we found in these areas, CIW should target clinical care assessments, transitions of care during patient hand-offs among staff, and communication between providers and nurses as areas for improvement in these locations.
- The CEO should have the EMRRC conduct clinical reviews of all non-scheduled emergency transports, including those that involved a patient's departure from mental health areas, including the PIP and the mental health CTC. We found substandard medical care in those areas, resulting in patients needing emergency transfers to higher levels of care.

- The CNE should reevaluate and improve the institution's current process of evaluating nurses' knowledge and skills competency because we found problems with nursing assessment and intervention and the lack of provider notification in the inpatient (CTC) and outpatient sick-call areas.
 - The CME should monitor and train the providers to be more thorough when making assessments and reviewing patient records, particularly in the specialized medical housing units. Furthermore, the CME should also arrange diabetes and opioid management training due to these problems we found.
 - The CEO should install bedside or mobile computers in the TTA to enable CIW staff to record their care documentation into the electronic health record system (EHRS) because we found that the TTA staff did not have sufficient computer access during our clinician onsite inspection.
-

Population-Based Metrics

In general, CIW performed well as measured by population-based metrics. In comprehensive diabetes care, CIW outperformed most state and national health care plans in the five diabetic measures. However, the institution scored lower than two health care plans for blood pressure control and lower than one health care plan for diabetic eye examinations.

With regard to immunization measures, CIW scored higher than all other health care plans for influenza immunizations for both younger and older adults. The institution also outperformed all health care plans regarding pneumococcal vaccine administration. Cancer screening scores were mixed, with the institution scoring higher than all health plans for breast cancer screening, higher than three and lower than three health plans for cervical cancer screening, and higher than three and lower than two health plans for colorectal screening.

CIW's population-based metrics were comparable to the other health care plans reviewed. The institution might improve its scores for screening for cervical and colorectal cancer by reducing the refusal rate via patient education.

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INTRODUCTION

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

The California Institution for Women (CIW) was the 27th medical inspection of Cycle 5. During the inspection process, the OIG assessed the delivery of medical care to patients using the primary clinical health care indicators applicable to the institution. The *Administrative Operations* indicator is secondary because it does not reflect the actual clinical care provided.

ABOUT THE INSTITUTION

Located in the city of Corona, in Riverside County, CIW was the state's only prison that housed female felons until 1987. This institution's mission is to provide a safe and secure environment for female offenders. CIW houses patients with special needs such as pregnancy, psychiatric care, and medical problems such as HIV infection.

CIW runs ten clinics in which health care staff members handle non-urgent requests for medical services. The institution also conducts patient screenings in its receiving and release (R&R) clinical area; treats patients requiring urgent or emergent care in its triage and treatment area (TTA); and treats patients requiring inpatient care in its licensed correctional treatment center (CTC). In its outpatient housing unit (OHU), CIW also treats patients requiring assistance with the activities of daily living but who do not require a higher level of inpatient care.

CCHCS has designated CIW as an intermediate (as opposed to a basic) care prison; these institutions are predominantly located in urban areas, close to tertiary care centers and specialty care providers likely to be used by an inmate population with higher medical needs, to provide the most cost-effective care.

After an initial accreditation in August 2014, the institution received reaccreditation from the Commission on Accreditation for Corrections on August 20, 2017. This accreditation program is a professional peer review process based on national standards set by the American Correctional Association (ACA).

Based on staffing data the OIG obtained from the institution, CIW’s vacancy rate among medical managers, primary care providers, supervisors, and rank-and-file nurses was 10 percent in September 2017, with the highest vacancy percentages among management and rank-and-file nursing staff. At the time of the OIG’s inspection, 18 health care personnel were on extended leave.

CIW Health Care Staffing Resources as of October 2017

Description	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff		Totals	
	Number	%	Number	%	Number	%	Number	%	Number	%
<i>Authorized Positions</i>	10	4%	8	3%	14.7	6%	199.5	86%	232.2	100%
<i>Filled Positions</i>	9	90%	8	100%	14	95%	179.2	90%	210.2	91%
<i>Vacancies</i>	1	10%	0	0%	0.7	5%	20.3	10%	22	9%
<i>Recent Hires (within 12 months)</i>	1	11%	1	13%	1	7%	22	12%	25	12%
<i>Staff Utilized from Registry</i>	0	0%	1	13%	0	0%	20	11%	21	10%
<i>Redirected Staff (to Non-Patient Care Areas)</i>	0	0%	0	0%	0	0%	0	0%	0	0%
<i>Staff on Extended Leave</i>	1	11%	1	13%	3	21%	13	7%	18	9%

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

As of September 11, 2017, the Master Registry for CIW showed that the institution had a total population of 1,894. Within that total population, 7.7 percent was designated as high medical risk, Priority 1 (High 1), and 13.4 percent was designated as high medical risk, Priority 2 (High 2). Patients’ assigned risk levels are based on the complexity of their required medical care related to their specific diagnoses, frequency of higher levels of care, age, and abnormal laboratory results and procedures. High 1 has at least two high-risk conditions; High 2 has only one. Patients at high medical risk are more susceptible to poor health outcomes than those at medium or low medical risk. Patients at high medical risk also typically require more health care

services than do patients with lower assigned risk levels. The table below illustrates the breakdown of the institution's medical risk levels at the start of the OIG medical inspection.

CIW Master Registry Data as of September 11, 2017

Medical Risk Level	Number of Patients	Percentage
High 1	145	7.7%
High 2	254	13.4%
Medium	817	43.1%
Low	678	35.8%
Total	1,894	100%

OBJECTIVES, SCOPE, AND METHODOLOGY

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

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

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

The OIG does not inspect for efficiency or cost-effectiveness of medical operations. Consistent with the OIG's agreement with the Receiver, this report only addresses the quality of CDCR's medical operations and its compliance with quality-related policies. Moreover, if the OIG learns of a patient needing immediate care, the OIG notifies the chief executive officer of health care services and requests a status report. Additionally, if the OIG learns of significant departures from community standards, it may report such departures to the institution's chief executive officer or to CCHCS. Because these matters involve confidential medical information protected by state and federal privacy laws, the OIG does not include specific identifying details related to any such cases in the public report.

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

CASE REVIEWS

The OIG added case reviews to the Cycle 4 medical inspections at the recommendation of its stakeholders, which continues in the Cycle 5 medical inspections. The following exhibit provides definitions that describe this process.

Exhibit 1. Case Review Definitions

Case = Sample = Patient

An appraisal of the medical care provided to one patient over a specific period, which can comprise detailed or focused case reviews.

Detailed 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.

Case Review 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 non-compliance, elevated risk of patient harm, or both.

Adverse Deficiency

A medical error that increases the risk of, or results in, serious patient harm. Most health care organizations refer to these errors as *adverse events*.

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

Patient Selection for Retrospective Case Reviews

Because retrospective case review is time consuming and requires qualified health care professionals to perform it, the OIG must carefully select a sample of patient records for clinician review. Accordingly, the group of patients the OIG targeted for case review carried the highest clinical risk and utilized the majority of medical services. The majority of patients selected for retrospective case review were high-utilizing patients with chronic care illnesses who were classified as high or medium risk. The reason the OIG targeted these patients for review is twofold:

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

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

1. If the institution is able to provide adequate clinical care to the most challenging patients with multiple complex and interdependent medical problems, it is more likely to provide adequate care to patients with less complicated health care issues. Because clinical expertise is required to determine whether the institution has provided adequate clinical care, the OIG utilizes experienced correctional physicians and registered nurses to perform this analysis.
2. The health of less complex patients is more likely to be affected by processes such as timely appointment scheduling, medication management, routine health screening, and immunizations. To review these processes, the OIG simultaneously performs a broad compliance review.
3. Patient cases generated during death reviews, sentinel events (unexpected occurrences involving death or serious injury, or risk thereof), and hospitalizations are more likely to comprise high-risk patients.

Benefits and Limitations of Targeted Subpopulation Review

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

Since the targeted subpopulation does not represent the institution's general prison population, the OIG cautions against inappropriate extrapolation of medical *conditions* or *outcomes* from the retrospective case reviews to the general population. For example, if the high-risk diabetic patients reviewed have poorly controlled diabetes, one cannot conclude that all the diabetics' conditions are poorly controlled. Similarly, if the high-risk diabetic patients under review have poor outcomes, one cannot conclude that the entire diabetic population is having similarly poor outcomes. The OIG does not extrapolate *conditions* or *outcomes*, but instead extrapolates the institution's *response* for those patients needing the most care because the *response* yields valuable system information.

In the above example, if the institution responds by providing appropriate diabetic monitoring, medication therapy, and specialty referrals for the high-risk patients reviewed, then it is reasonable to infer that the institution is also responding appropriately to all the diabetics in the prison. However, if these same high-risk patients needing monitoring, medications, and referrals are not getting those needed services, it is likely that the institution is not providing appropriate diabetic services.

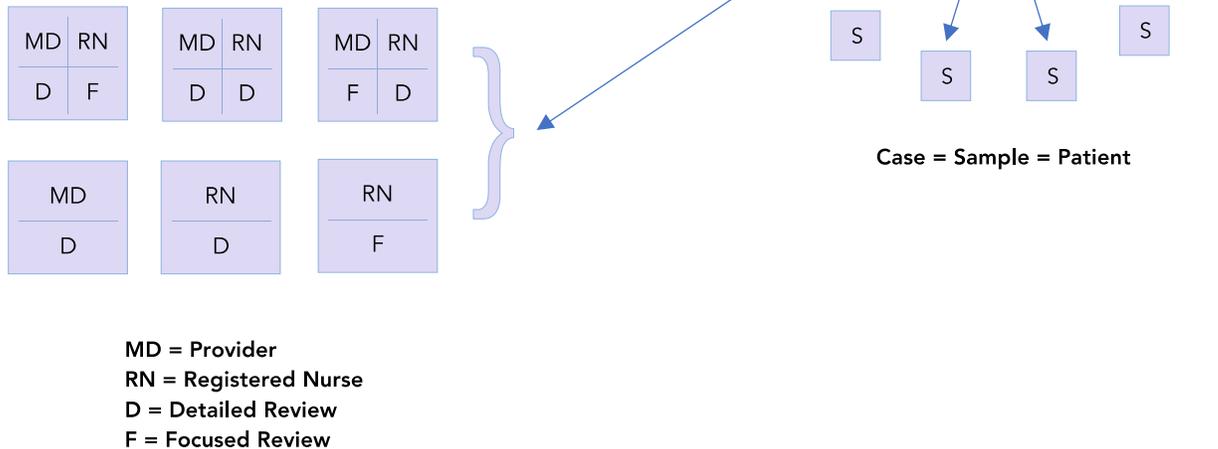
Case Review Sampling Methodology

Using a pre-defined case review sampling algorithm, OIG analysts apply various filters to each institution's patient population. The various filters include medical risk status, number of prescriptions, number of specialty appointments, number of clinic appointments, and other health-related data. The OIG uses these filters to narrow down the population to those patients with the highest utilization of medical resources (see Chart 1, next page). To prevent selection bias, the OIG ensures that the same clinicians who perform the case reviews do not participate in the sample selection process.

Chart 1. Case Review Sample Selection

Sample Selection

Analysts apply filters to the **population** to obtain **samples (S)** with high utilization. Six permutations, or arrangements, of case review types are possible for each sample.



The OIG’s case sample size matched those of other qualitative research. The empirical findings, supported by expert statistical consultants, showed adequate conclusions after 10 to 15 cases had undergone comprehensive, or detailed, clinician review. In qualitative statistics, this phenomenon is known as “saturation.” The OIG found the Cycle 4 medical inspection sample size of 30 for detailed physician reviews far exceeded the saturation point necessary for an adequate qualitative review. At the end of Cycle 4 inspections, the OIG reanalyzed the case review results using half the number of cases; there were no significant differences in the ratings. To improve inspection efficiency while preserving the quality of the inspection, the OIG reduced the number of the samples for Cycle 5 medical inspections to the current levels. For most basic institutions, the OIG samples 20 cases for detailed physician review. For intermediate institutions and several basic institutions with larger high-risk populations, the OIG samples 25 cases. For California Health Care Facility, the OIG samples 30 cases for detailed physician review.

Breadth of Case Reviews

As indicated in *Appendix B, Table B-1: CIW Sample Sets*, the OIG clinicians evaluated medical records for 63 unique cases. *Appendix B, Table B-4: CIW Case Review Sample Summary* clarifies that both nurses and physicians reviewed medical records for 15 of those cases, for 78 reviews in total. Physicians performed detailed reviews of 27 cases, and nurses performed

detailed reviews of 17 cases, totaling 44 detailed reviews. Nurses and physicians also performed a focused review for an additional 34 cases. These reviews generated 1,649 case review events (*Appendix B, Table B-3: CIW Event – Program*).

While the sample method specifically pulled only six chronic care patient records, i.e., three diabetes patients and three anticoagulation patients (*Appendix B, Table B-1: CIW Sample Sets*), the 63 unique patients sampled included patients with 302 chronic care diagnoses (*Appendix B, Table B-2: CIW Chronic Care Diagnoses*). The OIG’s sample selection tool allowed evaluation of many chronic care programs because the complex and high-risk patients selected from the different categories often had multiple medical problems. While the OIG did not evaluate every chronic disease or health care staff member, the OIG did assess for adequacy the overall operation of the institution’s system and staff.

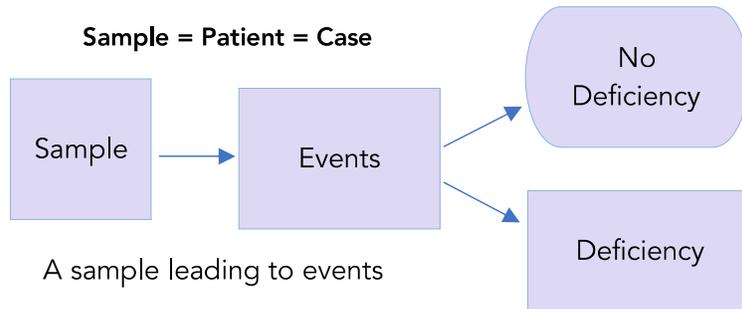
Case Review Testing Methodology

A physician, a nurse consultant, or both clinician inspectors review each case. The OIG clinician inspector can perform one of two different types of case review: detailed or focused (see Exhibit 1, page 5, and Chart 1, page 8). As the OIG clinician inspector reviews the medical record for each sample, the inspector records pertinent interactions between the patient and the health care system. These interactions are also known as case review *events*. When an OIG clinician inspector identifies a medical error, the inspector also records these errors as case review *deficiencies*. If a deficiency is of such magnitude that it caused, or had the potential to cause, serious patient harm, then the OIG clinician records it as an *adverse deficiency* (see Chart 2, next page).

Chart 2. Case Review Testing and Deficiencies

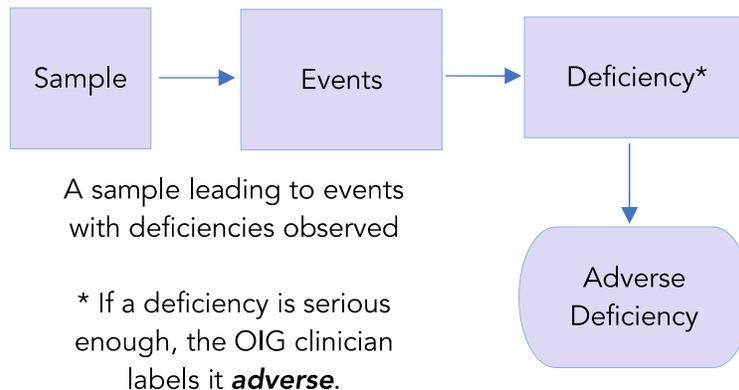
Case Review Testing

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



Deficiencies

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



When the OIG clinician inspectors have reviewed all cases, they analyze the deficiencies. OIG inspectors search for similar types of deficiencies to determine if a repeating pattern of errors existed. When the same type of error occurs multiple times, the OIG inspectors identify those errors as findings. When the error is frequent, the likelihood is high that the error is regularly recurring at the institution. The OIG categorizes and summarizes these deficiencies in one or more health care quality indicators in this report to help the institution focus on areas for improvement.

Additionally, the OIG physicians also rate each of the detailed physician cases for adequacy based on whether the institution met the patient’s medical needs and if it placed the patient at significant risk of harm. The cumulative analysis of these cases gives the OIG clinicians additional perspective to help determine whether the institution is providing adequate medical services or not.⁴

Based on the collective results of clinicians’ case reviews, the OIG clinicians rated each quality indicator *proficient* (excellent), *adequate* (passing), or *inadequate* (failing). A separate confidential *CIW Supplemental Medical Inspection Results: Individual Case Review Summaries* report details the case reviews the OIG clinicians conducted and is available to specific stakeholders. For further details regarding the sampling methodologies and counts, see *Appendix B — Clinical Data, Table B-1; Table B-2; Table B-3; and Table B-4.*

COMPLIANCE TESTING

Sampling Methods for Conducting Compliance Testing

Our registered nurse inspectors obtained answers to 94 objective medical inspection test (MIT) questions designed to assess the institution’s compliance with critical policies and procedures applicable to the delivery of medical care. To conduct most tests, inspectors randomly selected samples of patients for whom the testing objectives were applicable and reviewed their electronic medical records. In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed health records for 414 individual patients and analyzed specific transactions within their records for evidence that critical events occurred. Inspectors also reviewed management reports and meeting minutes to assess certain administrative operations. In addition, during the week of October 2, 2017, registered nurse field inspectors conducted a detailed onsite inspection of CIW’s medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,259 scored data points to assess care.

In addition to the scored questions, the OIG obtained information from the institution that it did not score. This included, for example, information about CIW’s plant infrastructure, protocols for tracking medical appeals and local operating procedures, and staffing resources.

⁴ Regarding individual provider performance, the OIG did not design the medical inspection to be a focused search for poorly performing providers; rather, the inspection assesses each institution’s systemic health care processes. Nonetheless, while the OIG does not purposefully sample cases to review each provider at the institution, the cases usually involve most of the institutions’ providers. Providers should only escape OIG case review if institutional managers assigned poorly performing providers the care of low-utilizing and low-risk patients, or if the institution had a relatively high number of providers.

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

Scoring of Compliance Testing Results

After compiling the answers to the 94 questions for the 11 indicators for which compliance testing was applicable, the OIG compliance team derived a score for each quality indicator by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Based on those results, the OIG assigned a rating to each quality indicator of *proficient* (greater than 85 percent), *adequate* (between 75 percent and 85 percent), or *inadequate* (less than 75 percent).

OVERALL QUALITY INDICATOR RATING FOR CASE REVIEWS AND COMPLIANCE TESTING

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

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

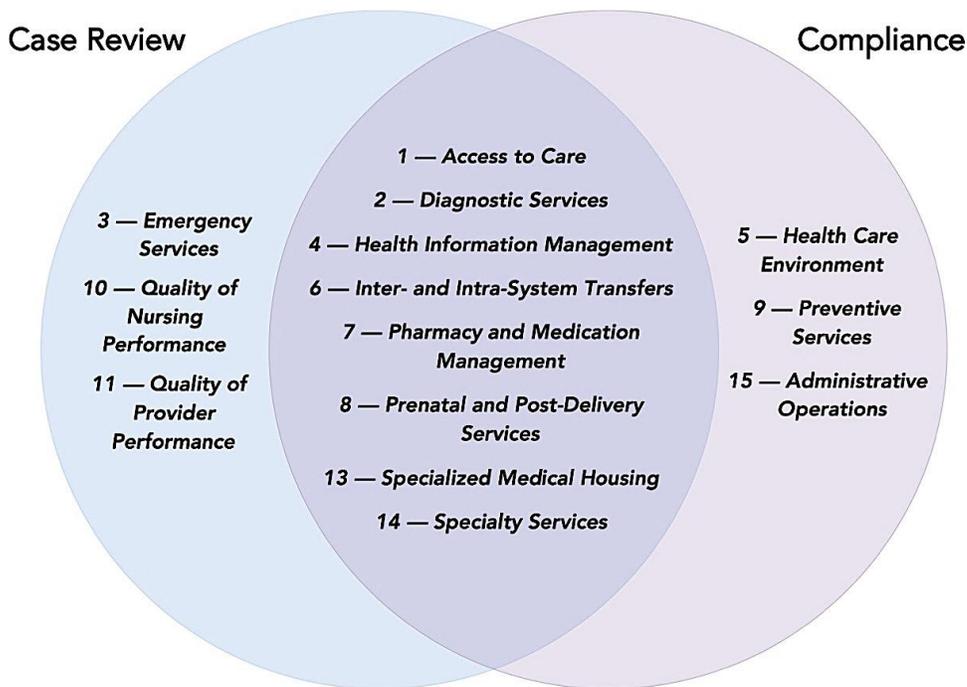
POPULATION-BASED METRICS

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

MEDICAL INSPECTION RESULTS

The OIG’s case review and clinician teams use quality indicators to assess the clinical aspects of health care. The *CIW Executive Summary Table* on page iv of this report identifies the 14 indicators applicable to this institution. The following chart depicts their union and intersection:

Chart 3. Inspection Indicator Review Distribution



The *Administrative Operations* indicator is a secondary indicator; therefore, the OIG did not rely upon this indicator when determining the institution’s overall score. Based on the analysis and results in all the primary indicators, the OIG experts made a considered and measured opinion that the quality of health care at CIW was *adequate*.

Summary of Case Review Results: The clinical case review component assessed 11 primary (clinical) indicators applicable to CIW. Of these 11 indicators, OIG clinicians rated 4 *proficient*, 5 *adequate*, and 2 *inadequate*.

The OIG physicians rated the overall adequacy of care for each of the 27 detailed case reviews they conducted. Of these 27 cases, 4 were *proficient*, 20 were *adequate*, and 3 were *inadequate*. In the 1,649 events reviewed, there were 251 deficiencies, 57 of which were considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

Adverse Deficiencies Identified During Case Review: Adverse deficiencies are medical errors that markedly increased the risk of, or resulted in, serious patient harm. Medical care is a complex and dynamic process with many moving parts, subject to human error even within the best health care organizations. All major health care organizations typically identify and track adverse deficiencies for the purpose of quality improvement. Adverse deficiencies are not typically representative of medical care delivered by the organization. The OIG normally identifies adverse deficiencies for the dual purposes of quality improvement and the illustration of problematic patterns of practice found during the inspection. Because of the anecdotal nature of these deficiencies, the OIG cautions against drawing inappropriate conclusions regarding the institution based solely on adverse deficiencies. The OIG identified two adverse deficiencies in the case reviews at CIW.

- In case 8, the diabetic patient experienced intermittent diarrhea, vomiting, and abdominal pain over the course of several weeks. On multiple occasions, the provider did not perform in-person examinations or order interventions to ensure the patient received adequate hydration and essential electrolytes. During this period, the patient had multiple episodes of low blood pressure, signs of fluid depletion, and episodes of black stool (a concern for the possibility of internal bleeding). Despite these worrisome signs and symptoms, the provider did not assess for internal bleeding or consider other potentially dangerous gastrointestinal diagnoses that should have warranted further medical tests. Moreover, the provider did not adjust the dose of the patient's blood pressure medication. The patient subsequently required hospitalization, where medical personnel determined she had insufficient blood flow to her intestines, and she died in the hospital. We also discuss this case in the *Quality of Provider Performance* and the *Specialized Medical Housing* indicators.
- In case 64, a hospital specialist recommended medication to prevent heart inflammation and an urgent abdominal computerized tomography (CT) scan to rule out a blood clot. CIW providers did not order the medication until eight days after the patient returned from the hospital. A provider ordered the CT as a "routine" procedure (to be completed within 90 days) instead of "urgent." Furthermore, CIW staff inappropriately transferred the patient to another facility eight days after an invasive cardiac procedure without having performed the CT scan first. CIW had failed to place a medical hold (an administrative action to prevent the patient's transfer) before the patient received important medical care. We also discuss this case in the *Inter- and Intra-System Transfers* and the *Specialized Medical Housing* indicators.

Summary of Compliance Results: The compliance component assessed 11 of the 14 indicators applicable to CIW. Of these 11 indicators, OIG inspectors rated 5 *proficient*, 2 *adequate*, and 4 *inadequate*.

Each section of this report summarizes the results of those assessments, whereas *Appendix A* provides the details of the test questions we used to assess compliance for each indicator.

1 — *ACCESS TO CARE*

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

Case Review Rating:

Proficient

Compliance Score:

Proficient

(88.2%)

Overall Rating:

Proficient

Case Review Results

We reviewed 543 provider, nurse, specialty, and hospital events that required a follow-up appointment. There were only 15 deficiencies related to *Access to Care*, 9 of which were significant. Although the deficiencies are summarized below, CIW demonstrated excellent health care access. The case review rating for this indicator was *proficient*.

Provider-to-Provider Follow-up Appointments

CIW demonstrated exceptional performance with provider-ordered appointments. These appointments are among the most important aspects of evaluating the *Access to Care* indicator as failure to accommodate these appointments can result in lapses of care. The OIG clinicians reviewed 177 provider-initiated follow-ups and found only one deficiency.

RN Sick Call Access

CIW's nursing sick call process functioned well. We reviewed 90 sick call requests and found only three deficiencies in cases 3, 7, and 23. The three deficiencies were related to delayed sick call appointments, were minor, and did not constitute any worrisome pattern.

RN-to-Provider Referrals

CIW ensured timely provider visits after nurse referral. In the 28 RN referrals reviewed, we found only two deficiencies. Both of these occurred because the nurse failed to create the referral order.

RN Follow-up Appointments

RN follow-up appointments took place as scheduled, with only two minor exceptions occurring one and two days late (cases 7 and 53).

Provider Follow-up After Specialty Services

Staff did not reliably schedule provider follow-ups after specialty appointments within the required time frames. Of the 16 applicable cases reviewed, we found four cases in which the provider follow-up occurred late or did not occur (cases 8, 9, 20, and 58).

Intra-System Transfers / Reception Center

We found no problems with access for newly arrived patients who transferred into the institution. CIW providers saw these patients timely.

Follow-up After Hospitalization

CIW scheduled post-hospitalization follow-up visits within required time frames.

Follow-up After Urgent/Emergent Care

CIW scheduled follow-up visits after urgent and emergent encounters within appropriate time frames.

Specialized Medical Housing

Medical staff evaluated patients held in specialized housing units within appropriate time frames. After the staff released patients from these units, the primary providers saw these patients timely.

Clinician Onsite Inspection

At the onsite visit, CIW's medical staff expressed their commitment to providing good access to care. CIW allotted extra time for the providers' schedules to accommodate unexpected and urgent appointments. CIW's leadership took a hands-on approach to ensure that patients had access to care by auditing pending appointments and creating remediation plans when these audits identified areas of concern.

Case Review Conclusion

Medical staff performed well with regard to *Access to Care*, diligently managing health care access for their patients. The OIG clinicians rated the *Access to Care* indicator *proficient*.

Compliance Testing Results

The institution performed in the *proficient* range, receiving a score of 88.2 percent in the *Access to Care* indicator. The following tests earned scores in the *proficient* range:

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

- We sampled 30 health care services request forms submitted by patients across all facility clinics. Nursing staff reviewed 29 of the 30 service request forms on the same day they were received (96.7 percent). Only one form showed no evidence of nursing review (MIT 1.003).
- For 26 of the 29 applicable patients (89.7 percent) who submitted health care services request forms, nursing staff completed a face-to-face encounter within one business day of reviewing the form. For two patients, the nurse completed a face-to-face encounter one and 12 days late; and for one patient, a face-to-face encounter did not occur (MIT 1.004).
- For the six sampled patients who submitted health care services request forms and whom nurses referred for a provider appointment, all six patients received their appointments timely (MIT 1.005).

Four tests received scores in the *adequate* range:

- We sampled 25 patients with one or more chronic care conditions; 19 patients received their provider-ordered follow-up appointments timely (76.0 percent). Five patients' follow-up appointments occurred between one and 20 days late; and one patient's appointment did not occur at all (MIT 1.001).
- We sampled 24 patients who transferred into CIW from other institutions and who were referred to a provider based on the nurse's initial health care screening; 19 patients (79.2 percent) were seen timely. Two patients received their provider appointments 14 and 25 days late; and three other patients received their appointments between three and seven months late (MIT 1.002).
- We sampled 25 patients who returned from a community hospital; 21 of them (84.0 percent) received their provider follow-up appointments timely. Four patients received their follow-up appointments one or two days late (MIT 1.007).
- We sampled 25 patients who received a high-priority or routine referral for specialty services; 20 of them (80.0 percent) received timely follow-up appointments with their provider. Five patients received their follow-up appointments from 5 to 11 days late (MIT 1.008).

2 — **DIAGNOSTIC SERVICES**

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

Case Review Rating:
Proficient
Compliance Score:
Inadequate
(71.1%)
Overall Rating:
Adequate

For this indicator, our case review and compliance testing yielded different results, with the case reviewers assigning a *proficient* rating and the compliance testing resulting in an *inadequate* score. The main reason for the *inadequate* score: providers did not communicate results from diagnostic tests to patients consistently. We considered the results obtained from both case review and compliance testing, and we concluded that while CIW providers could have done a better job of sending their patients diagnostic notifications, they reviewed the diagnostic reports and treated their patients appropriately. Our experts determined that the overall rating for this indicator was *adequate*.

Case Review Results

We reviewed 332 diagnostic events and found 5 deficiencies, 3 of which were significant. Deficiencies were rare and appeared to be isolated events. The case review rating for this indicator was *proficient*.

Test Completion

We found only one instance of a provider ordering a diagnostic test that the institution did not complete. CIW processed and performed nearly every test timely and notified the provider that the tests were ready for review within the electronic health record system (EHRs). If a provider was absent from work, other providers could review each other's messages and test results.

Health Information Management

We did not find any deficiency patterns with the management of diagnostic test results.

Clinician Onsite Inspection

CIW's radiology department scheduled all CT scans, magnetic resonance imaging (MRI) scans, ultrasounds, X-rays, and mammograms. An outside imaging service performed CT and MRI scans bi-monthly, depending on demand. CIW staff then scanned the radiology reports into the

EHRS and sent them to the ordering provider for review. We found the radiology scheduling system to be current and without backlog. Laboratory personnel was responsible for obtaining blood samples, tracking and retrieving bacterial culture and pathology results, and notifying providers when the results became available.

Case Review Conclusion

CIW performed timely and effective radiology and laboratory testing. The staff ensured that the results were available in the electronic medical record and notified the providers when the results became available. Deficiencies were rare, and the OIG clinicians rated the *Diagnostic Services* indicator *proficient*.

Compliance Testing Results

The institution received an *inadequate* compliance score of 71.1 percent in the *Diagnostic Services* indicator, which encompasses radiology, laboratory, and pathology services. For clarity, we discuss each type of diagnostic service separately below:

Radiology Services

- CIW timely performed provider-ordered radiology services for all ten sampled patients (MIT 2.001). Providers then timely reviewed and initialed corresponding diagnostic services reports for seven of the ten patients (70.0 percent), but providers reviewed three patients' reports 2, 4, and 20 days late (MIT 2.002). Finally, providers timely communicated test results to only five of the ten sampled patients (50.0 percent), and five other patients received their results from 4 to 20 days late (MIT 2.003).

Laboratory Services

- Seven of ten sampled patients (70.0 percent) received their provider-ordered laboratory services timely. For two patients, CIW provided their services from one to four days late; but for the remaining patient, the test was processed one day early and thus outside the time frame that the provider prescribed (MIT 2.004). While the institution's providers reviewed all ten of the resulting laboratory services reports within required time frames (MIT 2.005), CIW providers did not timely communicate the results to any of the ten sampled patients. Seven patients received their results from 3 to 24 days late; and for three other patients, the providers failed to communicate the reports to the patients at all (MIT 2.006).

Pathology Services

- CIW timely retrieved final pathology reports for nine of the ten sampled patients (90.0 percent) but retrieved one report 22 days late (MIT 2.007). Providers properly signed all ten resulting reports (MIT 2.008). Finally, providers timely communicated pathology results to only six of the ten sampled patients (60.0 percent), with four patients notified of their pathology results from one to 22 days late (MIT 2.009).
-

3 — *EMERGENCY SERVICES*

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

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

The OIG evaluates this quality indicator entirely through a clinician review of case files and conducts no separate compliance testing element.

Case Review Results

We reviewed 24 cases, which yielded 55 urgent/emergent events. We found 33 deficiencies, of which four were significant. Most deficiencies were minor and did not affect patient care. The case review rating for this indicator was *adequate*.

CPR Response

CIW custody and health care staff provided appropriate CPR interventions. The staff promptly initiated CPR, provided airway management and chest compressions, and used the automated external defibrillator (AED) correctly. The nurses recorded the events appropriately and demonstrated a well-organized team approach to cardiopulmonary resuscitation.

Provider Performance

CIW providers performed well in this area. The providers assessed, treated, and documented emergent events successfully. For patients who required after-hours care, the on-call providers recorded progress notes. The next morning, those providers communicated the events to the primary care providers, facilitating continuity of care. While most providers performed well in emergency services, we found two cases in which the providers failed to identify an emergency:

- In case 2, the provider inappropriately ordered an unmonitored (custody staff only, no medical personnel) transfer to a higher level of care for the head trauma patient who was medically unstable.
- In case 30, the patient was found to have a dangerously low hemoglobin count that could have caused a massive stroke, a heart attack, or death. The CIW provider should have

transferred the patient to a higher level of care emergently but had requested only a routine transfer.

Nursing Performance

During urgent and emergent encounters, CIW nurses usually performed well by making appropriate assessments and interventions. In some cases, TTA nurses did not completely assess their patients or did not promptly intervene for them.

Incomplete assessments occurred in cases 1, 7, 21, 25, 26, and 27. These were minor errors that did not result in any substantial risk of harm. For example, a nurse did not ask about the last meal eaten or did not perform a full abdominal examination.

When patients stayed in the TTA for an extended period, nurses did not always monitor them closely by rechecking vital signs or asking about pain levels. Nurses made these errors, which we considered minor, in cases 9, 21, 24, and 25.

Nursing Documentation

The nurses' emergency documentation was at times incomplete and lacked details. These documentation deficiencies did not affect patient care. Nonetheless, improper documentation occurred in cases 4, 6, 21, and 25, and in the following two cases:

- In case 2, the nurse did not document the time and method of TTA arrival.
- In case 9, the nurse documented vital signs at the wrong time.

Emergency Medical Response Review Committee

The EMRRC reviewed most emergent transports and correctly identified problems in their own emergency services. However, on a few occasions, the Emergency Medical Response Review Committee (EMRRC) did not always capture nursing deficiencies.

- In case 21, CIW staff activated a medical alarm after the patient developed left-sided numbness, weakness, and unequal grip strength after a recent fall. These were signs and symptoms suggestive of a stroke or intracranial bleed. The EMRRC did not identify the nurse's failure to reassess the patient's vital signs and mental status for three hours.
- In case 25, CIW staff transferred a patient with abdominal pain to a community hospital. The EMRRC did not identify the nurse's delay in contacting a provider, in reassessing the patient's abdominal pain, or in failing to assess a surgical wound.

Clinician Onsite Inspection

The TTA is a single room located in the central health building, containing two examination gurneys. TTA nurses responded to all medical emergencies and assessed patients returning from

offsite services (specialist appointment, community hospital, and emergency room care). In the TTA area, one desktop computer was available to CIW nurses, and a second nursing computer was located outside the examination area. These computer locations did not allow nurses to record their patient care in real time. As a result, nurses often took handwritten notes and documented their findings and observations in the EHRs after the patient had departed from their area. CIW's administrative staff reported several attempts to obtain "rover" or mobile computers without success.

Case Review Conclusion

CIW performed well regarding *Emergency Services*, but there were some areas in which the institution could improve. We believe CIW nurses can improve their performance by completing assessments, monitoring patients regularly, and recording complete documentation. The EMRRC can also improve by completing more careful clinical reviews. Nonetheless, CIW staff appropriately managed patients in urgent and emergent situations, and the OIG clinicians rated this indicator *adequate*.

4 — **HEALTH INFORMATION MANAGEMENT**

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

Case Review Rating:
Proficient
Compliance Score:
Adequate
(84.0%)
Overall Rating:
Proficient

In this indicator, our case review and compliance testing yielded different results, with the case reviewers assigning a *proficient* rating and the compliance testing resulting in an *adequate* score. Compliance testing found minor delays in retrieving certain documents. These delays were not clinically significant and did not increase the risk of patient harm. We considered the factors that led to both results and determined that the overall rating for this indicator was *proficient*.

CIW had converted to the new electronic health record system (EHRS) in October 2015; therefore, most testing occurred in the EHRS, with a minor portion of the testing done in the electronic unit health record (eUHR).

Case Review Results

We reviewed 1,649 events and found 18 deficiencies related to health information management, 5 of which were significant. The case review rating for this indicator was *proficient*.

Inter-Departmental Transmission

Medical staff tracked medical information throughout the institution efficiently. We found no pattern of deficiencies concerning the transmission of medical information within departments.

Hospital Records

CIW timely received and scanned medical information from outside hospitals. When a patient was hospitalized, CIW nurses obtained updated patient information daily for the medical providers to review. They also obtained a comprehensive package of medical information at the time of hospital discharge.

Specialty Services

CIW performed well with specialty records, retrieving most specialty records timely, scanning them into the patient’s medical record, and sending them to the primary care provider for review.

On five occasions (all in cases 10 and 54), a CIW provider did not sign specialty reports, but the provider clearly had reviewed the records because the provider documented the information in the progress notes and orders. We also discuss this performance in the *Specialty Services* indicator.

Diagnostic Reports

We found significant improvement in this area compared to the prior cycle, identifying only four deficiencies in this review. We also discuss this performance in the *Diagnostic Services* indicator.

Urgent/Emergent Records

CIW on-call providers performed well in documenting their telephone encounters. On the other hand, the CIW nurses recorded their care poorly and recorded many timeline errors. We also discuss this performance in the *Emergency Services* indicator.

Scanning Performance

CIW performed well with scanning and labeling medical records. We found mislabeled medical records in only 5 of the 63 cases reviewed.

Clinician Onsite Inspection

We observed good clinical information sharing during the morning provider meetings and the daily morning huddles, as well as when we interviewed health care staff with regards to the processing of medical reports.

Case Review Conclusion

Compared to Cycle 4, CIW demonstrated significant improvement in this indicator. CIW had no difficulty retrieving outside hospital and specialty reports. Provider and nursing progress notes were legible due to the EHRS conversion. The OIG clinicians rated CIW *proficient* in the *Health Information Management* indicator.

Compliance Testing Results

The institution scored in the *adequate* range, earning 83.7 percent in the *Health Information Management* indicator. The following test received a *proficient* score:

- The institution's medical records staff timely scanned all sampled non-dictated progress notes, patients' initial health care screening forms, and health care services request forms into patients' electronic medical records (MIT 4.001).

Four tests received *adequate* scores:

- CIW medical records staff timely scanned 16 of 20 specialty service consultant reports (80.0 percent) into patients' electronic medical records. Three specialty reports were scanned two days late; and the fourth report was missing from the patient's medical record (MIT 4.003).
- The institution timely scanned hospital discharge reports and treatment records into patients' medical records for 17 of the 20 sampled reports (85.0 percent); two reports were scanned one to two days late; and one report was scanned 26 days late (MIT 4.004).
- The institution scored 75.0 percent in its labeling and filing of documents scanned into patients' electronic medical records. For this test, once we identify 24 documents that are improperly entered into or missing from the electronic medical record, the maximum points are lost, and the resulting score is zero. In total, five documents were mislabeled, and one patient's medical record contained documents of another patient (MIT 4.006).
- We reviewed community hospital discharge reports and treatment records for 25 sampled patients sent to community hospitals for treatment who later returned to CIW. For 20 of the 25 patients (80.0 percent), the hospital discharge summary reports were complete, and CIW providers reviewed them timely. For four patients, providers reviewed the hospital discharge summary reports from one to 30 days late; and for one other patient, the discharge report that CIW received was incomplete (MIT 4.007).

5 — HEALTH CARE ENVIRONMENT

This indicator addresses the general operational aspects of the institution’s clinics, including certain elements of infection control and sanitation, medical supplies and equipment management, the availability of both auditory and visual privacy for patient visits, and the sufficiency of facility infrastructure to conduct comprehensive medical examinations. The OIG rates this component entirely on the compliance testing results from the visual observations inspectors make at the institution during their onsite visit; there is no case review portion.

Case Review Rating:

Not Applicable

Compliance Score:

*Inadequate
(69.1%)*

Overall Rating:

Inadequate

Compliance Testing Results

The institution received scores in the *inadequate* range for the following five tests:

- The non-clinic bulk medical supply storage areas did not meet the supply management protocol and did not support the needs of the medical health care program. We found several medical supplies stored past the manufacturers’ guidelines. As a result, CIW received a score of zero in this test (MIT 5.106).
- Of the 14 clinics inspected, only 5 followed adequate medical supply storage and management protocols (35.7 percent). One or more of the following deficiencies occurred in nine clinics: no adequate inventory replenishment system was in place to ensure the clinics were stocked or restocked with medical supplies on a regular basis; medical supplies were stored in the same area with personal food items and disinfectant wipes; medical supplies were stored directly on the floor; storage of medical supplies in cabinets was disorderly; and medical supplies were stored past the manufacturers’ guidelines (*Figure 1*) (MIT 5.107).



Figure 1: Expired medical supplies

- Eight of 14 clinic locations (57.1 percent) met compliance requirements for essential core medical equipment and supplies. The remaining six clinics were missing one or more functional pieces of core equipment or other medical supplies necessary to conduct a comprehensive examination. The missing items included an examination table, an oto-ophthalmoscope, lubricating jelly, and disposable paper for the examination table (Figure 2). In addition, during our inspection, at one clinic, an overhead light was not working, and at another clinic, an oto-ophthalmoscope was not working (MIT 5.108).

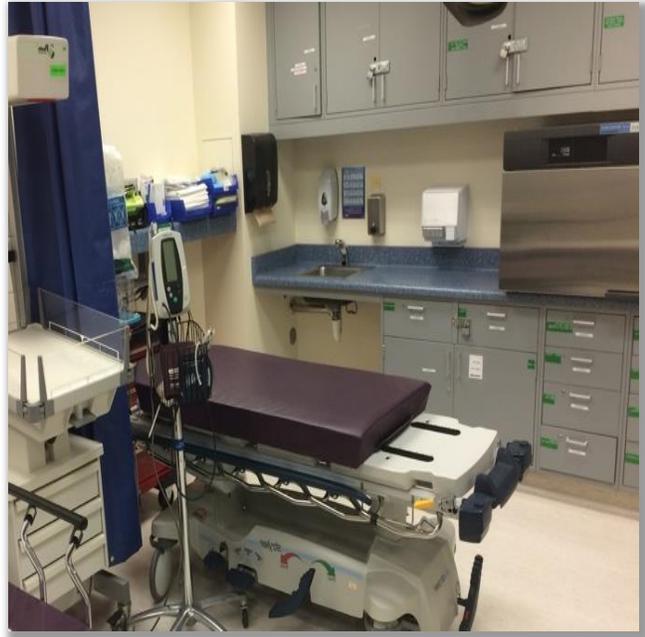


Figure 2: Examination table missing disposable paper cover

- Nine of the 14 clinic examination rooms observed (64.3 percent) had appropriate space, configuration, supplies, and equipment to allow clinicians to perform a proper clinical examination. In five clinics, we identified one or more of the following deficiencies: clinicians had impeded access to the examination tables; patients were unable to recline on the examination table fully due to physical obstructions; examination room supplies were disorderly and unorganized; and the configuration of examination room furniture and space prevented CIW clinicians from adequately performing patient examinations (MIT 5.110).
- We examined emergency medical response bags (EMRBs) and crash carts to determine if institution staff inspected the bags daily and inventoried them monthly and whether the bags contained all essential items. EMRBs and crash carts were compliant at 5 of the 11 applicable clinical locations (45.5 percent). We found one or more of the following deficiencies at six locations: staff did not inventory the EMRB within the previous 30 days; staff had not verified that the bag's compartments were sealed and intact; the EMRB lacked essential equipment needed to operate the portable oxygen tank; and the emergency crash cart was missing minimum par levels of the medical supplies inventoried at the time of inspection (MIT 5.111).

Six tests received scores in the *proficient* range:

- Staff appropriately disinfected, cleaned, and sanitized all 20 sampled clinics (MIT 5.101).

- Clinical health care staff at 12 of 14 applicable clinics (85.7 percent) ensured that reusable invasive and non-invasive medical equipment was properly sterilized or disinfected. Two clinics did not properly process, package, or store previously sterilized instruments (MIT 5.102).
- Twelve of the 14 clinic locations inspected (85.7 percent) had operating sinks and sufficient quantities of hand hygiene supplies in the examination areas. We found the following deficiencies in patient restrooms at two clinics: no disposable towels, a hand dryer that did not work, and a sink that was not working properly, despite CIW staff having submitted a work order requesting repair (MIT 5.103).
- We observed health care clinicians in each clinic to ensure they employed proper hand hygiene protocols. In all 14 clinics, clinicians adhered to universal hand hygiene precautions (MIT 5.104).
- Health care staff in all 14 clinics followed proper protocols to mitigate exposure to bloodborne pathogens and contaminated waste (MIT 5.105).
- Clinic common areas at 12 of the 14 clinics (85.7 percent) had environments conducive to providing medical services. In one clinic, however, the medication nurse did not have sufficient access to the EHRS, or enough working space to perform medication preparation. In another clinic, patients did not have enough seating to use while waiting for clinic appointments (MIT 5.109).

Non-Scored Results

- We gathered information to determine if the institution's physical infrastructure was maintained in a manner that supported health care management's ability to provide timely or adequate health care. We do not score this question. When we interviewed health care managers, they did not express any significant concerns. At the time of our medical inspection, CIW had several significant infrastructure projects underway. These projects were started in the summer of 2015, and the institution estimates they will be completed by the spring of 2018 (MIT 5.999).

6 — *INTER- AND INTRA-SYSTEM TRANSFERS*

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

Case Review Rating:
Adequate
Compliance Score:
Proficient
(85.5%)
Overall Rating:
Adequate

In this indicator, our case review and compliance testing yielded different results: case reviewers assigned the indicator an *adequate* rating, but compliance testing resulted in a *proficient* score. Both case review and compliance testing found that CIW did not consistently ensure post-hospital medication continuity. In addition, in the case reviews, CIW staff did not prevent a patient who required medical care from transferring to another institution. Despite substantial room for improvement in these areas, most transfers occurred without exposing the patients to excess medical risk. Our experts rated this indicator *adequate* overall.

Case Review Results

We reviewed 53 inter- and intra-system transfer events, including 27 hospitalization and outside emergency room events. All those outside hospital or emergency room events resulted in the patients transferring back to the institution. There were 14 deficiencies, 5 of which were significant. The case review rating for this indicator was *adequate*.

Transfers In

We reviewed ten patients who arrived from other CDCR facilities. Nurses correctly performed initial health screenings and initiated primary care appointments. The OIG found only four minor deficiencies.

Transfers Out

We reviewed five patients transferring out of CIW. Nurses performed pre-transfer record reviews and appropriately communicated health information to the receiving provider. We identified one significant deficiency as noted in the following case:

- In case 64, the patient was under evaluation for a blood clot, a potentially serious condition. The specialist recommended a CT scan to rule out this possibility. CIW failed to place a medical hold to prevent the patient from traveling to another institution. The travel may not have been safe for the patient, and the transfer increased the risk of a lapse in care.

Hospitalizations

Patients returning from hospitalizations are some of the highest-risk encounters due to two factors. First, these patients usually require hospitalization for a severe illness or injury, and second, they are at risk due to potential lapses in care that can occur during any transfer.

At CIW, providers and nurses usually assessed patients returning from the hospital properly and scheduled follow-up appointments with their primary care providers appropriately. Four of the ten hospital deficiencies were medication administration delays (cases 1, 25, 26, and 27). We discuss these cases in the *Pharmacy and Medication Management* indicator. The other six deficiencies were related to incomplete nursing and provider assessments (cases 7, 9, and 25), health information management errors (cases 6 and 27), and one minor appointment delay.

Clinician Onsite Inspection

One RN was assigned to each shift at the CIW R&R. In addition to assessing new arrivals and preparing patients for transfer, the RN conducted case and medication reviews for patients who had not yet arrived at the institution. This review process allowed the nurse to anticipate chronic care needs and pending specialty appointments, which improved the processing efficiency for patients when they did arrive at CIW. The RN also notified the pharmacy and the providers when the patient arrived at the institution.

Case Review Conclusion

CIW performed sufficiently with regard to *Inter- and Intra-System Transfers*. Although we noted room for improvement with CIW's post-hospital medication continuity and the institution's medical hold process, CIW staff managed most transfer events appropriately. The OIG clinicians rated the *Inter- and Intra-System Transfers* indicator *adequate*.

Compliance Testing Results

The institution scored in the *proficient* range for this indicator, with a score of 85.5 percent, receiving *proficient* scores in the following tests:

- Nursing staff timely completed the assessment and disposition sections of the health care screening forms for all 25 sampled patients who transferred into CIW from another CDCR facility (MIT 6.002).
- We inspected the transfer packages of nine patients who were transferred out of CIW to determine whether the packages included the required medications and supporting documentation. All nine transfer packages were compliant (MIT 6.101).

Two tests received scores in the *inadequate* range:

- We tested 25 patients who transferred into CIW from another CDCR institution to determine whether nurses made complete initial health screening assessments on the day they arrived. Nurses completed 18 of 25 sampled health care service forms (72.0 percent) the same day the patients arrived at CIW. For seven patients, nursing staff neglected to answer all applicable screening form questions (MIT 6.001).
- Of 25 sampled patients who transferred into CIW, only 10 patients had an existing medication order upon arrival. Seven of those ten patients (70.0 percent) received their medication without interruption. Three patients incurred medication interruptions of one or more dosing periods upon arrival (MIT 6.003).

7 — *PHARMACY AND MEDICATION MANAGEMENT*

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

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(68.4%)
Overall Rating:
Inadequate

Case Review Results

We reviewed 42 events related to medications and found 19 deficiencies, 9 of which were significant. The case review rating for this indicator was *inadequate*.

Medication Continuity

In the case reviews, CIW demonstrated a process in which the nurses notified providers of expiring prescriptions. Providers reordered and refilled chronic care medications before they ran out. However, we found occasional delays or breaks in medication continuity for patients returning from a community hospital. In four cases, CIW failed to continue chronic care medications (cases 1, 25, 26, and 27), and in two cases (cases 1 and 7), CIW did not provide needed antibiotics for patients returning from a community hospital. The following are examples of such deficiencies:

- In case 1, the patient returned from the hospital; the provider ordered an antibiotic, but the patient did not receive the medication for three days.
- In case 7, CIW staff admitted the patient to the OHU upon return from a community hospital. The provider ordered a ten-day course of antibiotics, but the patient did not receive antibiotics for two of those days (days 2 and 10).
- In cases 25 and 26, the patients returned from the hospital, but did not receive their chronic care medications for two days.
- In case 27, the patient returned from the hospital after she had an exacerbation of asthma. The patient did not receive two essential asthma medications (prednisone and a rescue inhaler) and medication for her eyes until two days later.

Medication Administration

CIW experienced problems with medication administration. We found a clear pattern of missed and delayed medications in the case reviews. CIW staff did not administer medications in cases 12, 25, and 38; and delayed delivery of medications in cases 25 and 34. The following cases demonstrate examples of this finding:

- In case 12, the provider ordered an antibiotic for a pregnant patient with a sexually transmitted disease, but the patient never received it.
- In case 25, the provider ordered a medication for nausea. The patient never received the medication, despite experiencing persistent symptoms.
- In case 34, the provider ordered two medications, but they were issued three days late.

Clinician Onsite Inspection

The CIW providers expressed concern that when a patient returned from a higher level of care, the EHRS automatically canceled all of the patient's prior orders. The providers had to reorder all prior orders and medications, or risk serious lapses in care. This process was tedious and took 15 to 20 minutes per patient. Other than this concern, CIW providers and medical staff reported no complaints about the medication delivery system or with the pharmacy's performance.

Case Review Conclusion

We found that CIW needed considerable improvement with its pharmacy and medication management processes, and we identified breaks in medication continuity when patients returned from an outside hospital. There were also problems with medication administration. The OIG clinicians rated this indicator *inadequate*.

Compliance Testing Results

The institution received a compliance score of 68.4 percent in the *Pharmacy and Medication Management* indicator. For discussion purposes below, we divide this indicator into three sub-indicators: medication administration, observed medication practices and storage controls, and pharmacy protocols.

Medication Administration

For this sub-indicator, the institution received an *inadequate* score of 55.3 percent. The following tests received scores in the *inadequate* range:

- Only 8 of 24 sampled patients at CIW (33.3 percent) timely received their ordered chronic care medications. Fourteen patients did not receive their medications within required time frames. For two other patients, CIW did not give them their medications (MIT 7.001).

- CIW timely delivered or administered newly ordered medications to only 15 of 25 sampled patients (60.0 percent). Eight patients received their medication one to six days late; and for two other patients, they never received their newly ordered medications (MIT 7.002).
- After discharge from a community hospital, only 11 of 25 sampled patients (44.0 percent) timely received their ordered medications upon returning to CIW. For 14 patients, their medications were either made available late, delivered late, or were never delivered (MIT 7.003).

One test earned a score in the *adequate* range:

- CIW ensured that 21 of 25 sampled patients (84.0 percent) received their medications without interruption when they transferred from one housing unit to another. Four patients did not receive their medication at the next dosing interval following transfer (MIT 7.005).

Observed Medication Practices and Storage Controls

The institution scored 67.5 percent in this sub-indicator, with the following tests scoring in the *inadequate* range:

- The institution had adequate security controls for narcotic medications in 8 of the 11 applicable clinic and medication line locations in which narcotics were stored (72.7 percent). In two clinics, two licensed nursing staff failed to perform a controlled substance inventory on multiple dates. In another clinic, staff left the medication cabinet in which they stored narcotics unsecured when they were not using it (MIT 7.101).
- CIW safely stored non-refrigerated, non-narcotic medications in 2 of the 13 applicable clinic and medication line storage locations (15.4 percent). In 11 locations, we observed one or more of the following deficiencies: the medication area lacked a designated area for return-to-pharmacy medications; topical and oral medications were not properly separated when stored; medication rooms and cabinets were unlocked; multi-use medication vials were not labeled with the date when staff opened them; medications were stored past their expiration dates; personal food items were stored in the same area with medications; medications were disorganized in the cart; and medications pending return to pharmacy were placed on the floor and subject to moisture (MIT 7.102).
- Refrigerated, non-narcotic medications were safely stored in only 5 of the 11 clinics and medication line storage locations (45.5 percent). In six locations, we found one or more of the following deficiencies: the temperature logbook was missing several temperature readings, and there was no designated area for return-to-pharmacy refrigerated medications (MIT 7.103).

Three tests received *proficient* scores:

- At six of the seven inspected medication line locations (85.7 percent), nursing staff were compliant with proper hand hygiene protocols. In one clinic, a staff member did not wash or sanitize hands between glove changes (MIT 7.104).
- CIW nursing staff at six of seven sampled locations (85.7 percent) employed appropriate administrative controls and protocols when preparing patients' medications. At one medication line location, nurses did not store medications in their original packaging (MIT 7.105).
- At all seven medication areas inspected, CIW employed appropriate administrative controls and protocols when nurses distributed medications to patients (MIT 7.106).

Pharmacy Protocols

CIW scored 80.0 percent in this sub-indicator, with the following tests earning *proficient* scores:

- CIW's main pharmacy followed general security, organizational, and cleanliness management protocols. In addition, the main pharmacy safely stored both non-refrigerated and refrigerated medications, resulting in the institution receiving full credit for these tests (MIT 7.107, 7.108, 7.109).
- CIW's PIC timely processed all 25 sampled medication error reports (MIT 7.111).

One test received an *inadequate* score:

- The institution's pharmacist in charge did not properly account for narcotic medications stored in the main pharmacy and did not review monthly inventories of controlled substances in the institution's clinical and medication line storage locations. We reviewed the Medication Area Inspection Checklist forms (CDCR Form 7477), examining records from the prior six months. In one medication line storage location, the Form 7477 was missing documentation of controlled medication inventory results, resulting in a score of zero for this test (MIT 7.110).

Non-Scored Tests

- In addition to our testing of reported medication errors, we follow up on any significant medication errors noted during compliance testing to determine whether the institution properly identified and reported the errors. We provide those results for informational purposes only. At CIW, we did not find any applicable medication errors (MIT 7.998).
 - We interviewed patients housed in isolation units to determine if they had immediate access to their prescribed KOP rescue inhalers. All ten applicable patients interviewed indicated they had access to their rescue medications (MIT 7.999).
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8 — *PRENATAL AND POST-DELIVERY SERVICES*

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

Case Review Rating:

Proficient

Compliance Score:

*Proficient
(93.3%)*

Overall Rating:

Proficient

Case Review Results

OIG clinicians reviewed four cases, which yielded 66 events related to prenatal or post-delivery care. There were seven deficiencies, two of which were significant (cases 12 and 13). The case review rating for this indicator was *proficient*.

Prenatal Care

CIW had a dedicated obstetrician on staff, who was responsible for prenatal and post-partum care. The obstetrician and the nurses saw patients with high-risk pregnancies frequently. A community specialist helped the obstetrician manage these high-risk patients during the prenatal period. Patients received timely laboratory tests, vaccinations, appointments, and consultations. We found no patterns of deficient prenatal care.

Post-partum Care

The OIG clinicians reviewed two post-partum cases and found two deficiencies in one case:

- In case 12, a specialist recommended ongoing laboratory monitoring for a possible chronic infection. The provider reviewed the specialty consultation, but failed to follow the specialist’s recommendations and did not provide any rationale for this poor decision.
- Also in case 12, the provider saw the same patient three weeks after treatment with antibiotics for a post-cesarean-section skin infection, but did not examine her abdomen.

Clinician Onsite Inspection

CIW’s primary care providers and leadership were pleased with their pregnant patients’ perinatal care. The medical staff experienced no difficulty in providing access to specialty care for this select group of patients, and we did not find any backlog in appointment scheduling. CIW providers were satisfied with the community specialist’s assistance and appreciated discussing their concerns by telephone or via consultation. The obstetrics team managed pregnancy-related care properly.

Case Review Conclusion

CIW provided excellent care for its high-risk pregnancy patients. These patients were followed closely at CIW, and we identified only rare deficiencies in these cases. Our experts thus rated the *Prenatal and Post-Delivery Services* at CIW *proficient*.

Compliance Testing Results

The institution scored in the *proficient* range with 93.3 percent in the *Prenatal and Post-Delivery* indicator. The following tests received scores of *proficient*:

- All ten pregnant patients whom we sampled at CIW saw an obstetrician or nurse practitioner within seven calendar days of arriving at the facility (MIT 8.001).
- CIW ensured that all ten pregnant patients whom OIG inspectors sampled were assigned to a lower bunk and placed in lower-tier housing upon arrival at the facility (MIT 8.002).
- Nine out of ten pregnant patients sampled (90.0 percent) promptly received their prenatal vitamins and daily nutritional supplements and food. One patient received her daily nutritional supplements and food three days late (MIT 8.003).
- All ten pregnant patients sampled received their prenatal visits with a supervising obstetrician or obstetrics nurse practitioner at the required intervals (MIT 8.004).
- CIW timely provided the required six-week post-partum visit to all nine applicable sampled patients (MIT 8.007).

One test received an *inadequate* score:

- Clinical staff documented weight and blood pressure readings at every prenatal visit for seven of the ten patients tested (70.0 percent). For three patients, nursing staff did not document weight or blood pressure at every appointment as required by policy (MIT 8.006).

9 — *PREVENTIVE SERVICES*

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

Case Review Rating:
Not Applicable
Compliance Score:
Proficient
(90.1%)
Overall Rating:
Proficient

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

Compliance Testing Results

The institution scored in the *proficient* range for this indicator at 90.1 percent. The following five tests earned scores in the *proficient* range:

- CIW offered annual influenza vaccinations to all 25 sampled patients during the most recent influenza season (MIT 9.004).
- The institution offered colorectal cancer screenings to 24 of 25 sampled patients (96.0 percent) subject to the annual screening requirement. For one patient, health care staff failed to offer her colorectal cancer screening within the previous 12 months, and she had not had a normal colonoscopy within the past ten years (MIT 9.005).
- All 30 sampled patients subject to screening requirements received or were offered a mammogram within CCHCS policy guidelines (MIT 9.006).
- CIW timely offered Pap smear screenings to 28 of 30 applicable sampled patients aged 21 through 65 (93.3 percent). For two patients, the institution did not offer the screening within the previous 36 months (MIT 9.007).
- We tested whether CIW offered patients who suffered from chronic care conditions vaccinations for influenza, pneumonia, and hepatitis. Among the 12 sampled patients with applicable chronic conditions, 11 of them (91.7 percent) were timely offered vaccinations. One patient neither received nor refused a pneumococcal immunization within the past five years (MIT 9.008).

Three tests received *adequate* scores:

- CIW timely administered TB medications to 18 of the 25 (78.3 percent) sampled patients. Nursing staff neglected to refer three patients to a provider for required counseling after they had missed a dose of medication. A provider did not see one other patient after she refused

TB treatment; and CIW staff did not administer another patient's medication on a specific date that the provider intended (MIT 9.001).

- We reviewed CIW's monitoring of 23 sampled patients who received TB medications and noted that the institution was in compliance for 18 of them (78.3 percent). For two patients, staff did not perform weekly or monthly monitoring. For one other patient, the nurse did not complete one month's consultation within the required time frame. For the remaining two patients, the nurse did not monitor all the required symptoms on the patient monitoring forms (MIT 9.002).
 - Of 30 sampled patients, 25 of them (83.3 percent) received their annual tuberculosis (TB) screenings within the last year and during their birth month, as required by policy. Five patients' TB screenings did not occur during their birth months (MIT 9.003).
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10 — *QUALITY OF NURSING PERFORMANCE*

The *Quality of Nursing Performance* indicator is a qualitative evaluation of the institution's nursing services. The evaluation is completed entirely by OIG nursing clinicians within the case review process and does not have a score under the OIG compliance testing component. Case reviews include face-to-face encounters and indirect activities performed by nursing staff on behalf of the patient. Review of nursing performance includes all nursing services performed onsite, such as outpatient, inpatient, urgent/emergent, patient transfers, care coordination, and medication management. The key focus areas for evaluation of nursing care include appropriateness and timeliness of patient triage and assessment, identification, and prioritization of health care needs, use of the nursing process to implement interventions, and accurate, thorough, and legible documentation. Although the OIG reports nursing services provided in specialized medical housing units in the *Specialized Medical Housing* indicator, and those provided in the TTA or related to emergency medical responses in the *Emergency Services* indicator, this *Quality of Nursing Performance* indicator summarizes all areas of nursing services.

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

Case Review Results

We reviewed 429 nursing encounters, 166 of which were in the outpatient setting. Most outpatient nursing encounters were for sick call requests, walk-in visits, and RN follow-up visits. In all, we identified 120 deficiencies related to nursing care performance, of which 11 were significant. Most nursing deficiencies occurred in the specialized medical housing and outpatient areas. The case review rating for this indicator was *adequate*.

Nursing Sick Call

We reviewed 90 nursing sick calls. Nurses performed timely triage, arranged same day face-to-face assessments when necessary, and initiated provider referrals when the patient's condition warranted it. Most nurses addressed all of their patients' complaints during face-to-face encounters. However, we identified a pattern of incomplete nursing assessments that demonstrated room for improvement, as noted in the following examples:

- In case 7, a percutaneous nephrostomy tube was inserted into the patient because of urinary blockage (a tube passed through the back into the kidney to collect urine). The patient, diagnosed with cancer, complained of coughing up blood, and flank pain. The nurse did not assess the patient's "coughing up blood" symptoms, did not determine when the flank pain began, and did not obtain a urine sample for analysis. The nurse's failure to assess this patient could have resulted in a lapse in care.

- In case 27, the nurse evaluated an asthmatic patient for a productive cough. The nurse noted an abnormally fast pulse rate (113 beats per minute). However, the RN did not reassess the pulse rate and did not ask about recent rescue inhaler use, which could have explained the increase in the pulse rate.
- In case 44, the patient complained of a swollen left leg for 11 days. One-sided leg swelling could indicate the presence of a blood clot. Blood clots can cause both pain and swelling. The nurse should have assessed the patient for leg pain and calf tenderness as well as for swelling.
- In case 56, the patient had a history of anemia and hepatitis C and was taking two blood thinning medications. The patient complained of rectal pain and bloody bowel movements. The nurse did not recognize the patient's elevated risk of intestinal bleeding and did not ask the patient about the blood color (dark red could indicate an upper intestinal source, whereas bright red could indicate lower intestinal bleeding). The nurse also did not examine the rectal area, did not assess for constipation, and did not ask about the patient's prescribed blood thinning medications. The nurse did not refer the patient to a provider, and the nurse's failure to assess the patient's condition could have placed the patient at risk of harm.

Care Management

CCHCS defines a care manager as a primary care RN who develops, implements, and evaluates patient care services and care plans for the institution's patients. The care manager provides direction for the patient; collaborates with the patient to develop and maintain the treatment plan; refers the patient to other services as appropriate; reviews data and coordinates patient care activities and education; and directs the members of the care coordination team to ensure that the patient receives necessary health care services in a safe, timely, and medically appropriate manner.

CIW had one RN care manager assigned to each of its medical clinics. The OIG clinicians found that CIW's RN care managers performed diabetes care only, and this care was limited to the simple distribution of diabetic supplies and assessment of skin complications. At the time of the OIG clinicians' onsite inspection, CIW nursing leadership denied that care managers were limited to managing diabetes. CIW's nursing leaders claimed that the care managers coordinated all chronic conditions. In addition, they claimed that the care managers educated patients for cervical cancer screening and assisted in family planning services. However, in our case reviews, we found that the care managers performed only basic diabetes care management.

Urgent/Emergent Care

We reviewed 55 urgent/emergent events and identified 21 deficiencies related to emergency nursing performance. Nurses performed acceptably in this area, but we noted some deficiencies

due to incomplete assessments or documentation. We discuss this performance further in the *Emergency Services* indicator.

Post-Hospital Returns

We reviewed 51 hospital events and identified two nursing deficiencies. The CIW nurses performed timely assessments and communicated appropriately with providers. We discuss this performance further in the *Inter- and Intra-System Transfers* indicator.

Specialized Medical Housing

Nursing care in CIW's specialized medical housing was poor. We identified patterns of incomplete assessment, interventions, and documentation that often placed patients at risk of harm. We discuss this performance further in the *Specialized Medical Housing* indicator.

Intra-System Transfers

CIW nurses performed well in the intra-system transfer process. Nurses conducted pre-transfer reviews and prepared for anticipated patient arrivals. The *Inter- and Intra-System Transfers* indicator provides specific findings in this area.

Specialty Services

We reviewed 36 nursing-related specialty services events and identified nine deficiencies. Most of these 36 events occurred when patients returned from pre-scheduled offsite specialty appointments. We found that the specialty nurses communicated well with the CIW providers and were proactive in providing pre-appointment patient education. The *Specialty Services* indicator offers specific findings in this area.

Clinician Onsite Inspection

We attended the morning huddles in the outpatient clinics. The RN care manager facilitated the huddle. The provider, the primary care RN, the provider line LVN, the supervising RN, the scheduler, and the mental health provider were present. The RN care manager followed a standardized huddle script; topics included RN appointments, provider appointments, TTA visits, hospital admissions and discharges, new patients, staffing, and supplies. The primary care team discussed specific patients and plans of care.

We visited several clinical areas and spoke with various nursing staff, including nurses in specialty services, utilization management, telemedicine, TTA, R&R, CTC, OHU, OB/GYN, and outpatient clinic areas. CIW had recently implemented nursing "post-and-bid" position changes (a practice in which nearly all the nurse positions in the institution are made available for reassignment, and nurses choose their new positions based on their seniority). Several of the nurses were new to their positions and were still learning their new duties. Nurses appeared

enthusiastic to learn their new positions. The nursing staff reported they experienced no barriers in communicating with supervisors, providers, and custody officers to meet patient care needs.

We also met with CIW nursing leaders, who discussed several ongoing special nursing projects. These projects included a shared governance committee and a care management team for a voluntary drug addiction treatment program.

Case Review Conclusion

We identified areas of nursing care that needed improvement, primarily in the specialized medical housing area and in several outpatient areas. Despite these problems, most nursing care was appropriate in the case reviews. We rated the *Quality of Nursing Performance* indicator *adequate*.

11 — *QUALITY OF PROVIDER PERFORMANCE*

In this indicator, the OIG physicians provide a qualitative evaluation of the adequacy of provider care at the institution. The case review clinicians review the provider care regarding appropriate evaluation, diagnosis, and management plans for programs including, but not limited to, nursing sick call, chronic care programs, TTA, specialized medical housing, and specialty services. OIG physicians alone assess provider care. There is no compliance testing component associated with this quality indicator.

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

Case Review Results

We reviewed 27 cases which yielded 324 provider events and 69 deficiencies. Of the 69 deficiencies, 22 were significant. We rated four cases *proficient*, 20 cases *adequate*, and three cases *inadequate*. The case review rating for this indicator was *adequate*.

Assessment and Decision-Making

CIW providers usually made sound medical decisions. Providers communicated well with other medical staff members. Providers were familiar with their patients' medical needs and frequently provided good care.

In general, CIW providers gave appropriate medical care and ordered proper diagnostic and specialty consultations. However, we observed 17 deficiencies related to provider assessments and decision-making. The majority of these deficiencies resulted from CIW clinicians not intervening correctly when abnormal findings arose. The following two cases offer examples:

- In case 7, the patient developed several bouts of vomiting blood with abdominal pain. The provider did not assess orthostatic blood pressure levels (blood pressure readings obtained in the reclining, sitting, and standing positions) to evaluate the patient for severe blood loss. Furthermore, the provider ordered a follow-up appointment with a lengthy time interval that placed the patient at serious risk for bleeding complications.
- In case 8, the patient developed diarrhea and low blood pressure over several days. The provider did not evaluate the patient's fluid status, did not order tests to check for electrolyte abnormalities or kidney function, and did not adjust the patient's blood pressure medications. When the patient later developed severe abdominal pain and had signs of bloody diarrhea, the provider did not address the pain and did not transfer the patient to a higher level of care.

Review of Records

Although CIW providers usually reviewed patients' records appropriately, they occasionally struggled in this regard. Sometimes, they did not fully address a specialist's recommendation or act upon diagnostic findings. While such deficiencies were uncommon, they offer future opportunities for practice improvement. We found 13 deficiencies related to the review of records; the following cases offer examples:

- In case 3, the provider noted an abnormal laboratory test result that suggested the possibility of primary biliary cirrhosis (inflammation of the bile ducts and liver damage), but failed to address the problem.
- In case 19, the provider did not address the findings of a wound culture result that showed a bacterial infection.
- In case 27, the provider did not address the specialist's concern about the patient's abnormally frequent use of her rescue inhaler for shortness of breath. The provider missed an opportunity to identify and treat the underlying reason for the patient's condition.

Chronic Care

CIW providers' chronic care performance was sufficient. The providers regularly monitored, assessed, and treated their patients' chronic care conditions properly. They scheduled the sickest patients more frequently to capture early signs of medical deterioration. We found several deficiencies which, although occurring uncommonly, represented an opportunity for future practice improvement.

On several occasions, CIW providers did not manage low and high blood sugar levels properly, which resulted in delayed diabetes control. We also identified deficiencies in pain management. Occasionally, the providers did not justify their decisions to increase the dose of narcotic medications. We illustrate these problems in the following examples:

- In case 3, the provider ordered morphine for the patient's chronic back pain. The patient had no problems with her day-to-day function, and her back and neurologic examinations did not warrant the increased narcotic dose. The provider also did not complete a chronic pain intake sheet or obtain a patient safety agreement when prescribing the narcotic medication.
- In case 9, the patient experienced multiple low blood sugar episodes. The provider made a negligible change to the long-acting insulin dose, which placed the patient at risk for continued episodes of low blood sugar.
- In case 18, the patient had critically elevated blood sugar levels. The provider should have scheduled the patient for a close follow-up appointment to address the problem, but did not.

Specialty Services

CIW providers requested specialty consultations appropriately. We observed no problems in this area.

Emergency Care

Providers usually made appropriate triage decisions and often formulated appropriate plans for these critical patients. We provide additional details in the *Emergency Services* indicator.

Specialized Medical Housing

Providers struggled to consistently make correct diagnoses or intervene appropriately. We provide more details in the *Specialized Medical Housing* indicator.

Clinician Onsite Inspection

CIW providers were content with their leadership and ancillary services, and they believed that the services they provided were sufficient for the medical needs of their patients. The health information shared during daily morning meetings and clinic huddles offered providers a comprehensive way to learn about overnight and weekend medical events and allowed them to address any new concerns efficiently.

During the Cycle 4 medical inspection, the CIW providers universally expressed concern that the electronic health record system (EHRS) would prove to be a barrier to good medical management. However, during this onsite visit, the providers noted that the new EHRS had helped their practice become more comprehensive and efficient.

Case Review Conclusion

Although the providers usually performed sufficiently, they could improve in several areas: the providers could be more consistent with making appropriate assessments and more careful when reviewing records, and they could also be more attentive regarding their diabetic and opioid management. Additionally, provider performance in the specialized housing units was generally poor. Nonetheless, CIW medical providers gave appropriate care to their patients in most of the cases we reviewed. We rated CIW's overall provider performance *adequate*.

12 — *RECEPTION CENTER ARRIVALS*

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

Case Review Rating:

Not Applicable

Compliance Score:

Not Applicable

Overall Rating:

Not Applicable

CIW does not have a reception center; therefore, this indicator does not apply.

13 — *SPECIALIZED MEDICAL HOUSING*

This indicator addresses whether the institution follows appropriate policies and procedures when admitting patients to onsite inpatient facilities, including completion of timely nursing and provider assessments. The case review assesses all aspects of medical care related to these housing units, including quality of provider and nursing care. CIW's specialized medical housing units consist of an outpatient housing unit (OHU), a correctional treatment center (CTC), and a psychiatric inpatient program (PIP).

Case Review Rating:
Inadequate
Compliance Score:
Adequate
(84.6%)
Overall Rating:
Inadequate

For this indicator, our case review and compliance testing yielded different results, with the case reviewers assigning an *inadequate* rating and the compliance testing resulting in an *adequate* score. In this indicator, there were only four compliance tests which marginally affected the quality of patient care. Therefore, we heavily relied upon the case review rating for the overall rating of this indicator, which was *inadequate*.

Case Review Results

At the time of our clinician onsite inspection, the OHU had seven beds for medical patients and ten temporary mental health beds. The CTC had eight beds for medical patients and ten beds for mental health patients. We reviewed 13 cases, which yielded 92 provider events, 121 nursing events, and 70 deficiencies. Fourteen of the deficiencies were significant. CIW's providers and nurses made poor assessments and interventions in their specialized medical housing units. The case review rating for this indicator was *inadequate*.

Provider Performance

Most significant provider deficiencies occurred within four cases; the providers recurrently made poor assessments, interventions, and plans of care. The following cases are examples:

- In case 8, the diabetic patient had several weeks of intermittent diarrhea, vomiting, and abdominal pain. On multiple occasions, the provider did not examine the patient or make interventions to ensure the patient received sufficient hydration and essential electrolytes. During this period, the patient had multiple episodes of low blood pressure, signs of fluid depletion, and episodes of black stool (a concern for the presence of internal bleeding). Despite these worrisome signs and symptoms, the provider did not assess the patient for internal bleeding or consider other potentially dangerous diagnoses that should have warranted further medical tests. Moreover, the provider did not adjust the patient's blood pressure medications when the patient's blood pressure was low. The patient subsequently required hospitalization and the hospital physicians determined she had insufficient blood flow to her intestines. The patient died in the hospital.

- In case 9, the diabetic patient had multiple episodes of low blood sugar. Initially, the provider did not address these findings. Eventually, the provider made negligible reductions to the insulin dose. The provider’s failure to appropriately manage this patient’s hypoglycemia resulted in the patient’s transfer to a higher level of care.
- In case 64, the patient had an invasive cardiac procedure (cardiac ablation). At the time of hospital discharge, the hospital physician recommended medication to prevent heart inflammation and also recommended an urgent abdominal CT scan. CIW staff did not order the recommended medication for eight days and ordered the CT scan to occur with “routine” priority (within 90 days) instead of with “urgent” priority (within 14 days). The patient was inappropriately transferred to another facility eight days later without receiving the CT scan.

Nursing Performance

Specialized medical housing nurses should record their patient assessments, including the general medical status of the patients. We found patterns of poor nursing assessment, intervention, and documentation that placed patients at risk of harm. At times, CIW nurses did not communicate abnormal findings to the provider, resulting in delayed care. The primary RN often did not review care recorded by the LVN and the CNA, and often missed significant abnormal findings. The following examples illustrate this problem:

- In case 8, the patient had multiple chronic care problems (asthma, congestive heart failure, dementia, diabetes, and hypertension). The patient required daily assistance and was housed in the OHU, where the CNAs, LVNs, and RNs helped her. However, the nurses did not always communicate abnormal findings. On several occasions, the patient’s oxygen levels were low, which should have prompted the nurses to contact the providers for further assessment and intervention. The nurses did not listen to the patient’s lung sounds, administer the prescribed inhaler, recheck the oxygen levels, or notify the provider. Also, the patient began having diarrhea, abdominal pain, nausea, and vomiting. These problems can lead to dehydration, low blood sugar levels, and low blood pressure. On several occasions, the patient had persistent and significantly low blood pressure, but the nurses continued to administer blood-pressure-lowering medication, which was not the proper course of action.
- In case 9, the patient had diabetes and asthma. CIW staff admitted the patient to the CTC after a vital artery repair surgery. All inhalers should be ordered as “keep-on-person.” Instead, the physician inappropriately ordered the patient’s rescue inhaler as “nurse-administered.” CIW nurses did not question this inappropriate order, which restricted the patient’s access to critical medications.
- Also in case 9, the patient had severely low blood sugar on several occasions. The nurses did not always communicate these low blood sugar levels to the provider. In fact, out of fear that her blood sugar was dangerously low, the patient refused insulin on several occasions, but the nurse still did not inform the provider of the situation.

- Also in case 9, the patient was continuing to experience weakness, abdominal pain, and hypoglycemia (low blood sugar). CIW staff sent the patient to a community hospital for an emergency room evaluation. When she returned to CIW, the provider admitted her to the OHU. Upon her return, the patient was hypotensive and had an elevated heart rate. The TTA RN reported to the night shift OHU LVN, who was serving as the primary nurse. When the LVN checked the patient, the patient's blood pressure had dropped further, and her heart rate had risen. The LVN did not contact the provider or reassess the patient's abnormal vital signs. Nine hours later, the patient's vital signs remained abnormal, and the nurse finally notified the provider of the persistently abnormal vital signs. The provider sent the patient back to the hospital for hypotension and abdominal pain. In addition to the above deficiencies, the RN failed to administer a critical blood thinner medication for this patient.
- In case 63, the diabetic patient was in the CTC. The patient had several episodes of low blood sugar and needed insulin adjustments. CIW nurses did not always document the times when they checked blood sugar levels or note the interventions they made to increase the patient's blood sugar levels. Furthermore, the nurses did not always notify the provider of the low blood sugar levels so that the provider could consider medication adjustments.
- In case 64, this patient returned to the PIP after an invasive cardiac procedure (cardiac ablation) to treat a heart arrhythmia. The nurse failed to assess the patient's heart rate or listen for heart sounds.

Clinician Onsite Inspection

At the time of the onsite visit, one CIW provider cared for patients in both the PIP and the CTC. Another provider managed TTA and OHU patients. On average, CIW providers saw ten patients per day. In the OHU, an RN gave nursing care during the day shift, while an LVN served as the primary nurse during the evening and overnight shifts. CIW leadership did not audit clinical care in the OHU. However, after discussing some of the OHU nursing deficiencies we identified, CIW's nursing leadership agreed to begin auditing the care they were giving to OHU patients.

Case Review Conclusion

CIW providers sometimes failed to make correct diagnoses or intervene appropriately. CIW nurses often failed to recognize their patients' dangerous medical conditions or notify the provider when required. When patients began to experience clinical declines, nurses and providers often acted slowly and inefficiently. CIW LVNs demonstrated an inability to provide adequate nursing care, as we saw in the case reviews when the LVN served as the primary nurse in the OHU during the evening and overnight shifts. With medically complex patients, the risk for medical error increased because the LVNs practiced without significant provider or RN oversight. We rated the *Specialized Medical Housing* indicator *inadequate*.

Compliance Testing Results

The institution received a score of 84.6 percent in this indicator. Three tests earned scores in the *proficient* range:

- Nursing staff completed an initial assessment on the date of admission to the CTC/OHU for all 15 patients whose records we sampled (MIT 13.001).
- CIW providers completed required history and physical examinations for all eight sampled patients within 24 hours of admission to the CTC (MIT 13.002).
- We observed the working order of sampled call buttons in the CTC and the PIP, and all were working properly. In the OHU, staff conducted 30-minute welfare checks in the absence of a call-light system. In addition, staff members whom the OIG interviewed reported that custody officers and clinicians were able to expeditiously access patients' locked rooms when emergent events occurred (MIT 13.101).

One test received a score in the *inadequate* range:

- When we tested if providers completed their Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes at required 3-day intervals for the CTC and 14-day intervals for the OHU, we discovered SOAPE notes were timely and accurately completed for only 5 of the 13 patients sampled (38.5 percent). For six patients, providers recorded SOAPE notes between one and seven days late or did not include the required patient education component in the note. For two other patients, providers did not record their SOAPE note documentation (MIT 13.003).

14 — *SPECIALTY SERVICES*

This indicator focuses on specialist care from the time a physician makes the referral for specialist care to the time of receipt of the specialist's recommendations. This indicator also evaluates the providers' timely review of specialist records, documentation of those recommendations, and whether the results of specialists' reports are communicated to the patients. For specialty services denied by the institution, the OIG determines whether the denials are timely and appropriate, and whether the provider updates the patient on the plan of care.

Case Review Rating:
Adequate

Compliance Score:
Proficient
(90.1%)

Overall Rating:
Adequate

In this indicator, our case review and compliance testing yielded different results, with the case review giving an *adequate* rating and the compliance testing resulting in a *proficient* score. Case review testing evaluated many more specialty appointments than compliance testing did. Because our case review testing found that CIW could improve in some important areas, such as nursing assessment and specialty report handling, we determined that the overall rating of *adequate* was most appropriate for this indicator.

Case Review Results

We reviewed 264 events related to *Specialty Services*, the majority of which were specialty consultations and procedures. In this category, 24 deficiencies occurred, 6 of which were significant. The case review rating for this indicator was *adequate*.

Access to Specialty Services

CIW usually provided patients with proper access to specialty services. The institution scheduled specialty appointments within appropriate time frames and arranged subsequent specialty follow-up appointments accordingly. Problems in this area were uncommon, but the following examples are two exceptions:

- In case 9, a two-week cardiothoracic postoperative follow-up appointment never occurred.
- In case 58, a provider ordered physical therapy. Almost five months later, the institution still had not scheduled the appointment. Fortunately, the provider reordered the service, and the appointment occurred a month after the second request.

Nursing Performance

CIW specialty nurses coordinated specialty appointments and ensured the specialists had access to all pertinent medical records. These records were paramount to the specialists' ability to assess and make proper recommendations. In addition, CIW nurses assessed the patients when they returned from the specialty appointments to ensure the specialist's recommendations were

received and to communicate any urgent recommendations to the provider. At CIW, the specialty nurses prepared and educated their patients extensively for upcoming specialty appointments. This practice resulted in improved patient compliance with specialty care.

We reviewed 36 specialty nursing events and found nine nursing deficiencies. Seven of the nine deficiencies resulted from incomplete nursing assessments after an offsite specialist appointment, but most of these deficiencies were relatively minor. The following are some examples of these deficiencies:

- In case 7, the patient had a percutaneous nephrostomy tube placement (a tube was passed through the back into the kidney to collect urine). When the patient returned to the institution, the RN did not examine the site of the nephrostomy tube or ascertain the color and consistency of urine in the collection bag.
- In case 24, the cancer patient returned after offsite chemotherapy. The patient's blood pressure was high, and she complained of pain. The RN did not properly assess the pain or discuss the problem with the provider.
- In case 27, the patient's heart rate was high (119 beats per minute). The RN did not properly assess possible reasons for the rapid heart rate or recheck the abnormal finding.

Provider Performance

CIW providers performed well with specialty services. Providers referred their patients to specialists when appropriate and used the correct priority and timing. We found no patterns of deficiencies in this area in the case reviews.

Health Information Management

Most of the deficiencies in this indicator were related to health information management. We identified two deficiency patterns.

The first deficiency pattern was that CIW's providers did not always sign the specialty reports. Although the providers did not always sign the reports, they did properly address the specialists' recommendations at their patients' follow-up appointments, and there was no apparent increase in the risk of harm. This deficiency occurred four times in cases 10 and 32.

The second deficiency pattern noted was that CIW staff did not always retrieve and scan the specialty reports. This problem occurred twice in cases 7 and 10.

Clinician Onsite Inspection

The OIG clinicians met with the specialty nurses and discussed onsite, offsite, and telemedicine specialty services. At CIW, various specialties (ophthalmology, physical therapy, podiatry, HIV, and sleep medicine (to diagnose sleep-related disorders)) were available onsite at the institution.

CIW staff reported these specialists often provided timely services and effectively communicated with the institution's medical staff. Telemedicine services made up approximately 25 percent of all the specialty services rendered. CIW leaders explained that another benefit to onsite and telemedicine specialty services was that they were also cost-effective, as their patients did not need to leave the institution. CIW used offsite specialty services only when onsite or telemedicine services were not available.

While the specialty department reported it had no significant backlogs in any individual specialty, its staff had the greatest difficulty with scheduling rheumatology and endocrinology services. Despite this difficulty, the CIW providers did not notice any problems with access to specialty care.

Case Review Conclusion

CIW staff performed well in recognizing the need for specialty care, arranging timely appointments, and providing appropriate nurse and provider follow-up appointments. In addition, we found that CIW specialty nurses took a proactive role in educating their patients about upcoming specialty appointments, which helped the patients improve their compliance with specialty care. Nonetheless, we saw a few problems in specialty care, which included the occasionally missed specialty appointment, incomplete nursing assessments, or the mishandling of specialty reports. In general, CIW performed sufficiently in *Specialty Services*, and we rated this indicator *adequate*.

Compliance Testing Results

The institution received a score of 90.1 percent in this indicator, with the following five tests scoring in the *proficient* range:

- For all 15 sampled patients, high-priority specialty service appointments occurred within 14 calendar days of the provider's order. In addition, CIW providers timely received and reviewed the corresponding specialists' reports for all of the 12 applicable sampled patients' appointments (MIT 14.001, 14.002).
- For all 15 sampled patients, routine-priority specialty service appointments occurred within 90 calendar days of the provider's order (MIT 14.003).
- Providers timely received and reviewed the routine-priority specialists' reports for 12 of 14 applicable sampled patients (85.7 percent). Two patients' specialty service reports were reviewed one and four days late (MIT 14.004).
- When patients are approved or scheduled for specialty service appointments at one institution, and then transfer to another institution, CCHCS policy requires that the receiving institution ensure patients receive these appointments promptly. Of the 20 sampled patients, 18 of them (90.0 percent) timely received their ordered specialty

services appointments. One patient received her specialty appointment four days late, and one other patient did not receive her appointment at all (MIT 14.005).

One test earned a score in the *adequate* range:

- CIW's health care management team timely denied providers' specialty services requests for 17 of 20 sampled patients (85.0 percent). Three specialty services request denials were out of compliance from two to four days (MIT 14.006).

One test received an *inadequate* score:

- Among 20 sampled patients for whom CIW's health care management team denied a specialty service request, 14 patients (70.0 percent) received timely notification of the service denial, which included a provider follow-up within 30 days to discuss the denial and offer alternative treatment strategies. For five patients, their provider follow-up visits occurred from 3 to 18 days late; and for the remaining patient, we found no evidence that a provider follow-up occurred (MIT 14.007).
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15 — *ADMINISTRATIVE OPERATIONS (SECONDARY)*

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

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(68.7%)
Overall Rating:
Inadequate

Compliance Testing Results

The institution received a score of 68.7 percent in this indicator with several tests demonstrating room for improvement:

- We reviewed the one reported adverse/sentinel event (ASE) that occurred at CIW during the prior six-month period that, per policy, needed a root cause analysis and four monthly status reports. Although CIW staff reported the event to CCHCS’s ASE Committee within policy guidelines, the institution submitted only one status report during the four-month period. As a result, CIW received a score of zero for this test (MIT 15.002).
- We reviewed documentation for 12 emergency medical response incidents addressed by CIW’s EMRRC during a six-month period and found the institution did not include two required EMRRC documents in any of the incident review packages. As a result, the institution received a score of zero for this test (MIT 15.005).
- We reviewed 12 months of CIW’s local governing body (LGB) meeting minutes and determined that the LGB met at least quarterly; however, the meeting minutes were insufficient and did not include adoption of local operating procedures or general management and planning consistent with CCHCS policies. In addition, the meeting minutes were missing the dates that the LGB approved the minutes. Because of these deficiencies, CIW received a score of zero for this test (MIT 15.006).

- We reviewed the summary reports and related documentation for three medical emergency response drills conducted in the prior quarter at CIW. The institution conducted comprehensive response drills for the evening and night shifts, but for the response drill held during the day shift, multiple mandatory forms were incomplete. As a result, the institution received a score of 66.7 percent for this test (MIT 15.101).
- We inspected records of five nurses from August 2016 to determine if their nursing supervisors properly completed monthly performance reviews. Only two of five monthly performance reviews (40.0 percent) met the compliance standard. We identified the following deficiencies in the three non-compliant nurse reviews (MIT 15.104):
 - For two nurses, the supervisor did not complete the required number of reviews;
 - For two nurses, the supervisor did not summarize the aspects in which the nurses performed well;
 - For one nurse, the supervisor did not include the aspects that the nurse needed to improve.
- CIW hired 33 nurses within the last 12 months. One nurse did not receive new-employee orientation training timely, and another nurse received training four weeks late (MIT 15.111).

One test earned a score in the *adequate* range:

- For four of the five cases we tested, medical staff reviewed and timely submitted the Initial Inmate Death Report (CDCR Form 7229A) to CCHCS's Death Review Unit, resulting in a score of 80.0 percent. CIW did not submit the death report by noon on the business day following one patient's death; instead, the institution submitted it 21 minutes late (MIT 15.103).

Several tests earned *proficient* scores:

- We reviewed data to determine if the institution timely processed at least 95 percent of its monthly patient medical appeals during the most recent 12-month period. CIW correctly processed 11 of the 12 months' appeals reviewed (91.7 percent). For one month, the institution correctly processed 88 percent of its patient medical appeals (MIT 15.001).
- CIW's QMC met monthly, evaluated program performance, and acted when management identified areas for improvement opportunities (MIT 15.003).
- CIW took adequate steps to ensure the accuracy of its Dashboard data reporting (MIT 15.004).

- Based on a sample of ten second-level medical appeals, the institution's responses addressed all the patients' appealed issues (MIT 15.102).
- Nine of the ten nurses sampled (90.0 percent) were current with their clinical competency validations. One nurse did not receive a clinical competency validation within the required period (MIT 15.105).
- The OIG reviewed performance evaluation packets for CIW's eight providers and found the institution met all performance review requirements for its providers (MIT 15.106).
- All providers at the institution were current with their professional licenses. Similarly, all nursing staff and the PIC were current with their professional licenses and certification requirements (MIT 15.107, 15.109).
- All active-duty providers and nurses were current with their emergency response certifications (MIT 15.108).
- All pharmacy staff and providers who prescribed controlled substances had current Drug Enforcement Agency registrations (MIT 15.110).

Non-Scored Results

- The OIG gathered non-scored data regarding the completion of death review reports by CCHCS's Death Review Committee (DRC). Five deaths occurred at CIW during our review period: one unexpected (Level 1) death and four expected (Level 2) deaths. For the Level 1 death, the DRC was required to complete its death review summary report within 60 days from the date of death; for the Level 2 deaths, the reports were due within 30 days. After it completes the reports, the DRC should submit the reports to the institution's chief executive officer (CEO) within seven calendar days. None of the DRC reports were compliant with CCHCS policy. For the one Level 1 death at CIW, the DRC completed its report 37 days late (97 days after death) and submitted it to CIW's CEO 53 days late; for the four Level 2 deaths, the DRC completed its reports 44, 48, 49, and 55 days late (74, 78, 79, and 85 days after death) and submitted them to the CEO 20, 50, 56, and 57 days late (MIT 15.998).
- The OIG discusses the institution's health care staffing resources in the *About the Institution* section of this report (MIT 15.999).

RECOMMENDATIONS

The OIG recommends the following:

- The pharmacist in charge and the chief nurse executive (CNE) should implement quality improvement processes to improve the medication administration of newly prescribed medications and to improve the medication continuity for chronic care patients and patients returning from an outside hospital or emergency department. We found significant problems in these medication delivery areas during this inspection.
- The CEO should expand the institution's quality improvement efforts to include both nursing and medical provider care in the psychiatric inpatient program (PIP) and the outpatient housing unit (OHU). Because of the problems we found in these areas, CIW should target clinical care assessments, transitions of care during patient hand-offs among staff, and communication between providers and nurses as areas for improvement in these locations.
- The CEO should have the EMRRC conduct clinical reviews of all non-scheduled emergency transports, including those that involved a patient's departure from mental health areas, including the PIP and the mental health CTC. We found substandard medical care in those areas, resulting in patients needing emergency transfers to higher levels of care.
- The CNE should reevaluate and improve the institution's current process of evaluating nurses' knowledge and skills competency because we found problems with nursing assessment and intervention and the lack of provider notification in the inpatient (CTC) and outpatient sick-call areas.
- The CME should monitor and train the providers to be more thorough when making assessments and reviewing patient records, particularly in the specialized medical housing units. Furthermore, the CME should also arrange diabetes and opioid management training due to these problems we found.
- The CEO should install bedside or mobile computers in the TTA to enable CIW staff to record their care documentation into the electronic health record system (EHRS) because we found that the TTA staff did not have sufficient computer access during our clinician onsite inspection.

POPULATION-BASED METRICS

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

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

Methodology

For population-based metrics, we used a subset of HEDIS measures applicable to the CDCR patient population. We selected measures based on the availability, reliability, and feasibility of the data needed for performing the measurement. We collected data using various information sources, including the electronic medical record, the CCHCS Master Registry, as well as a random sample of patient records analyzed and abstracted by trained personnel. We did not independently validate data obtained from the CCHCS Master Registry and Diabetic Registry; we presumed it to be accurate. For some measures, we used the entire population rather than statistically random samples. While the OIG is not a certified HEDIS compliance auditor, we use similar methods to ensure that measures are comparable to those published by other organizations.

Comparison of Population-Based Metrics

For the California Institution for Women, we selected 13 HEDIS measures and listed them in the following *CIW Results Compared to State and National HEDIS Scores* table. Multiple health plans publish their HEDIS performance measures at the state and national levels. We provide selected results for several health plans in both categories for comparative purposes.

Results of Population-Based Metric Comparison

Comprehensive Diabetes Care

For chronic care management, we chose measures related to the management of diabetes. Diabetes is the most complex common chronic disease requiring a high level of intervention on the part of the health care system in order to produce optimal results.

When compared statewide, CIW outperformed Medi-Cal in all five diabetic measures and outperformed Kaiser in four of the five diabetic measures. The institution scored lower than Kaiser (North and South) with regard to blood pressure control.

When compared nationally, CIW outperformed Medicaid, commercial plans, and Medicare in all five diabetic measures. CIW outperformed the United States Department of Veterans Affairs (VA) in three of the four applicable measures, with the institution scoring lower in diabetic eye examinations.

Immunizations

Comparative data for immunizations was only fully available for the VA and partially available for Kaiser, commercial plans, Medicaid, and Medicare. Regarding influenza vaccinations for younger and older adults, CIW outperformed all health plans. Regarding pneumococcal vaccines for older adults, CIW scored higher than both Medicare and the VA.

Cancer Screening

CIW scored higher than all other reporting entities for breast cancer screening. For cervical cancer screening, CIW scored higher than Medi-Cal, Medicaid, and commercial plans, but scored lower than Kaiser (North and South) and the VA. For colorectal cancer screening, CIW scored higher than Kaiser North, commercial plans, and Medicare, but the institution scored lower than Kaiser South and the VA.

Prenatal and Post-partum Care

CIW scored higher than all reporting entities regarding prenatal care and outperformed all other reporting entities related to post-partum care except Kaiser (North and South).

Summary

CIW performed well in comparison to other health care plans regarding population-based metrics. The institution may improve its scores in screening for cervical cancer and colorectal cancer by reducing the number of refusals by educating patients about the benefits of such preventive services.

CIW Results Compared to State and National HEDIS Scores

Clinical Measures	California					National		
	CIW Cycle 5 Results ¹	HEDIS Medi-Cal 2017 ²	HEDIS Kaiser (No. CA) 2016 ³	HEDIS Kaiser (So. CA) 2016 ³	HEDIS Medicaid 2017 ⁴	HEDIS Com- mercial 2017 ⁴	HEDIS Medicare 2017 ⁴	VA Average 2016 ⁵
Comprehensive Diabetes Care								
HbA1c Testing (Monitoring)	100%	87%	94%	94%	87%	91%	94%	99%
Poor HbA1c Control (>9.0%) ^{6, 7}	7%	38%	20%	23%	43%	33%	26%	18%
HbA1c Control (<8.0%) ⁶	84%	52%	70%	63%	47%	56%	63%	-
Blood Pressure Control (<140/90) ⁶	79%	63%	83%	83%	60%	62%	64%	76%
Eye Exams	82%	57%	68%	81%	55%	54%	70%	89%
Immunizations								
Influenza Shots - Adults (18–64)	62%	-	56%	57%	39%	48%	-	52%
Influenza Shots - Adults (65+)	82%	-	-	-	-	-	71%	72%
Immunizations: Pneumococcal	96%	-	-	-	-	-	74%	93%
Cancer Screening								
Breast Cancer Screening (50–74) ⁸	90%	59%	87%	87%	59%	73%	72%	85%
Cervical Cancer Screening	76%	56%	91%	85%	58%	74%	-	93%
Colorectal Cancer Screening	80%	-	79%	82%	-	62%	67%	82%
Prenatal and Post-partum Care								
Prenatal Care	100%	82%	96%	97%	82%	85%	-	-
Post-partum Care	90%	64%	96%	91%	64%	74%	-	-

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

2. HEDIS Medi-Cal data was obtained from the California Department of Health Care Services *Medi-Cal Managed Care External Quality Review Technical Report (July 1, 2016 – June 30, 2017)*.

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

4. National HEDIS data for Medicaid, commercial plans, and Medicare was obtained from the 2017 *State of Health Care Quality Report*, available on the NCQA website: www.ncqa.org. The results for commercial plans were based on data received from various health maintenance organizations.

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

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

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

8. The Kaiser HEDIS data range is 52–74.

APPENDIX A — COMPLIANCE TEST RESULTS

California Institution for Women Range of Summary Scores: 68.4% – 93.3%	
Indicator	Compliance Score (Yes %)
1 – <i>Access to Care</i>	88.2%
2 – <i>Diagnostic Services</i>	71.1%
3 – <i>Emergency Services</i>	Not Applicable
4 – <i>Health Information Management (Medical Records)</i>	84.0%
5 – <i>Health Care Environment</i>	69.1%
6 – <i>Inter- and Intra-System Transfers</i>	85.5%
7 – <i>Pharmacy and Medication Management</i>	68.4%
8 – <i>Prenatal and Post-Delivery Services</i>	93.3%
9 – <i>Preventive Services</i>	90.1%
10 – <i>Quality of Nursing Performance</i>	Not Applicable
11 – <i>Quality of Provider Performance</i>	Not Applicable
12 – <i>Reception Center Arrivals</i>	Not Applicable
13 – <i>Specialized Medical Housing (OHU, CTC, SNF, Hospice)</i>	84.6%
14 – <i>Specialty Services</i>	90.1%
15 – <i>Administrative Operations</i>	68.7%

Reference Number	1 – Access to Care	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
1.001	Chronic care follow-up appointments: Was the patient’s most recent chronic care visit within the health care guideline’s maximum allowable interval or within the ordered time frame, whichever is shorter?	19	6	25	76.0%	0
1.002	For endorsed patients received from another CDCR institution: If the nurse referred the patient to a provider during the initial health screening, was the patient seen within the required time frame?	19	5	24	79.2%	1
1.003	Clinical appointments: Did a registered nurse review the patient’s request for service the same day it was received?	29	1	30	96.7%	0
1.004	Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed?	26	3	29	89.7%	1
1.005	Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter?	6	0	6	100.0%	24
1.006	Sick call follow-up appointments: If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified?	Not Applicable				
1.007	Upon the patient’s discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame?	21	4	25	84.0%	0
1.008	Specialty service follow-up appointments: Do specialty service primary care physician follow-up visits occur within required time frames?	20	5	25	80.0%	5
1.101	Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms?	6	0	6	100.0%	0
Overall percentage:					88.2%	

Reference Number	2 – Diagnostic Services	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
2.001	Radiology: Was the radiology service provided within the time frame specified in the provider's order?	10	0	10	100.0%	0
2.002	Radiology: Did the primary care provider review and initial the diagnostic report within specified time frames?	7	3	10	70.0%	0
2.003	Radiology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	5	5	10	50.0%	0
2.004	Laboratory: Was the laboratory service provided within the time frame specified in the provider's order?	7	3	10	70.0%	0
2.005	Laboratory: Did the primary care provider review and initial the diagnostic report within specified time frames?	10	0	10	100.0%	0
2.006	Laboratory: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	0	10	10	0.0%	0
2.007	Pathology: Did the institution receive the final diagnostic report within the required time frames?	9	1	10	90.0%	0
2.008	Pathology: Did the primary care provider review and initial the diagnostic report within specified time frames?	10	0	10	100.0%	0
2.009	Pathology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	6	4	10	60.0%	0
Overall percentage:					71.1%	

3 – Emergency Services

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

Reference Number	4 – <i>Health Information Management</i>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated healthcare documents (provider progress notes) scanned within 3 calendar days of the patient encounter date?	5	0	5	100.0%	0
4.002	Are dictated/transcribed documents scanned into the patient’s electronic health record within five calendar days of the encounter date?	Not Applicable				
4.003	Are High-Priority specialty notes (either a Form 7243 or other scanned consulting report) scanned within the required time frame?	16	4	20	80.0%	0
4.004	Are community hospital discharge documents scanned into the patient’s electronic health record within three calendar days of hospital discharge?	17	3	20	85.0%	0
4.005	Are medication administration records (MARs) scanned into the patient’s electronic health record within the required time frames?	Not Applicable				
4.006	During the inspection, were medical records properly scanned, labeled, and included in the correct patients’ files?	18	6	24	75.0%	0
4.007	For patients discharged from a community hospital: Did the preliminary hospital discharge report include key elements and did a primary care provider review the report within three calendar days of discharge?	20	5	25	80.0%	0
Overall percentage:					83.7%	

Reference Number	5 – Health Care Environment	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
5.101	Are clinical health care areas appropriately disinfected, cleaned, and sanitized?	14	0	14	100.0%	0
5.102	Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	12	2	14	85.7%	0
5.103	Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	12	2	14	85.7%	0
5.104	Does clinical health care staff adhere to universal hand hygiene precautions?	14	0	14	100.0%	0
5.105	Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	14	0	14	100.0%	0
5.106	Warehouse, Conex and other non-clinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program?	0	1	1	0.0%	0
5.107	Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	5	9	14	35.7%	0
5.108	Do clinic common areas and exam rooms have essential core medical equipment and supplies?	8	6	14	57.1%	0
5.109	Do clinic common areas have an adequate environment conducive to providing medical services?	12	2	14	85.7%	0
5.110	Do clinic exam rooms have an adequate environment conducive to providing medical services?	9	5	14	64.3%	0
5.111	Emergency response bags: Are TTA and clinic emergency medical response bags inspected daily and inventoried monthly, and do they contain essential items?	5	6	11	45.5%	3
Overall percentage:					69.1%	

Reference Number	6 – <i>Inter- and Intra-System Transfers</i>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
6.001	For endorsed patients received from another CDCR institution or COCF: Did nursing staff complete the initial health screening and answer all screening questions on the same day the patient arrived at the institution?	18	7	25	72.0%	0
6.002	For endorsed patients received from another CDCR institution or COCF: When required, did the RN complete the assessment and disposition section of the health screening form; refer the patient to the TTA, if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening?	25	0	25	100.0%	0
6.003	For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption?	7	3	10	70.0%	15
6.004	For patients transferred out of the facility: Were scheduled specialty service appointments identified on the patient's health care transfer information form?	Not Applicable				
6.101	For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents?	9	0	9	100.0%	0
Overall percentage:					85.5%	

Reference Number	7 – Pharmacy and Medication Management	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.001	Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows?	8	16	24	33.3%	1
7.002	Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames?	15	10	25	60.0%	0
7.003	Upon the patient’s discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames?	11	14	25	44.0%	0
7.004	For patients received from a county jail: Were all medications ordered by the institution’s reception center provider administered, made available, or delivered to the patient within the required time frames?	Not Applicable				
7.005	Upon the patient’s transfer from one housing unit to another: Were medications continued without interruption?	21	4	25	84.0%	0
7.006	For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption?	Not Applicable				
7.101	All clinical and medication line storage areas for narcotic medications: Does the Institution employ strong medication security over narcotic medications assigned to its clinical areas?	8	3	11	72.7%	3
7.102	All clinical and medication line storage areas for non-narcotic medications: Does the Institution safely store non-narcotic medications that do not require refrigeration in assigned clinical areas?	2	11	13	15.4%	1
7.103	All clinical and medication line storage areas for non-narcotic medications: Does the institution safely store non-narcotic medications that require refrigeration in assigned clinical areas?	5	6	11	45.5%	3
7.104	Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes?	6	1	7	85.7%	7
7.105	Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients?	6	1	7	85.7%	7
7.106	Medication preparation and administration areas: Does the Institution employ appropriate administrative controls and protocols when distributing medications to patients?	7	0	7	100.0%	7
7.107	Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and satellite pharmacies?	1	0	1	100.0%	0

Reference Number	7 – Pharmacy and Medication Management	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.108	Pharmacy: Does the institution’s pharmacy safely store non-refrigerated medications?	1	0	1	100.0%	0
7.109	Pharmacy: Does the institution’s pharmacy safely store refrigerated or frozen medications?	1	0	1	100.0%	0
7.110	Pharmacy: Does the institution’s pharmacy properly account for narcotic medications?	0	1	1	0.0%	0
7.111	Does the institution follow key medication error reporting protocols?	25	0	25	100.0%	0
Overall percentage:					68.4%	

Reference Number	8 – Prenatal and Post-delivery Services	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
8.001	For patients identified as pregnant, did the institution timely offer initial provider visits?	10	0	10	100.0%	0
8.002	Was the pregnant patient timely issued a comprehensive accommodation chrono for a lower bunk and lower-tier housing and did the patient receive the correct housing placement?	10	0	10	100.0%	0
8.003	Did medical staff promptly order recommended vitamins, extra daily nutritional supplements, and food for the patient?	9	1	10	90.0%	0
8.004	Did timely patient encounters occur with an OB physician or OB nurse practitioner in accordance with the pregnancy encounter guidelines?	10	0	10	100.0%	0
8.005	Were the results of the patient’s initial prenatal screening tests timely completed and reviewed?	Not Applicable				
8.006	Was the patient’s weight and blood pressure documented at each clinic OB visit?	7	3	10	70.0%	0
8.007	Did the patient receive her six-week post-partum obstetric visit?	9	0	9	100.0%	1
Overall percentage:					93.3%	

Reference Number	9 – Preventive Services	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
9.001	Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed?	18	5	23	78.3%	0
9.002	Patients prescribed TB medication: Did the institution monitor the patient monthly for the most recent three months he or she was on the medication?	18	5	23	78.3%	0
9.003	Annual TB Screening: Was the patient screened for TB within the last year?	25	5	30	83.3%	0
9.004	Were all patients offered an influenza vaccination for the most recent influenza season?	25	0	25	100.0%	0
9.005	All patients from the age of 50 – 75: Was the patient offered colorectal cancer screening?	24	1	25	96.0%	0
9.006	Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy?	30	0	30	100.0%	0
9.007	Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy?	28	2	30	93.3%	0
9.008	Are required immunizations being offered for chronic care patients?	11	1	12	91.7%	13
9.009	Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	Not Applicable				
Overall percentage:					90.1%	

10 – Quality of Nursing Performance

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

11 – Quality of Provider Performance

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

12 – Reception Center Arrivals

The institution had no reception center, so this indicator was not applicable.

Reference Number	13 – <i>Specialized Medical Housing</i>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient on the day of admission, or within eight hours of admission to CMF’s Hospice?	15	0	15	100.0%	0
13.002	For CTC and SNF only: Was a written history and physical examination completed within the required time frame?	8	0	8	100.0%	0
13.003	For OHU, CTC, SNF, and Hospice: Did the primary care provider complete the Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes on the patient at the minimum intervals required for the type of facility where the patient was treated?	5	8	13	38.5%	0
13.101	For OHU and CTC only: Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter patient’s cells?	3	0	3	100.0%	0
Overall percentage:					84.6%	

Reference Number	14 – Specialty Services	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	Did the patient receive the high priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service?	15	0	15	100.0%	0
14.002	Did the primary care provider review the high priority specialty service consultant report within the required time frame?	12	0	12	100.0%	0
14.003	Did the patient receive the routine specialty service within 90 calendar days of the primary care provider order or Physician Request for Service?	15	0	15	100.0%	0
14.004	Did the primary care provider review the routine specialty service consultant report within the required time frame?	12	2	14	85.7%	1
14.005	For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames?	18	2	20	90.0%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	17	3	20	85.0%	0
14.007	Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame?	14	6	20	70.0%	0
Overall percentage:					90.1%	

Reference Number	15 – Administrative Operations	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.001	Did the institution promptly process inmate medical appeals during the most recent 12 months?	11	1	12	91.7%	0
15.002	Does the institution follow adverse / sentinel event reporting requirements?	0	1	1	0.0%	0
15.003	Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified?	6	0	6	100.0%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	1	0	1	100.0%	0
15.005	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	0	12	12	0.0%	0
15.006	For institutions with licensed care facilities: Does the Local Governing Body (LGB), or its equivalent, meet quarterly and exercise its overall responsibilities for the quality management of patient health care?	0	4	4	0.0%	0
15.101	Did the institution complete a medical emergency response drill for each watch and include participation of health care and custody staff during the most recent full quarter?	2	1	3	66.7%	0
15.102	Did the institution's second level medical appeal response address all of the patient's appealed issues?	10	0	10	100.0%	0
15.103	Did the institution's medical staff review and submit the initial inmate death report to the Death Review Unit in a timely manner?	4	1	5	80.0%	0
15.104	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	2	3	5	40.0%	0
15.105	Are nursing staff who administer medications current on their clinical competency validation?	9	1	10	90.0%	0
15.106	Are structured clinical performance appraisals completed timely?	8	0	8	100.0%	0
15.107	Do all providers maintain a current medical license?	11	0	11	100.0%	0
15.108	Are staff current with required medical emergency response certifications?	2	0	2	100.0%	1
15.109	Are nursing staff and the Pharmacist-in-Charge current with their professional licenses and certifications, and is the pharmacy licensed as a correctional pharmacy by the California State Board of Pharmacy?	6	0	6	100.0%	1

Reference Number	15 – <i>Administrative Operations</i>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.110	Do the institution’s pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	1	0	1	100.0%	0
15.111	Are nursing staff current with required new employee orientation?	0	1	1	0.0%	0
Overall percentage:					68.7%	

APPENDIX B — CLINICAL DATA

Table B-1: CIW Sample Sets

Sample Set	Total
Anticoagulation	3
CTC/OHU	3
Death Review/Sentinel Events	3
Diabetes	3
Emergency Services – CPR	3
Emergency Services – Non-CPR	3
High Risk	5
Hospitalization	3
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	24
Specialty Services	3
	63

Table B-2: CIW Chronic Care Diagnoses

Diagnosis	Total
Anemia	15
Anticoagulation	4
Arthritis/Degenerative Joint Disease	21
Asthma	19
COPD	9
Cancer	10
Cardiovascular Disease	9
Chronic Kidney Disease	6
Chronic Pain	28
Cirrhosis/End-Stage Liver Disease	1
Deep Venous Thrombosis/Pulmonary Embolism	5
Diabetes	24
Gastroesophageal Reflux Disease	25
Gastrointestinal Bleed	2
Hepatitis C	16
Hyperlipidemia	21
Hypertension	26
Mental Health	30
Migraine Headaches	6
Rheumatological Disease	2
Seizure Disorder	3
Sleep Apnea	4
Thyroid Disease	16
	302

Table B-3: CIW Event – Program

Diagnosis	Total
Diagnostic Services	354
Emergency Care	87
Hospitalization	53
Intra-System Transfers In	17
Intra-System Transfers Out	12
Outpatient Care	491
Prenatal & Postpartum Care	66
Specialized Medical Housing	271
Specialty Services	298
	1,649

Table B-4: CIW Review Sample Summary

	Total
MD Reviews Detailed	27
MD Reviews Focused	1
RN Reviews Detailed	17
RN Reviews Focused	33
Total Reviews	78
Total Unique Cases	63
Overlapping Reviews (MD & RN)	15

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

California Institution for Women

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
<i>Access to Care</i>			
MIT 1.001	Chronic Care Patients (25)	Master Registry	<ul style="list-style-type: none"> Chronic care conditions (at least one condition per patient—any risk level) Randomize
MIT 1.002	Nursing Referrals (25)	OIG Q: 6.001	<ul style="list-style-type: none"> See <i>Intra-system Transfers</i>
MITs 1.003–006	Nursing Sick Call (5 per clinic) (30)	MedSATS	<ul style="list-style-type: none"> Clinic (each clinic tested) Appointment date (2–9 months) Randomize
MIT 1.007	Returns from Community Hospital (25)	OIG Q: 4.007	<ul style="list-style-type: none"> See <i>Health Information Management (Medical Records)</i> (returns from community hospital)
MIT 1.008	Specialty Services Follow-up (30)	OIG Q: 14.001 & 14.003	<ul style="list-style-type: none"> See <i>Specialty Services</i>
MIT 1.101	Availability of Health Care Services Request Forms (6)	OIG onsite review	<ul style="list-style-type: none"> Randomly select one housing unit from each yard
<i>Diagnostic Services</i>			
MITs 2.001–003	Radiology (10)	Radiology Logs	<ul style="list-style-type: none"> Appointment date (90 days–9 months) Randomize Abnormal
MITs 2.004–006	Laboratory (10)	Quest	<ul style="list-style-type: none"> Appt. date (90 days–9 months) Order name (CBC or CMPs only) Randomize Abnormal
MITs 2.007–009	Pathology (10)	InterQual	<ul style="list-style-type: none"> Appt. date (90 days–9 months) Service (pathology related) Randomize

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Health Information Management (Medical Records)			
MIT 4.001	Timely Scanning (5)	OIG Qs: 1.001, 1.002, & 1.004	<ul style="list-style-type: none"> Non-dictated documents 1st 10 IPs MIT 1.001, 1st 5 IPs MITs 1.002, 1.004
MIT 4.002	(0)	OIG Q: 1.001	<ul style="list-style-type: none"> Dictated documents First 20 IPs selected
MIT 4.003	(20)	OIG Qs: 14.002 & 14.004	<ul style="list-style-type: none"> Specialty documents First 10 IPs for each question
MIT 4.004	(20)	OIG Q: 4.007	<ul style="list-style-type: none"> Community hospital discharge documents First 20 IPs selected
MIT 4.005	(0)	OIG Q: 7.001	<ul style="list-style-type: none"> MARs First 20 IPs selected
MIT 4.006	(6)	Documents for any tested inmate	<ul style="list-style-type: none"> Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.007	Returns from Community Hospital (25)	Inpatient claims data	<ul style="list-style-type: none"> Date (2–8 months) Most recent 6 months provided (within date range) Rx count Discharge date Randomize (each month individually) First 5 patients from each of the 6 months (if not 5 in a month, supplement from another, as needed)
Health Care Environment			
MIT 5.101–105 MIT 5.107–111	Clinical Areas (14)	OIG inspector onsite review	<ul style="list-style-type: none"> Identify and inspect all onsite clinical areas.
Inter- and Intra-System Transfers			
MIT 6.001–003	Intra-System Transfers (25)	SOMS	<ul style="list-style-type: none"> Arrival date (3–9 months) Arrived from (another CDCR facility) Rx count Randomize
MIT 6.004	Specialty Services Send-Outs (0)	MedSATS	<ul style="list-style-type: none"> Date of transfer (3–9 months) Randomize
MIT 6.101	Transfers Out (9)	OIG inspector onsite review	<ul style="list-style-type: none"> R&R IP transfers with medication

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Pharmacy and Medication Management			
MIT 7.001	Chronic Care Medication (25)	OIG Q: 1.001	<ul style="list-style-type: none"> See <i>Access to Care</i> At least one condition per patient—any risk level Randomize
MIT 7.002	New Medication Orders (25)	Master Registry	<ul style="list-style-type: none"> Rx count Randomize Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns from Community Hospital (25)	OIG Q: 4.007	<ul style="list-style-type: none"> See <i>Health Information Management (Medical Records)</i> (returns from community hospital)
MIT 7.004	RC Arrivals – Medication Orders (N/A at this institution)	OIG Q: 12.001	<ul style="list-style-type: none"> See <i>Reception Center Arrivals</i>
MIT 7.005	Intra-Facility Moves (25)	MAPIP transfer data	<ul style="list-style-type: none"> Date of transfer (2–8 months) To location/from location (yard to yard and to/from ASU) Remove any to/from MHCB NA/DOT meds (and risk level) Randomize
MIT 7.006	En Route (0)	SOMS	<ul style="list-style-type: none"> Date of transfer (2–8 months) Sending institution (another CDCR facility) Randomize NA/DOT meds
MITs 7.101–103	Medication Storage Areas (varies by test)	OIG inspector onsite review	<ul style="list-style-type: none"> Identify and inspect clinical & med line areas that store medications
MITs 7.104–106	Medication Preparation and Administration Areas (varies by test)	OIG inspector onsite review	<ul style="list-style-type: none"> Identify and inspect onsite clinical areas that prepare and administer medications
MITs 7.107–110	Pharmacy (1)	OIG inspector onsite review	<ul style="list-style-type: none"> Identify & inspect all onsite pharmacies
MIT 7.111	Medication Error Reporting (25)	Monthly medication error reports	<ul style="list-style-type: none"> All monthly statistic reports with Level 4 or higher Select a total of 5 months
MIT 7.999	Isolation Unit KOP Medications (10)	Onsite active medication listing	<ul style="list-style-type: none"> KOP rescue inhalers & nitroglycerin medications for IPs housed in isolation units
Prenatal and Post-Delivery Services			
MIT 8.001–007	Recent Deliveries (5)	OB Roster	<ul style="list-style-type: none"> Delivery date (2–12 months) Most recent deliveries (within date range)
	Pregnant Arrivals (5)	OB Roster	<ul style="list-style-type: none"> Arrival date (2–12 months) Earliest arrivals (within date range)

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
<i>Preventive Services</i>			
MITs 9.001–002	TB Medications (23)	Maxor	<ul style="list-style-type: none"> • Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • Randomize
MIT 9.003	TB Evaluation, Annual Screening (30)	SOMS	<ul style="list-style-type: none"> • Arrival date (at least 1 year prior to inspection) • Birth Month • Randomize
MIT 9.004	Influenza Vaccinations (25)	SOMS	<ul style="list-style-type: none"> • Arrival date (at least 1 year prior to inspection) • Randomize • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening (25)	SOMS	<ul style="list-style-type: none"> • Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • Randomize
MIT 9.006	Mammogram (30)	SOMS	<ul style="list-style-type: none"> • Arrival date (at least 2 yrs. prior to inspection) • Date of birth (age 52–74) • Randomize
MIT 9.007	Pap Smear (30)	SOMS	<ul style="list-style-type: none"> • Arrival date (at least three yrs. prior to inspection) • Date of birth (age 24–53) • Randomize
MIT 9.008	Chronic Care Vaccinations (25)	OIG Q: 1.001	<ul style="list-style-type: none"> • Chronic care conditions (at least 1 condition per IP—any risk level) • Randomize • Condition must require vaccination(s)
MIT 9.009	Valley Fever (number will vary) (<i>N/A at this institution</i>)	Cocci transfer status report	<ul style="list-style-type: none"> • Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • All

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Reception Center Arrivals			
MITs 12.001–008	RC (N/A at this institution)	SOMS	<ul style="list-style-type: none"> • Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • Randomize
Specialized Medical Housing			
MITs 13.001–003	CTC & OHU (15)	CADDIS	<ul style="list-style-type: none"> • Admit date (1–6 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • Randomize
MIT 13.101	Call Buttons CTC (all)	OIG inspector onsite review	<ul style="list-style-type: none"> • Review by location
Specialty Services			
MITs 14.001–002	High-Priority (15)	MedSATS	<ul style="list-style-type: none"> • Approval date (3–9 months) • Randomize
MITs 14.003–004	Routine (15)	MedSATS	<ul style="list-style-type: none"> • Approval date (3–9 months) • Remove optometry, physical therapy, or podiatry • Randomize
MIT 14.005	Specialty Services Arrivals (20)	MedSATS	<ul style="list-style-type: none"> • Arrived from (other CDCR institution) • Date of transfer (3–9 months) • Randomize
MIT 14.006–007	Denials (10)	InterQual	<ul style="list-style-type: none"> • Review date (3–9 months) • Randomize
	(10)	IUMC/MAR Meeting Minutes	<ul style="list-style-type: none"> • Meeting date (9 months) • Denial upheld • Randomize

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
<i>Administrative Operations</i>			
MIT 15.001	Medical Appeals (all)	Monthly medical appeals reports	<ul style="list-style-type: none"> Medical appeals (12 months)
MIT 15.002	Adverse/Sentinel Events (1)	Adverse/sentinel events report	<ul style="list-style-type: none"> Adverse/sentinel events (2–8 months)
MITs 15.003–004	QMC Meetings (6)	Quality Management Committee meeting minutes	<ul style="list-style-type: none"> Meeting minutes (12 months)
MIT 15.005	EMRRC (12)	EMRRC meeting minutes	<ul style="list-style-type: none"> Monthly meeting minutes (6 months)
MIT 15.006	LGB (4)	LGB meeting minutes	<ul style="list-style-type: none"> Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills (3)	Onsite summary reports & documentation for ER drills	<ul style="list-style-type: none"> Most recent full quarter Each watch
MIT 15.102	2nd Level Medical Appeals (10)	Onsite list of appeals/closed appeals files	<ul style="list-style-type: none"> Medical appeals denied (6 months)
MIT 15.103	Death Reports (5)	Institution-list of deaths in prior 12 months	<ul style="list-style-type: none"> Most recent 10 deaths Initial death reports
MIT 15.104	RN Review Evaluations (5)	Onsite supervisor periodic RN reviews	<ul style="list-style-type: none"> RNs who worked in clinic or emergency setting six or more days in sampled month Randomize
MIT 15.105	Nursing Staff Validations (10)	Onsite nursing education files	<ul style="list-style-type: none"> On duty one or more years Nurse administers medications Randomize
MIT 15.106	Provider Annual Evaluation Packets (8)	Onsite provider evaluation files	<ul style="list-style-type: none"> All required performance evaluation documents
MIT 15.107	Provider licenses (11)	Current provider listing (at start of inspection)	<ul style="list-style-type: none"> Review all
MIT 15.108	Medical Emergency Response Certifications (all)	Onsite certification tracking logs	<ul style="list-style-type: none"> All staff <ul style="list-style-type: none"> Providers (ACLS) Nursing (BLS/CPR) Custody (CPR/BLS)
MIT 15.109	Nursing staff and Pharmacist in Charge Professional Licenses and Certifications (all)	Onsite tracking system, logs, or employee files	<ul style="list-style-type: none"> All required licenses and certifications

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
<i>Administrative Operations</i>			
MIT 15.110	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations (all)	Onsite listing of provider DEA registration #s & pharmacy registration document	<ul style="list-style-type: none"> All DEA registrations
MIT 15.111	Nursing Staff New Employee Orientations (all)	Nursing staff training logs	<ul style="list-style-type: none"> New employees (hired within last 12 months)
MIT 15.998	Death Review Committee (5)	OIG summary log - deaths	<ul style="list-style-type: none"> Between 35 business days & 12 months prior CCHCS death reviews

**CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES'
RESPONSE**

August 22, 2018

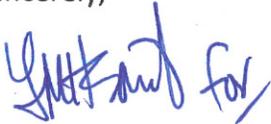
Roy Wesley, Inspector General
Office of the Inspector General
10111 Old Placerville Road, Suite 110
Sacramento, CA 95827

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 Institution for Women (CIW) conducted from October 2017 to January 2018. 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) 691-3747.

Sincerely,



DEANNA GOULDY
Associate Director
Risk Management Branch
California Correctional Health Care Services



cc: Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Clark Kelso, Receiver
Richard Kirkland, Chief Deputy Receiver
Stephen Tseng, M.D., Chief of Medical Inspections, OIG
Penny Horper, R.N., MSN, CPHQ, Nurse Consultant Program Review, OIG
Yulanda Mynhier, Director, Health Care Policy and Administration, CCHCS
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Renee Kanan, M.D., Deputy Director, Medical Services, CCHCS
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James Elliot, Chief Executive Officer, CIW
Amanda Oltean, Staff Services Manager II, Program Compliance Section, CCHCS
Allan Blackwood, Staff Services Manager I, Program Compliance Section, CCHCS
Misty Polasik, Staff Services Manager I, OIG