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Inspector General

Office of the Inspector General

Calipatria State Prison
Medical Inspection Results
Cycle 4

September 2016

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

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Cycle 4

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EXECUTIVE SUMMARY

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

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

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

The OIG performed its Cycle 4 medical inspection at CAL from March to May 2016. The inspection included in-depth reviews of 68 inmate-patient files conducted by clinicians, as well as reviews of documents from 388 inmate-patient files, covering 92 objectively scored tests of compliance with policies and procedures applicable to the delivery of medical care. The OIG assessed the case review and compliance results at CAL using 14 health care quality indicators applicable to the institution, made up of 12 primary clinical indicators and two secondary administrative indicators. To conduct clinical case reviews, the OIG employs a clinician team consisting of a physician and a registered nurse consultant, while compliance testing is done by a team of deputy inspectors general and registered nurses trained in monitoring medical compliance. Of the 12 primary indicators, seven were rated by both case review clinicians and compliance inspectors, three were rated by case review clinicians only, and two were rated by compliance inspectors only; both secondary indicators were rated by compliance inspectors only. See the *Health Care Quality Indicators* table on page *ii*. Based on that analysis, OIG experts made a considered and measured overall opinion that the quality of health care at CAL was ***adequate***.

Health Care Quality Indicators

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

Overall Assessment: Adequate

Overall Assessment Rating:

Adequate

Based on the clinical case reviews and compliance testing, the OIG's overall assessment rating for CAL was *adequate*. Of the 12 primary (clinical) quality indicators applicable to CAL, the OIG found two *proficient*, seven *adequate*, and three *inadequate*. Of the two secondary (administrative) quality indicators, the OIG found one *proficient* and one *adequate*. To determine the overall assessment for CAL, the OIG considered individual clinical ratings and individual compliance question scores within each of the indicator categories, putting emphasis on the primary indicators. Based on that analysis, OIG experts made a considered and measured overall opinion about the quality of health care observed at CAL.

Clinical Case Review and OIG Clinician Inspection Results

The clinicians' case reviews sampled patients with high medical needs and included a review of 1,341 patient care events.[1] Of the 12 primary indicators applicable to CAL, ten were evaluated by clinician case review; two were *proficient*, seven were *adequate*, and one was *inadequate.* When determining the overall adequacy of care, the OIG paid particular attention to the clinical nursing and provider quality indicators, as adequate health care staff can sometimes overcome suboptimal processes and programs. However, the opposite is not true; inadequate health care staff cannot provide adequate care, even though the established processes and programs onsite may be adequate. The OIG clinicians identify inadequate medical care based on the risk of significant harm to the patient, not the actual outcome.

Program Strengths — Clinical

- Diagnostic services were proficient, with only one significant deficiency found among 112 encounters.
- The morning huddles were informative, pertinent, and effective for relaying necessary information.
- CAL had minimal clinic backlogs, giving patients good access to specialty services and CAL providers.

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

Program Weaknesses — Clinical

- While providers generally delivered appropriate care in emergent events, two patients with possible heart conditions failed to receive appropriate medical care prior to transfer to an outside hospital for further treatment.

- The nursing care provided during emergency events displayed patterns of incomplete assessment and management, as well as delays in consulting the provider.

- Providers delayed treatment and management of some patients with poorly controlled diabetes.

Compliance Testing Results

Of the 14 total health care indicators applicable to CAL, 11 were evaluated by compliance inspectors.[2] There were 92 individual compliance questions within those 11 indicators, generating 1,141 data points, testing CAL's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[3] Those 92 questions are detailed in *Appendix A — Compliance Test Results*. The institution's inspection scores in the 11 applicable indicators ranged from 63.2 percent to 98.0 percent, with the primary (clinical) indicator *Preventive Services* receiving the lowest score, and the primary indicator *Specialized Medical Housing* receiving the highest. Of the nine primary indicators applicable to compliance testing, the OIG rated four *proficient,* three *adequate,* and two *inadequate.* Of the two secondary indicators, which involve administrative health care functions, one was rated *proficient* and one, *adequate*.

Program Strengths — Compliance

As the *CAL Executive Summary Table* on page *vii* indicates, the institution's compliance ratings were *proficient*, scoring above 85 percent, in the following four primary indicators: *Access to Care*, *Diagnostic Services*, *Specialized Medical Housing*, and *Specialty Services*. The institution also received a *proficient* score in the secondary indicator *Job Performance, Training, Licensing, and Certifications*. The following are some of CAL's strengths based on its compliance scores on individual questions in all the primary health care indicators:

- Nursing staff reviewed patients' health care requests and conducted face-to-face visits with patients within required time frames. Also, when nursing staff referred patients to providers upon sick call encounters, the appointments were timely.

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

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

- Patients discharged from a community hospital received a timely provider follow-up appointment upon returning to the institution.

- All patients sampled received their radiology or laboratory service within the required time frame.

- Clinical staff legibly signed health care records when required.

- All clinics were appropriately disinfected, cleaned, and sanitary; clinical staff properly controlled exposure to blood-borne pathogens and contamination; and clinical staff properly sterilized or disinfected medical equipment.

- Nursing staff properly documented an assessment and disposition on the Initial Health Screening form (CDCR Form 7277), and signed and dated the form on the same day the inmate arrived at the institution for newly arrived patients.

- Nursing staff timely administered or delivered patients' newly ordered medications and ensured that patients transferring from one housing unit to another received their medications without interruption.

- Nurses employed appropriate administrative controls and followed proper protocols while preparing patients' medications.

- In its main pharmacy, CAL followed general security, organization, and cleanliness management protocols; properly stored and monitored refrigerated, frozen, and non-refrigerated medications; and properly accounted for narcotic medications.

- Patients timely received their high-priority and routine specialty services, and providers timely reviewed specialty service consultant reports. In addition, the institution denied provider requests for specialty services within the required time frame.

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

- The Emergency Medical Response Review Committee performed timely incident package reviews that included the use of required review documents.

- All providers timely received structured clinical performance appraisals, and sampled nursing staff received annual clinical competency validations.

Program Weaknesses — Compliance

The institution received ratings of *inadequate*, scoring below 75 percent, in the following two primary indicators: *Pharmacy and Medication Management* and *Preventive Services*. The following are some of the weaknesses identified by CAL's compliance scores on individual questions in all the primary health care indicators:

- Several clinics did not have any hygiene supplies in patient bathrooms, and clinical staff failed to routinely adhere to universal hand hygiene practices.

- Many clinics were lacking core equipment and essential supplies in the common areas and exam rooms, and they did not always have an environment conducive to providing adequate medical services due to insufficient space, hindered access to exam tables, or tables in disrepair.

- For many of the sampled patients received from another CDCR institution or from a county facility, patients who had an existing medication order upon arrival, medications were not administered or delivered without interruption.

- Nursing staff did not timely administer prescribed chronic care medications to patients within the required time frames, nor administer existing medication orders to patients who had a temporary layover at CAL while en route from one institution to another.

- The institution's clinic and medication line locations did not employ strong medication security controls over narcotic medications, did not properly store non-narcotic medications (refrigerated or non-refrigerated), and did not always employ appropriate administrative controls and protocols when distributing medications to patients.

- Patients being treated for active tuberculosis (TB) infections were not always administered TB medications as prescribed. In addition, the institution did not always properly document that these patients were being monitored for their TB condition while on TB medication.

- Nursing staff did not properly conduct annual tuberculosis screenings.

The following weakness was identified within the secondary administrative indicators:

- CAL did not ensure that emergency medical response drills include all required forms and information.

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

CAL Executive Summary Table

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

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

Secondary Indicators (Administrative)		Compliance Rating	Overall Indicator Rating
Internal Monitoring, Quality Improvement, and Administrative Operations	Not Applicable	*Adequate*	*Adequate*
Job Performance, Training, Licensing, and Certifications	Not Applicable	*Proficient*	*Proficient*

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

Population-Based Metrics

The institution generally performed adequately as measured by population-based metrics. Statewide, the institution outperformed Medi-Cal in all five diabetic measures, and outperformed Kaiser in four of five measures, with Kaiser beating out the institution in blood pressure control. Nationally, CAL outperformed Medicaid, Medicare, and commercial health plans in all five diabetic measures, and outperformed the United States Department of Veterans Affairs (VA) in three of the four applicable measures, and matched the VA in diabetic blood pressure control.

With regard to immunizations for younger adults, the institution performed less well than all statewide and national health care organizations. However, the 64 percent refusal rate among the patients sampled negatively affected the institution's score. The institution outperformed Medicaid, Medicare, and Kaiser North for colorectal cancer screenings, but did not perform as well as Kaiser South or the VA.

Overall, CAL's performance calculated by population-based metrics demonstrated a generally adequate chronic care and preventive services program. The institution could improve by making interventions to lower the refusal rates of immunizations for younger adults.

INTRODUCTION

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

Calipatria State Prison (CAL) was the 23rd medical inspection of Cycle 4. During the inspection process, the OIG assessed the delivery of medical care to patients for 12 primary clinical health care indicators and two secondary administrative health care indicators applicable to the institution. It is important to note that while the primary quality indicators represent the clinical care being provided by the institution at the time of the inspection, the secondary quality indicators are purely administrative and are not reflective of the actual clinical care provided.

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

ABOUT THE INSTITUTION

Calipatria State Prison (CAL) protects the public by providing safe custody, quality health care and the appropriate supervision of sentenced offenders. CAL also provides meaningful work programs for inmates who do not meet the criteria for assignment to a conservation camp. The institution runs eight medical clinics where staff handle non-urgent requests for medical services, and it treats inmates needing urgent or emergency care in its triage and treatment area (TTA). CAL also treats patients who require assistance with the activities of daily living but who do not require a higher level of inpatient care in the institution's outpatient housing unit (OHU). CAL has been designated by CCHCS as a "basic" care institution. Basic institutions are located in rural areas, away from tertiary care centers and specialty care providers whose services would likely be used frequently by higher-risk patients. Basic institutions have the capability to provide only limited specialty medical services and consultation for a generally healthy inmate-patient population.

At the time of the inspection, CAL was under review from the Commission on Accreditation for Corrections, a professional peer review process based on national standards set by the American Correctional Association. The institution's onsite review started in April 2016, and CAL was recommended for accreditation. As of July 2016, CAL's warden and CEO were scheduled to participate in the committee hearings, after which a final decision will be made.

Based on unaudited staffing data reported by the institution, CAL's vacancy rate among licensed medical managers, primary care providers (PCPs), supervisors, and nonsupervisory nurses was 3 percent in February 2016, with the highest vacancy percentages among nursing supervisors at 11 percent. Based on the reported data, CAL had one vacant nursing supervisor position, one vacant nursing staff position, and four additional nursing staff who were on long-term medical leave. The institution did not employ any registry nurses.

CAL Health Care Staffing Resources as of February 2016

	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff		Totals	
Description	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Authorized Positions	3	4%	6.5	9%	9.5	13%	55.1	74%	74.1	100%
Filled Positions	3	100%	6.5	100%	8.5	89%	54.1	98%	72.1	97%
Vacancies	0	0%	0	0%	1	11%	1	2%	2	3%
Recent Hires (within 12 months)	0	0%	1	15%	0	0%	5	9%	6	8%
Staff Utilized from Registry	0	0%	0	0%	0	0%	0	0%	0	0%
Redirected Staff (to Non-Patient Care Areas)	0	0%	0	0%	0	0%	0	0%	0	0%
Staff on Long-term Medical Leave	0	0%	0	0%	0	0%	4	7%	4	6%

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

As of February 22, 2016, the Master Registry for CAL showed that the institution had a total population of 3,834. Within that total population, 0.08 percent were designated as high medical risk, Priority 1 (High 1), and 0.55 percent were 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 labs and procedures. High 1 has at least two high-risk conditions; High 2 has only one. Patients at high medical risk are more susceptible to poor health outcomes than those at medium or low medical risk. Patients at high medical risk also typically require more health care services than do patients with lower assigned risk levels. The chart below illustrates the breakdown of the institution's medical risk levels at the start of the OIG medical inspection.

CAL Master Registry Data as of February 22, 2016

Medical Risk Level	# of Inmate-Patients	Percentage
High 1	3	0.08%
High 2	21	0.55%
Medium	733	19.12%
Low	3,077	80.26%
Total	**3,834**	**100%**

Commonly Used Abbreviations

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

OBJECTIVES, SCOPE, AND METHODOLOGY

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

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

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

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

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

CASE REVIEWS

The OIG has added case reviews to the Cycle 4 medical inspections at the recommendation of its stakeholders. At the conclusion of Cycle 3, the federal Receiver and the Inspector General determined that the health care provided at the institutions was not fully evaluated by the compliance tool alone, and that the compliance tool was not designed to provide comprehensive qualitative assessments. Accordingly, the OIG added case reviews in which OIG physicians and nurses evaluate selected cases in detail to determine the overall quality of health care provided to the inmate-patients. The OIG's clinicians perform a retrospective chart review of selected patient files to evaluate the care given by an institution's primary care providers and nurses. Retrospective chart review is a well-established review process used by health care organizations that perform peer reviews and patient death reviews. Currently, CCHCS uses retrospective chart review as part of its death review process and in its pattern-of-practice reviews. CCHCS also uses a more limited form of retrospective chart review when performing appraisals of individual primary care providers.

PATIENT SELECTION FOR RETROSPECTIVE CASE REVIEWS

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

1. The goal of retrospective chart review is to evaluate all aspects of the health care system. Statewide, high-risk and high-utilization patients consume medical services at a disproportionate rate; 11 percent of the total patient population are considered high-risk and

account for more than half of the institution's pharmaceutical, specialty, community hospital, and emergency costs.

2. Selecting this target group for chart review provides a significantly greater opportunity to evaluate all the various aspects of the health care delivery system at an institution.

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

1. If the institution is able to provide adequate clinical care to the most challenging patients with multiple complex and interdependent medical problems, it will be providing adequate care to patients with less complicated health care issues. Because clinical expertise is required to determine whether the institution has provided adequate clinical care, the OIG utilizes experienced correctional physicians and registered nurses to perform this analysis.

2. The health of less complex patients is more likely to be affected by processes such as timely appointment scheduling, medication management, routine health screening, and immunizations. To review these processes, the OIG simultaneously performs a broad compliance review.

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

BENEFITS AND LIMITATIONS OF TARGETED SUBPOPULATION REVIEW

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

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

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

CASE REVIEWS SAMPLED

As indicated in *Appendix B, Table B–1, CAL Sample Sets*, the OIG clinicians evaluated medical charts for 68 unique inmate-patients. *Appendix B, Table B–4, CAL Case Review Sample Summary*, clarifies that both nurses and physicians reviewed charts for 14 of those patients, for 82 reviews in total. Physicians performed detailed reviews of 30 charts, and nurses performed detailed reviews of 17 charts, totaling 47 detailed reviews. For detailed case reviews, physicians or nurses looked at all encounters occurring in approximately six months of medical care. Nurses also performed a limited or focused review of medical records for an additional 35 inmate-patients. These generated 1,341 clinical events for review (*Appendix B, Table B–3, CAL Event—Program*). The reporting format provides details on whether the encounter was adequate or had significant deficiencies, and identifies deficiencies by programs and processes to help the institution focus on improvement areas.

While the sample method specifically pulled only 8 chronic care patient records, i.e., eight diabetes patients (*Appendix B, Table B–1, CAL Sample Sets*), the 68 unique inmate-patients sampled included patients with 136 chronic care diagnoses, including three additional patients with diabetes (for a total of 11) (*Appendix B, Table B–2, CAL Chronic Care Diagnoses*). The OIG's sample selection tool evaluated many chronic care programs because the complex and high-risk patients selected from the different categories often had multiple medical problems. While the OIG did not evaluate every chronic disease or health care staff member, the overall operation of the institution's system and staff were assessed for adequacy. The OIG's case review methodology and sample size matched other qualitative research. The empirical findings, supported by expert statistical consultants, showed adequate conclusions after 10 to 15 charts had undergone full clinician review. In qualitative statistics, this phenomenon is known as "saturation." The OIG asserts that the physician sample size of over 30 detailed reviews certainly far exceeds the saturation point necessary for an adequate qualitative review. With regard to reviewing charts from different providers, the case review is not intended to be a focused search for poorly performing providers; rather, it is focused on how the system cares for those patients who need care the most. Nonetheless, while not sampling cases by each provider at the institution, the OIG inspections adequately review most providers. Providers would only escape OIG case review if institutional management successfully mitigated patient risk by having the more poorly performing providers care for the less

complicated, low-utilizing, and lower-risk patients. The OIG's clinicians concluded that the case review sample size was more than adequate to assess the quality of services provided.

Based on the collective results of clinicians' case reviews, the OIG rated each quality indicator as either *proficient* (excellent), *adequate* (passing), *inadequate* (failing), or *not applicable*. A separate confidential *CAL Supplemental Medical Inspection Results: Individual Case Review Summaries* report details the case reviews OIG clinicians conducted and is available to specific stakeholders. For further details regarding the sampling methodologies and counts, see *Appendix B — Clinical Data, Table B–1; Table B–2; Table B–3;* and *Table B–4*.

COMPLIANCE TESTING

SAMPLING METHODS FOR CONDUCTING COMPLIANCE TESTING

From March to May 2016, deputy inspectors general and registered nurses obtained answers to 92 objective medical inspection test (MIT) questions designed to assess the institution's compliance with critical policies and procedures applicable to the delivery of medical care. To conduct most tests, inspectors randomly selected samples of inmate-patients for whom the testing objectives were applicable and reviewed their electronic unit health records. In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed health records for 388 individual inmate-patients and analyzed specific transactions within their records for evidence that critical events occurred. Inspectors also reviewed management reports and meeting minutes to assess certain administrative operations. In addition, during the week of March 7, 2016, field inspectors conducted a detailed onsite inspection of CAL's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,141 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 CAL's plant infrastructure, protocols for tracking medical appeals and local operating procedures, and staffing resources.

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

SCORING OF COMPLIANCE TESTING RESULTS

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

- Primary indicators: *Access to Care*; *Diagnostic Services*; *Health Information Management (Medical Records)*; *Health Care Environment*; *Inter- and Intra-System Transfers*; *Pharmacy*

and Medication Management; *Preventive Services*; *Specialized Medical Housing*; and *Specialty Services.*

- Secondary indicators: *Internal Monitoring, Quality Improvement, and Administrative Operations*; and *Job Performance, Training, Licensing, and Certifications*.

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

DASHBOARD COMPARISONS

In the first ten medical inspection reports of Cycle 4, the OIG identified where similar metrics for some of the individual compliance questions were available within the CCHCS Dashboard, which is a monthly report that consolidates key health care performance measures statewide and by institution. However, there was not complete parity between the metrics due to differing time frames for data collecting and differences in sampling methods, rendering the metrics non-comparable. Some of the OIG's stakeholders suggested removing the Dashboard comparisons from future reports to eliminate confusion. Dashboard data is available on CCHCS's website, www.cphcs.ca.gov.

OVERALL QUALITY INDICATOR RATING FOR CASE REVIEWS AND COMPLIANCE TESTING

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

To derive an overall assessment rating 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 inmate-patients. Based on that analysis, OIG experts made a considered and measured overall opinion about the quality of health care observed.

POPULATION-BASED METRICS

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

MEDICAL INSPECTION RESULTS

PRIMARY (CLINICAL) QUALITY INDICATORS OF HEALTH CARE

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

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

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

The OIG physicians rated the overall adequacy of care for each of the 30 detailed case reviews they conducted. Of these 30 cases, 25 were *adequate*, and 5 were *inadequate*. In the 1,341 events reviewed, there were 214 deficiencies, of which 66 were considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

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

There were no adverse events identified in the case reviews at CAL.

Summary of Compliance Results: The compliance component assessed 9 of the 12 primary (clinical) indicators applicable to CAL. Of these nine indicators, OIG inspectors rated four *proficient*, three *adequate*, and two *inadequate*. The results of those assessments are summarized within this section of the report. The test questions used to assess compliance for each indicator are detailed in *Appendix A*.

ACCESS TO CARE

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

Case Review Rating:
Adequate
Compliance Score:
Proficient
(88.7%)

Overall Rating:
Adequate

In this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance review resulting in a *proficient* score. The case reviews found 11 significant deficiencies, preventing the institution from receiving a *proficient* rating in this area. The OIG's internal review process considered those factors that led to both scores and ultimately rated this indicator *adequate*.

Case Review Results

The OIG's review of 809 provider and nursing encounters identified only 16 deficiencies relating to *Access to Care*. Most appointments were appropriately scheduled. Providers and specialists were able to see patients in a timely manner. There were no significant nursing issues related to *Access to Care*. Although there were 11 significant deficiencies, the majority of patient-staff interactions resulted in provider appointments within appropriate time frames. The institution performed well with regard to *Access to Care*, and the case review rating was *adequate*.

- In case 3, the provider ordered an urgent Dilantin level (blood test) that was not completed until seven days later.
- In case 8, the provider ordered a four- to eight-week follow-up appointment, but the patient was not seen until five months later.
- Also in case 8, the provider ordered a 14-day follow-up for the patient after a colonoscopy was performed, but the follow-up did not occur until three months later.
- In case 12, neurology evaluated the patient for worsening weakness and tingling of the arm. Neurology recommended a two-week follow-up with the provider for consideration of IVIG (immune globulin therapy administered intravenously). The follow-up occurred one month late.

- In case 13, the patient was not evaluated until nine days after a five-day hospitalization for an abscess, which was four days later than policy required.

- In case 14, the provider ordered a one-day follow-up with the clinic nurse that did not occur. Two days later, the institution sent the patient to the hospital for suspected pneumonia.

- In case 17, the specialty services nurse failed to schedule a provider-ordered imaging test and surgery for a rectal lesion. The provider also failed to recognize for over nine months that the surgery was not scheduled.

- In case 24, optometry recommended a follow-up for visual field testing and a glaucoma evaluation in one to two weeks, but the appointment did not occur until two months later. This is also discussed in *Specialty Services* indicator.

- In case 25, after the patient received an endocrinology consult, a provider follow-up appointment did not occur until four months later.

- In case 27, the provider ordered a four-week follow-up appointment that did not occur for nearly three months.

Compliance Testing Results

The institution performed in the *proficient* range in the *Access to Care* indicator, with a compliance score of 88.7 percent, and scored well in the following test areas:

- Inmates had access to Health Care Services Request forms (CDCR Form 7362) at all six housing unit locations inspected (MIT 1.101).

- For all 30 patients sampled who submitted a Health Care Services Request form (CDCR Form 7362), nursing staff completed a face-to-face visit within one business day of receiving the form (MIT 1.004). Among those 30 sampled patients, 15 were referred by the nurse to a provider, and all 15 were seen within the required time frame (MIT 1.005). Of those 15 provider appointments, six ultimately resulted in a provider ordering a second visit to monitor or treat the patient's conditions. All of the six patients received their subsequent follow-up appointments timely (MIT 1.006).

- The institution offered follow-up appointments with a provider within five days of discharge from a community hospital for all eight patients sampled (MIT 1.007).

- Inspectors sampled 30 Health Care Services Request forms submitted by patients across all facility clinics. For 29 patients (97 percent), nursing staff reviewed the request form on the same day it was received. The only exception was when a nurse reviewed the form one day late (MIT 1.003).

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

- The OIG reviewed recent appointments for 30 patients who suffered with one or more chronic care conditions and found that 25 (83 percent) had received timely follow-up appointments. Five patients received their follow-up appointments from 4 to 30 days late (MIT 1.001).

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

- Among 25 sampled patients who transferred into CAL from other institutions and were referred to a provider based on nursing staff's initial health care screening, only 13 (52 percent) were seen timely. Twelve patients received their referral appointment from one to 76 days late (MIT 1.002).

- Among 24 patients sampled who received a specialty service, 16 (67 percent) received a timely follow-up appointment with a provider. Eight patients received their appointment from one to 43 days late (MIT 1.008).

Recommendations

No specific recommendations.

DIAGNOSTIC SERVICES

Case Review Rating:
Proficient
Compliance Score:
Proficient
(85.6%)

Overall Rating:
Proficient

This indicator addresses several types of diagnostic services. Specifically, it addresses whether radiology and laboratory services were timely provided to inmate-patients, whether the primary care provider timely reviewed the results, and whether the results were communicated to the inmate-patient within the required time frames. In addition, for pathology services, the OIG determines whether the institution received a final pathology report and whether the primary care 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 Results

The institution provided excellent diagnostic services, with diagnostic tests performed timely and providers reviewing test results and notifying patients within the required time frame. As a result, CAL was *proficient* in the *Diagnostic Services* indicator. The OIG clinicians reviewed 112 diagnostic events and found only six deficiencies, two of which were significant:

- In case 11, a patient had altered arm sensations. The provider ordered multiple laboratory tests, but they were never performed. This is also discussed in *Quality of Provider Performance* indicator.

- In case 26, the provider ordered an electrocardiogram (EKG) for a patient with palpitations and shortness of breath. The EKG was not performed until two weeks later. This is also discussed in *Quality of Provider Performance* indicator.

Compliance Testing Results

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

Radiology Services

- In all ten of the radiology services sampled, the service was performed timely, the ordering provider timely reviewed the diagnostic results, and the test results were timely communicated to the patient (MIT 2.001, 2.002, 2.003).

Laboratory Services

- All ten of the laboratory services sampled were provided within the required time frame (MIT 2.004). However, providers only properly reviewed seven of the ten reports within the required period (70 percent). Providers reviewed three of the reports from two to eight days late (MIT 2.005). Also, providers communicated the laboratory results to only seven of the ten patients within the required time frame (70 percent). Three patients received their results from two to eight days late (MIT 2.006).

Pathology Services

- The institution timely received the final pathology report for nine of ten patients sampled (90 percent). For one patient, the pathology report was eight days late (MIT 2.007). In addition, providers documented sufficient evidence that they timely reviewed the final report results for eight of those ten patients (80 percent); for two patients, the PCPs' reviews were five and nine days late (MIT 2.008). Providers timely communicated the final pathology test results to only six of the ten patients (60 percent). For three patients, the provider communicated the pathology test results from 5 to 16 days late; for another patient, there was no evidence the provider communicated the test results at all (MIT 2.009).

Recommendations

No specific recommendations**.**

EMERGENCY SERVICES

Case Review Rating:
Inadequate
Compliance Score:
Not Applicable

Overall Rating:
Inadequate

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 the emergency situation, clinical condition, and need for a higher level of care. The OIG reviews emergency response services including first aid, basic life support (BLS), and advanced cardiac life support (ACLS) consistent with the American Heart Association guidelines for cardiopulmonary resuscitation (CPR) and emergency cardiovascular care, and the provision of services by knowledgeable staff appropriate to each individual's training, certification, and authorized scope of practice.

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

Case Review Results

The OIG clinicians reviewed 44 urgent/emergent events and found 38 deficiencies. Eighteen of the deficiencies were significant. Twelve of the serious deficiencies were in nursing care. The institution received an *inadequate* rating in the *Emergency Services* indicator.

Provider Performance

The providers generally made appropriate assessments and plans during urgent or emergent events. However, four serious provider performance deficiencies were identified. Two of these significant deficiencies were for patients with heart conditions. Fortunately, there were no adverse outcomes for these patients. These cases are also described in the *Quality of Provider Performance* indicator:

- In case 4, the nurse called the provider regarding a patient with symptoms of chest pain and shortness of breath. The patient was sent to the emergency room without being given aspirin and nitroglycerin as recommended for cardiac-associated chest pain. The provider ordered a code 2 ambulance transport, instead of the faster code 3, for a patient with possible acute coronary syndrome (impending heart attack), potentially delaying arrival at the emergency room. The physician's progress note did not address why the code 2 transportation was ordered.

- In case 17, the provider ordered 7 mg of intramuscular lorazepam (sedative) within a 20-minute period for an agitated patient. This could have resulted in severe respiratory depression.

- In case 22, the provider failed to order cervical spine precautions (protection of an unstable neck) with a patient who suffered severe traumatic facial fractures and a possible loss of consciousness.

- In case 27, the provider noted the patient had chest pain and sent the patient to the ER to rule out acute coronary syndrome. The provider failed to order appropriate emergency treatment, which should have included morphine, oxygen, nitroglycerin, and aspirin, prior to transporting the patient.

Nursing Performance

Nurses often failed to follow the requirements of nursing protocol. The nursing staff used a progress note to document events and situations of an urgent or emergent visit, not allowing for documentation of multiple assessments. This resulted in the failure to document information essential to the patients' care. Critical time frames were not well documented, which suggested lapses in care.

- In case 4, the patient had chest pain and difficulty breathing. The nurse did not notify the provider until 30 minutes after the patient was in the TTA. In addition, vital signs were not taken every five minutes as required by protocol guidelines, and an EKG was performed 1 hour and 13 minutes after the patient's arrival in the TTA, just prior to transferring the patient to the local emergency department. In addition, the patient was not given aspirin or nitroglycerin.

- In case 7, the patient was found unconscious from a suspected heroin overdose. Neither the LVN first medical responder nor the TTA RN initiated oxygen or measured oxygen saturation. The RN failed to assess the patient for head trauma, perform a finger-stick blood glucose, or urgently notify the on-call provider. The TTA staff did not notify the provider until 20 minutes after admission. Hospital notes indicated the patient's temperature was 105.6° F upon arrival, which further highlights the TTA staff failure to identify a critically abnormal vital sign. The RN failed to complete essential documentation, including the time the ambulance was called and the time it arrived and departed, and the stability of the patient when transferred. Nursing notes did not include what care was rendered in the TTA. The on-call provider's notes included that the patient was vomiting, but the RN notes did not mention this.

- In case 10, the RN did not complete a proper eye exam of the patient per the eye injury and irritation protocol guidelines, resulting in an incomplete assessment.

- In case 16, the patient was found unresponsive in his cell. While the patient was in the TTA, the nurse did not monitor his vital signs, neurological status, and oxygen levels every 15 minutes as required by the loss of consciousness protocol guidelines. Nursing documentation was incomplete; the RN did not document essential patient care information,

such as the exact times of the initiation of first aid, BLS, and other lifesaving measures, the number of staff involved and their classifications, and the time custody placed the 9-1-1 emergency call.

- In case 17, the patient arrived at the TTA with chest pain. However, the RN did not use the chest pain protocols to monitor the patient's heart rate and rhythm, and did not notify the provider for over one-half hour after the patient arrived. The RN also should have administered nitroglycerin and aspirin to the patient.

Emergency Medical Response Review Committee

A review of the Emergency Medical Response Review Committee (EMRRC) minutes revealed documentation only for patients transported to a higher level of care or by air ambulance services on an unscheduled basis, and only reflect the total number of unscheduled transports to outside facilities. Minutes did not include a review, discussion, or possible corrective action for problematic unscheduled transports to a higher level of care. The committee's review was limited and did not comply with current CCHCS policy. The review was insufficient to adequately monitor and evaluate the institution's emergency responses, which typically involve ground response only, not air ambulance transportation. After the OIG onsite discussions with the chief nurse executive (CNE), changes were made to the EMRRC to expand the review to include unscheduled transports.

Conclusion

The medical care of patients with heart conditions is an essential component in an emergency services program. Although the physicians performed at an adequate level for most patient care, cardiac care was deficient. With regard to nursing, multiple encounters lacked full documentation of emergency services. In addition, CAL staff did not always follow established protocols. Institution staff must document why any actions taken outside of CCHCS policy was necessary. The institution's EMRRC did not always follow CCHCS policy, which affects the usefulness of the EMRRC as a feedback tool to improve emergency response performance. Factoring in the multiple instances of insufficient nursing documentation, and the need for improved cardiac care in an emergency setting, the OIG rated the *Emergency Services* indicator *inadequate*.

Recommendations

The OIG recommends that CAL implement the following:

- Training for providers on the CCHCS chest pain protocol and guidelines.
- Training for providers regarding consistency in assessment and planning documentation.
- Training for nursing staff on emergency care protocols.

HEALTH INFORMATION MANAGEMENT (MEDICAL RECORDS)

Case Review Rating:
Adequate
Compliance Score:
Adequate
(81.6%)

Overall Rating:
Adequate

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

Case Review Results

The OIG clinicians found 22 health information management deficiencies. Only one of the deficiencies was significant, placing the patient at risk for serious harm (case 3, below). The minor deficiencies were in most program areas. In one case, a progress notes was not in the eUHR for a TTA patient transported to the emergency room for chest pain. In two other cases, the transfer information for patients was also not in the eUHR. In addition, the sick call and TTA notes were occasionally mislabeled in the eUHR. Overall, the institution performed at an *adequate* level.

- In case 3, the orthopedic physician evaluated the patient and dictated the consult note two months later. The note was reviewed by a primary care physician an additional seven days later.

Compliance Testing Results

The institution received an *adequate* compliance score of 81.6 percent in the *Health Information Management (Medical Records)* indicator and performed well in the following areas:

- The institution scored 100 percent for the timely scanning of dictated or transcribed provider progress notes into the patients' electronic health records (MIT 4.002).

- All 11 sampled medication administration records were scanned timely into the patients' eUHRs (MIT 4.005).

- When the OIG reviewed various medical documents such as hospital discharge reports, initial health screening forms, certain medication records, and specialty services reports to ensure that clinical staff legibly documented their names on the forms, all 32 samples showed compliance (MIT 4.007).

- The institution timely scanned 19 of 20 sampled non-dictated progress notes, initial health screening forms, and requests for health care services into patients' eUHRs, scoring 95 percent. Only one document was scanned one day late (MIT 4.001).

- The OIG tested 20 high-priority and routine specialty services reports and found that 19 of them were scanned into the eUHR within the required time frame (95 percent). One report was scanned ten days late (MIT 4.003).

- Inspectors reviewed eUHR files for eight patients sent or admitted to the hospital and found that providers reviewed the hospital discharge reports or treatment records within three calendar days of discharge for seven patients (88 percent). A provider reviewed one discharge report seven days late for one patient (MIT 4.008).

The institution received an *adequate* score in the following area:

- CAL timely scanned community hospital discharge reports or treatment records into the patient's eUHR in six of the eight sampled instances (75 percent); two reports were scanned one day late (MIT 4.004).

The institution scored poorly in the following area:

- The institution scored zero in its labeling and filing of documents scanned into patients' eUHRs; some documents were mislabeled, such as a primary care provider note that was scanned and labeled as a physician's order, and other documents were missing from the eUHR altogether. For this test, once the OIG identifies 12 mislabeled or misfiled documents, the maximum points are lost and the resulting score is zero. For the CAL medical inspection, inspectors identified 12 documents either mislabeled or misfiled (MIT 4.006).

Recommendations

No specific recommendations.

HEALTH CARE ENVIRONMENT

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

Case Review Rating:
Not Applicable
Compliance Score:
Adequate
(80.9%)

Overall Rating:
Adequate

Compliance Testing Results

The institution received an *adequate* compliance score of 80.9 percent in the *Health Care Environment* indicator, and performed well in 6 of 11 test areas, as described below:

- The institution appropriately disinfected, cleaned, and sanitized all ten clinic locations observed; cleaning logs indicated that porters regularly cleaned all clinics as scheduled (MIT 5.101).
- Clinical health care staff in all nine clinic locations tested properly sterilized and disinfected reusable invasive and non-invasive medical equipment (MIT 5.102).
- All ten clinics followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste (MIT 5.105).
- Based on the OIG's inspection of the institution's non-clinic storage area for bulk medical supplies and responses from the warehouse manager and the CEO, the medical supply management process supported the needs of the medical health care program. As a result, CAL scored 100 percent on this test (MIT 5.106).
- All ten clinic locations followed adequate protocols for managing and storing bulk medical supplies (MIT 5.107).
- Inspectors examined emergency response bags to determine if institution staff inspected the bags daily and inventoried them monthly, and whether the bags contained all essential items. Emergency response bags were compliant at all seven applicable clinical locations (MIT 5.111).

The following areas showed room for improvement:

- Seven of the ten clinic locations inspected (70 percent) had operable sinks and sufficient quantities of hygiene supplies in clinical areas. At three other clinics, one or more deficiencies were found; the clinics' patient bathrooms did not have a sink, soap, or disposable hand towels (*Figure 1*) (MIT 5.103).

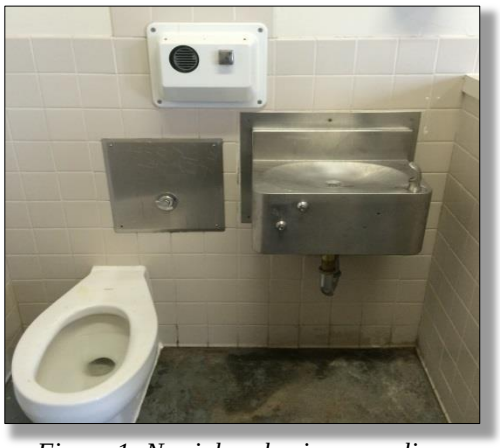

Figure 1: No sink or hygiene supplies in inmate-patient bathroom

- Seven of the ten clinics' common areas (70 percent) had an environment conducive to providing medical services, such as acceptable wheelchair access, adequate patient waiting areas, sufficient clinician work space, and reasonable patient privacy in triage stations. However, at three other clinic locations, the vital sign stations were within audible range of the clinic's inmate holding cell, and thus, lacked auditory privacy (*Figure 2*) (MIT 5.109).

Figure 2: No auditory privacy with vital station next to patient holding cell

- Only six of the ten clinics observed (60 percent) had appropriate space, configuration, supplies, and equipment to allow clinicians to perform a proper clinical examination. Specifically, three clinic locations had exam tables with rips or tears in the vinyl cover, and the exam table at another clinic location impeded access to the biohazard receptacle (MIT 5.110).

- In only four of eight clinics tested, clinicians adhered to universal hand hygiene precautions, scoring 50 percent. OIG inspectors observed clinicians who, while treating patients, either did not remove their gloves or did not wash or sanitize their hands before or after patient contact (MIT 5.104).

- Clinic common areas and exam rooms were sometimes missing core equipment or other essential supplies necessary to conduct a comprehensive exam. As a result, only four of the ten clinic locations were compliant (40 percent). Equipment and supply deficiencies in six clinics' common areas or exam rooms included the following: two clinics without hemoccult cards or a developer, two clinics with no biohazard receptacle or bag, two clinic locations without a medication refrigerator, and another clinic without a Snellen chart (MIT 5.108).

Other Information Obtained from Non-Scored Results

The OIG gathered information to determine if the institution's physical infrastructure was maintained in a manner that supported health care management's ability to provide timely or adequate health care. This question is not scored. When OIG inspectors interviewed CAL's health care management, staff did not have any significant concerns about the existing infrastructure at the institution or its effect on staff's ability to provide adequate health care. The institution had a system in place to identify and report facility infrastructure problems when they occurred. At the time of the OIG inspection, CAL had two ongoing projects:

- Project A: Statewide Medication Distribution Management

  This statewide project included the design and construction of improved medication distribution facilities, allowing CAL to provide appropriately sized space with proper infrastructure for secure distribution, infection control, and environmentally controlled and secure medication storage. The project started in April 2015 and completed in May 2016.

- Project B: Health Care Facility Improvement Program Expansion

  This project will include primary care clinic renovations and additions to Facilities A, B, C, and D, a new administrative segregation primary care clinic, and renovations to the central health services and health care administration buildings. Groundbreaking construction is slated to start in June or July 2016 and be completed in fiscal year 2017–18.

Recommendations for CCHCS

The OIG recommends that CCHCS develop a statewide policy to identify required core equipment and supplies for each type of clinical setting, including primary care clinics, specialty clinics, TTA, R&R, and inpatient units.

Recommendations for CAL

The OIG recommends the institution develop local operating procedures that help to ensure that all clinical areas supply a standardized full complement of core equipment that includes a medication refrigerator and Snellen eye chart and that each exam room has a biohazard waste receptacle and hemoccult cards and developer.

INTER- AND INTRA-SYSTEM TRANSFERS

Case Review Rating:
Adequate
Compliance Score:
Adequate
(80.7%)

Overall Rating:
Adequate

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

Case Review Results

Clinicians reviewed 51 encounters relating to *Inter- and Intra-System Transfers*, including information from both the sending and receiving institutions. These included 29 hospitalization events, each of which resulted in a transfer back to the institution. Nine deficiencies were discovered with only one significant deficiency (case 13). In general, the inter- and intra-system transfer processes at CAL were *adequate.*

Transfers In

Among 15 reviewed transfers-in events, there were no issues with health screening or the appropriateness of referrals. Transfer information forms were signed by both the sending and the receiving RNs. Nurses assessed patients arriving as direct admissions to the OHU and implemented new orders. The RN notes were complete. Patients with specialty needs and appointments were seen timely. There were two minor deficiencies: a missed diagnosis of chronic thrombocytopenia (low platelets for blood clotting), and one missed transfer information sheet.

Transfers Out

An RN did not include a hematology specialty appointment or follow-up labs on the Health Care Transfer Information form (CDCR Form 7371). The laboratories were not completed as ordered. The labs included a complete metabolic panel, complete blood count, and INR (to check the status of anti-embolization therapy). However, the scheduled hematology appointment was kept.

Hospitalizations

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

- In case 13, after the patient was hospitalized for a skin infection, the primary care provider failed to prescribe one of the two antibiotics recommended by the hospital at the time of discharge. Fortunately, this did not adversely affect the patient.

Clinician Onsite Inspection

The onsite visit provided valuable insight into the institution's workflow. Interviews with the onsite receiving and release (R&R) nursing staff members revealed that they were proud participants of the health care delivery system. They had the freedom to create plans to ensure consistency for covering staff when a temporary vacancy occurred. Nursing staff created an RN orientation skills checklist for each watch in the R&R. Skills included start-of-day duties, assessment of patients who arrived at the institution, transfers to other prisons, parole medications, end-of-day clinic duties, and COCF (California Out-of-State Correctional Facility) transfers. A new patient arrival blood pressure sheet was created to assess and reassess blood pressure readings. Instructions were given to monitor all patients not in the chronic care program with a blood pressure reading of 140/90 mmHg or higher.

Compliance Testing Results

The institution obtained an *adequate* score of 80.7 percent in the *Inter- and Intra-System Transfers* indicator. CAL performed in the *proficient* range in the tests below:

- For 27 of 30 sampled patients who transferred into the institution (90 percent), nursing staff completed an Initial Health Screening form (CDCR Form 7277) on the same day the patient arrived. For three patients, the screening nurse did not answer all of the necessary questions on the form (MIT 6.001). For all 30 of the same sampled patients, nursing staff timely completed the assessment and disposition sections of the form on the same day that they performed the patient's screening (MIT 6.002).

- The institution scored 100 percent when the OIG tested transfer packages for two patients who transferred out of CAL during the OIG's onsite inspection and had been prescribed medications. Both transfer packages included the required medications and related documentation (MIT 6.101).

The institution scored within the *inadequate* range in the following two tests:

- Of 11 sampled patients who transferred into CAL with an existing medication order, only seven continued to receive their medications without interruption (64 percent). Two patients

received their nurse-administered, direct observation therapy (NA/DOT) medications one day late, and another patient received his keep-on-person (KOP) medication two days late; for one other patient, there was no MAR indicating that his three KOP medications arrived with him (MIT 6.003).

- The OIG sampled 20 patients who transferred out of CAL to another CDCR institution to determine whether their pending specialty service appointments were listed on their Health Care Transfer Information forms (CDCR Form 7371). The institution identified the previously approved and still pending appointments for ten of the patients (50 percent), but failed to do so for the remaining ten (MIT 6.004).

Recommendations

No specific recommendations.

PHARMACY AND MEDICATION MANAGEMENT

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(71.4%)

Overall Rating:
Inadequate

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

In this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance review resulting in an *inadequate* score. The OIG's internal review process considered those factors that led to both scores and ultimately rated this indicator *inadequate*, as the compliance testing is more robust in this area than the case review testing. As a result, the compliance review rating of *inadequate* was deemed a more appropriate reflection of the overall indicator rating.

Case Review Results

The OIG clinicians reviewed 81 pharmacy encounters. Review of medication administration records showed that patients received KOP medications as ordered and timely. The OIG clinicians rated the pharmacy and medication management *adequate*. There were four deficiencies related to pharmacy performance, two of which were significant:

- In case 14, the primary care provider ordered an albuterol (asthma medication) rescue inhaler. It was dispensed 17 days later by the ancillary staff, two weeks late.

- In case 30, a provider ordered the patient's daily dose of insulin lowered. The order was incorrectly implemented with the patient receiving both old and new doses on the same day. This placed the patient at risk of serious harm from a low blood sugar. Fortunately, no harm came to the patient. In addition, a medication error report was not completed.

Compliance Testing Results

The institution received an *inadequate* compliance score of 71.4 percent in the *Pharmacy and Medication Management* indicator. For discussion purposes below, this indicator is divided into three sub-indicators: medication administration, observed medication practices and storage controls, and pharmacy protocols.

Medication Administration

For this sub-indicator, the institution received an average score of 78.5 percent in the five applicable questions. The institution scored in the *proficient* range in the following medication administration areas:

- All 30 patients sampled who transferred from one housing unit to another received their medication at the next dosing interval after the transfer occurred (MIT 7.005).

- Twenty-eight of the 30 patients sampled (93 percent) timely received their new medication orders. Two patients received their medication one day late (MIT 7.002).

- Clinical staff timely provided new and previously prescribed medications to seven of eight patients sampled (88 percent) who were recently discharged from a community hospital and returned to the institution. One patient received his medication two days late (MIT 7.003).

The institution has an opportunity to improve in the following medication administration areas:

- Chronic care medications were provided timely to only 6 of the 11 patients sampled (55 percent). Two patients had missed doses of their medication and either did not receive the required provider counseling or the provider counseling was late. One patient had one unexplained missed dose of two DOT medications, but received an extra dose of another DOT medication; and for two other patients there was no MAR found in the eUHR indicating that the patients received their KOP medications (MIT 7.001).

- The OIG sampled seven patients who were in transit to another institution and were temporarily laid over at CAL, only four (57 percent) received their medications without interruption. For the remaining three patients, the CDCR Form 7277 indicated that the patients arrived with their KOP medication, but the institution did not issue a MAR indicating the medication was given to the patients during the layover (MIT 7.006).

Observed Medication Practices and Storage Controls

This sub-indicator, in which the institution received an average score of 46.1 percent, consists of six applicable questions. The institution has an opportunity to improve in the following four test areas:

- Calipatria State Prison did not demonstrate strong medication security controls over narcotics. All seven applicable clinic and medication line storage locations sampled failed this test due to missing co-signer signatures in the narcotics log book regarding shift change narcotics inventory counts. Specifically, they were missing from one to 38 signatures during February and March 2016 (MIT 7.101).

- The institution did not properly store non-narcotic medications that required refrigeration at any of the nine applicable clinics and medication line storage locations inspected. In eight of the areas inspected, refrigerated medication awaiting return back to the pharmacy was not clearly identified or stored separately from other medications. In one of those eight locations, inspectors found Lantus (diabetes medication) previously opened that had passed the manufacturer's guideline for continued use; in another, a patient's bottle of insulin was found in the staff refrigerator with food because the clinic's medication refrigerator was not operable; and one other medication line location had a medication refrigerator with a temperature reading outside of CCHCS policy guidelines as well as personal food items in the refrigerator (see *Figure 3*) (MIT 7.103)

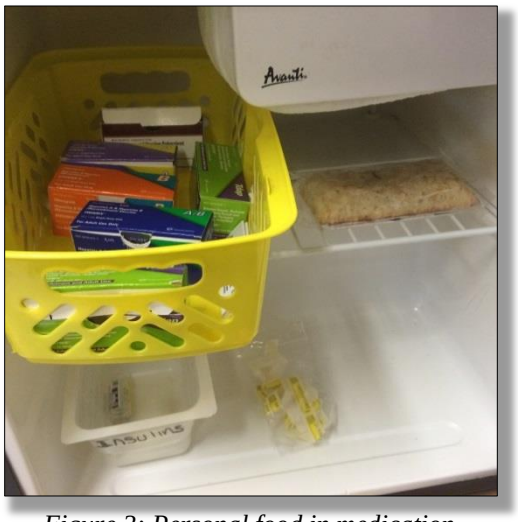

Figure 3: Personal food in medication refrigerator

- Nursing staff followed appropriate administrative controls and protocols during the medication distribution process at only two of the six medication line locations observed (33 percent). Four of the medication line locations had an insufficient overhang or no overhang to protect patients waiting in line for medication during inclement weather. In addition, at one of the same four clinics the LVN did not ensure that the patient had swallowed his DOT medications (MIT 7.106).

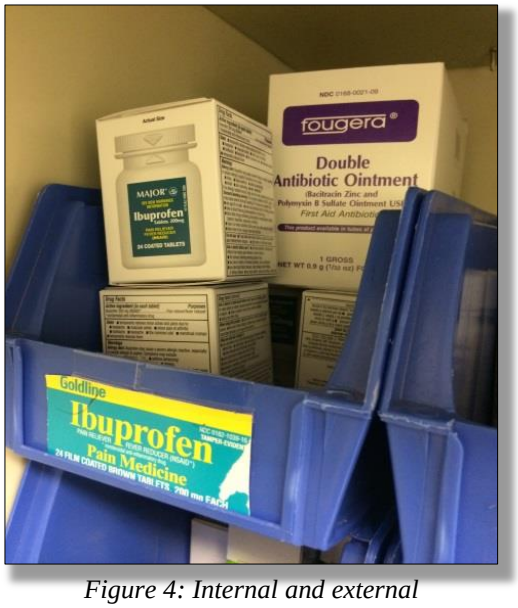

Figure 4: Internal and external medications stored together

- The institution properly stored non-narcotic medications that did not require refrigeration at 9 of the 15 applicable clinics and medication line storage locations sampled (60 percent). Inspectors found the following various types of deficiencies: three locations had one or more bottles of hydrogen peroxide that were not labeled with the date they were opened; another medication line had antibiotic ointments that had expired March 2013; another location had internal and external medications were stored together; and one other location had lidocaine gel that was not labeled with the date it was opened (see *Figure 4*) (MIT 7.102).

The institution received a *proficient* and an *adequate* score in the following two tests:

- Nursing staff at all six sampled medication and preparation administration locations (100 percent) followed appropriate administrative controls and protocols during medication preparation (MIT 7.105).

- At five out of six sampled medication lines (83 percent), nursing staff were compliant with proper hand hygiene contamination control protocols. At one medication line location, a nurse failed to sanitize their hands prior to preparing and administering medications or prior to initially putting on gloves and between subsequent glove changes (MIT 7.104).

Pharmacy Protocols

For this sub-indicator, the institution received an average score of 95 percent, falling within the *proficient* range, and comprised of five scores received at the institution's main pharmacy.

The institution scored 100 percent in the following four tests:

- In its main pharmacy, the institution followed general security, organization, and cleanliness management protocols; properly stored and monitored non-narcotic medications that required refrigeration and those that did not; and maintained adequate controls and properly accounted for narcotic medications (MIT 7.107, 7.108, 7.109, 7.110).

The institution has an opportunity to improve in the following area:

- CAL followed key medication error reporting protocols for 22 of 30 samples tested (73 percent). For eight samples, the pharmacist in charge (PIC) did not follow proper protocols. Specifically, for three samples the PIC was unable to provide evidence that the medication error was reported and shared with the institution's Pharmacy and Therapeutic Sub-Committee, and in five other instances the PIC follow-up report was from 2 to 12 days late (MIT 7.111).

Non-Scored Tests

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

The OIG tested patients housed in isolation units to determine if they had immediate access to their prescribed KOP rescue inhalers and nitroglycerin medications. At CAL, two applicable patients housed in isolation units did not have immediate access to their prescribed KOP rescue medications. One patient reported that he did not have symptoms so he threw his inhaler away, and another patient said he had not used an inhaler for a couple of years so he did not know where his inhaler

was. Inspectors immediately notified the institution's CEO, who took timely action to ensure that inhalers were issued to both patients (MIT 7.999).

Recommendation

No specific recommendations.

PREVENTIVE SERVICES

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

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(63.2%)

Overall Rating:
Inadequate

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

Compliance Testing Results

The institution performed in the *inadequate* range in the *Preventive Services* indicator with a compliance score of 63.2 percent. The institution received *inadequate* scores in three of six test areas, as described below:

- The institution scored only 3 percent for conducting annual tuberculosis screenings. Although all 30 patients sampled were screened for tuberculosis within the prior year, none of the 15 patients classified as Code 22 (requiring a tuberculosis skin test in addition to signs and symptoms screening) was properly tested. For each of the 15 sampled Code 22 patient screenings, there was one or more of the following deficiencies: the 48-to-72-hour window to read test results was not determinable because nursing staff did not document either the administered (start) or read (end) date and time of the skin test; or an LVN read and interpreted the test results rather than an RN, public health nurse, or primary care provider. In addition to the sampled Code 22 patients, inspectors also sampled 15 patients classified as Code 34 (those who had previously tested positive for tuberculosis and did not receive a skin test). Nursing staff did not complete the history section of the Tuberculin Test Order (CDCR Form 7331) for 14 of the 15 patients sampled (MIT 9.003).

- Eight of 21 patients sampled (38 percent) were properly monitored while taking TB medications. Thirteen patients either did not receive the required monthly or weekly monitoring, or the monitoring evaluation was not scanned into the eUHR during the week or month that the evaluation occurred. (MIT 9.002).

- The institution scored 67 percent for timely administration of TB medications. Of 21 patients sampled, only 14 received all required doses of TB medications for the most recent three month period. Six of the patients missed one or more medication doses, and none of them received provider counseling about the missed medication. One other patient,

according to his medical administration records (MAR), received one dose of his medication on the wrong day (MIT 9.001).

The institution scored at the *proficient* level in the following three areas:

- The institution offered annual influenza vaccinations to 28 of 30 patients sampled (93 percent). Two patients did not either receive or refuse an influenza vaccination during the most recent influenza season (MIT 9.004).

- The institution provided colorectal cancer screenings to 27 of 30 sampled patients subject to the annual screening requirement (90 percent). For two patients, there was no evidence of a fecal occult blood test (FOBT) within the previous 12 months, even though the provider ordered them. For another patient, there was an abnormal colonoscopy result in January 2015 (with an order to repeat the colonoscopy in five years), but no evidence that the patient was offered or refused an FOBT within the previous 12 months (MIT 9.005).

- The OIG tested whether the institution offered vaccinations for influenza, pneumonia, and hepatitis to patients who suffered from a chronic care condition; 22 of the 25 sampled patients (88 percent) received all recommended vaccinations at the required interval. However, no evidence was found that one patient was offered or received a pneumonia vaccination, and there was no evidence that two other patients received or were offered a hepatitis A or B vaccination (MIT 9.008).

Recommendations

No specific recommendations.

QUALITY OF NURSING PERFORMANCE

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

Overall Rating:
Adequate

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

Case Review Results

The OIG nursing clinicians rated the *Quality of Nursing Performance* at CAL *adequate*. Among 341 reviewed outpatient nursing encounters, there were 49 deficiencies, 11 of which were significant deficiencies, all occurring in case 30, 37, 38, 47, or 52. Some of these cases had multiple deficiencies, with case 52 having four of the significant deficiencies.

Nurses generally evaluated patients timely and made appropriate assessments and interventions. However, several patterns of deficiencies emerged. Some outpatient RNs allowed LVNs to practice outside the scope of CCHCS policy. Two examples were assessment of patients and the reading and interpretation of TB and coccidioidomycosis skin tests. Occasionally, RNs at CAL failed to notify the primary care providers of significant changes in patients' conditions, or failed to adequately assess patients. About one-third of the minor deficiencies were failures to assess thoroughly and appropriately. Another third were failures to document carefully and completely. Despite the significant nursing deficiencies described below, the overall nursing care was appropriate, and the institution's outpatient nursing performance was *adequate*.

Nursing Assessment/Documentation

- In case 38, the patient with psoriasis requested to be seen for a rash on his hand. However, the RN failed to inquire about past skin conditions or medications, resulting in an incomplete assessment. Two of the patient's medications were specific for the treatment of plaque psoriasis. The failure of the nurse to review his medications led to the incorrect conclusion that the patient had eczema, instead of an acute exacerbation of chronic psoriasis.

- In case 47, the RN failed to assess swelling in the patient's neck and the open wound on his arm. Instead, the RN used a headache protocol to issue medications.

- In case 52, the triage nurse reviewed the Health Care Services Request form (CDCR Form 7362) with the complaint of chest discomfort and fast heart rate. However, the nurse failed to see the patient face-to-face to assess the patient's symptoms and to determine the urgency of care. The next day, the RN failed to completely assess the patient with episodic chest discomfort they felt was related to stress. The nursing assessment did not include activity or anxiety level, when the onset of pain occurred, how long the pain lasted, other associated symptoms, factors that eased or aggravated the pain, the severity level, or prior episodes of chest pain. The RN also failed to consult with the primary care provider for the patient's chest pain. The RN made an inappropriately long 28-day referral to the provider.

Nursing Decision-Making

- In case 37, the patient had elbow pain. Instead of completing a face-to-face assessment with the patient, the RN relied on an assessment by an LVN, which was outside the scope of practice for an LVN. The RN triaged the patient without conducting a patient encounter.

Onsite Clinician Inspection

The onsite visit provided valuable insight into the institution's workflow. Nursing staff in outpatient clinics were well prepared for primary care team huddles, which were well attended and effective. Attendees from across the institution shared information about currently hospitalized and transferred patients, TTA visits, specialty appointments, and other patient issues. One provider attended by telephone from an outpatient clinic. Within the OHU, the nurses monitored essential patient information, and charted findings on every shift regarding the patient's condition. This charting was a valuable component to team nursing, and is also discussed in the *Specialized Medical Housing* indicator, which the OIG rated *proficient*. During walking rounds, nurses expressed pride and enthusiasm about new processes they had developed to ensure continuity of patient care, and interviews with the onsite receiving and release nursing staff indicated that they were proud participants in the health care model. Utilization management and specialty nurses developed communication systems and backup systems to ensure that patients were prepared for specialty visits and that specialty consultations were completed on time. Hospitalized patients were

closely followed in preparation for discharge and return to the facility. Nursing staff in all areas reported good working relationships with their supervisors and with the chief nursing executive.

Summary

The nursing environment at CAL generally functioned well, but the number of significant deficiencies and the patterns of minor deficiencies in nursing care prevented the institution from receiving the highest possible rating for this indicator. The *Quality of Nursing Performance* was rated *adequate*.

Recommendations

No specific recommendations.

QUALITY OF PROVIDER PERFORMANCE

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

Case Review Rating:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

Case Review Results

The OIG clinicians reviewed over 210 provider encounters and identified 68 deficiencies, related to provider performance. Of these, 24 were significant deficiencies. Of the 30 cases reviewed by the OIG physicians, 26 were *adequate*, and four were *inadequate*. Overall, the OIG rated provider performance *adequate*.

Assessment and Decision-Making

In most cases, the providers at CAL made appropriate assessments and medical plans. There were five serious deficiencies:

- In case 3, the provider noted an elevated phenytoin (seizure medication) blood level. The provider's order was for the phenytoin to not be given for three days, and then for a blood draw to be completed to determine the patient's phenytoin level. However, the provider failed to order an immediate evaluation of the patient for symptoms of toxicity, such as lack of coordination, slurred speech, nausea, or vomiting. Symptoms of toxicity require immediate medical treatment.

- In case 6, the provider ordered an orthopedic consult and consideration of surgery for a patient with knee pain. The provider, however, failed to carefully assess the patient with imaging and lower-risk management strategies such as physical therapy or anti-inflammatory medications. In addition, the provider did not review the functional status of the patient, which included recent progress notes showing the patient performed vigorous exercise daily.

- In case 13, after the patient returned from the hospital for a skin infection, the primary care provider failed to prescribe one of the two antibiotics the hospital recommended upon the patient's discharge. Fortunately, this did not adversely affect the care of the patient. This case is also discussed in the *Inter- and Intra-System Transfers* indicator.

- In case 17, the provider failed to recognize for over nine months that specialty services failed to schedule a surgical procedure to remove a rectal tumor. This is also discussed in the *Access to Care* indicator.

- In addition, in case 17, the provider had scheduled the patient for many specialty consultations. Lower-priority appointments interfered with the most important consults. The neurology consult was rescheduled and thereby delayed, with the patient continuing to have seizures and several hospitalizations. The lower-priority appointment was for a physical therapy session for this patient, who was able to perform vigorous exercise.

Review of Records

Three provider deficiencies were for inadequate medical record review:

- In case 3, several providers reviewed the patient's lab results but failed to recognize a low platelet count (high risk of bleeding).

- In case 17, the providers inadequately reviewed recent hospital records and did not address the patient's worsening anemia with a recent significant change within the last month. The provider also failed to note a CT (computerized tomography) scan finding of cardiomegaly (enlarged heart) with bilateral pleural effusions (fluid accumulating in the chest).

- In case 20, the provider documented a normal heart exam, but the patient's medical records showed a heart murmur. In addition, the provider failed to evaluate the heart as a possible cause of the patient's prior loss of consciousness, which did not have an identified cause.

Emergency Care

Providers generally made appropriate triage decisions when a patient presented to the TTA. They were readily available for consultation with the TTA nursing staff. However, there were significant deficiencies, also discussed in the *Emergency Services* indicator, regarding chest pain evaluation.

- In case 4, the provider was called by the nurse of a patient with chest pain and shortness of breath. The patient was sent to the emergency room (ER). However, the provider failed to order appropriate urgent medication in this setting. Aspirin and nitroglycerin are recommended for cardiac associated chest pain. In addition, the provider inappropriately ordered a code 2 ambulance to the ER, instead of a faster code 3 ambulance, for this patient with possible acute coronary syndrome (impending heart attack). This case is also discussed in the *Emergency Services* indicator.

- In case 17, the provider ordered 7 mg of intramuscular lorazepam (a sedative) within a 20-minute period for an agitated patient. This high dose could have impaired or stopped the patient's breathing.

- In case 22, the provider failed to order cervical spine precautions (neck protection and collar) for a patient with severe traumatic facial fractures and a possible loss of consciousness from an altercation. This case is also discussed in the *Emergency Services* indicator.

- In case 27, the provider noted that the patient had chest pain, and sent him to the ER for possible acute coronary syndrome. However, the provider failed to order appropriate medication such as morphine, oxygen, nitroglycerin, or aspirin prior to transferring the patient to a higher level of care. This case is also discussed in the *Emergency Services* indicator.

Chronic Care — Diabetes

Chronic care was adequate as most providers demonstrated good care for chronic care diseases such as hypertension, hepatitis C infection, and asthma. However, the OIG noted delays in the care of poorly controlled patients with diabetes. Overall, diabetic care was good, as shown in other sections of this report and in the HEDIS measures. The HEDIS measures, however, sample all patients with diabetes mellitus, whereas the case reviews select fewer patients and only those whose condition is under poor control.

- In case 26, the provider failed to start a patient on diabetic medications with repeatedly elevated blood sugar levels.

- At a later date, in case 26, the provider documented suboptimal blood sugar control. No change of diabetic medication was ordered for management, and an inappropriate three-month follow-up was ordered.

- In case 27, the provider failed to start diabetic medication on a patient with known diabetes for five months when exercise and diet alone failed.

- In case 29, the provider failed to prescribe diabetic medication to a diabetic patient with an elevated blood sugar level.

Chronic Care — Hepatitis C

- In case 24, the patient had hepatitis C. The provider failed to test the patient for cirrhosis for over one year. Current recommendations require annual fibrosis scores (an equation that provides an estimate of the amount of scar tissue in the liver) for hepatitis C patients.

Diagnostics

On occasion, physicians' orders were not carried out and the physicians failed to seek the missing diagnostic results:

- In case 11, multiple laboratory tests were ordered by the physician for the evaluation of altered arm sensation. These lab tests were not drawn. This is also discussed in the *Diagnostic Services* indicator.

- In case 26, the provider ordered an electrocardiogram (EKG) for concerns of palpitations and shortness of breath. The EKG was not performed for three and one-half months. This is also discussed in the *Diagnostic Services* indicator.

Clinician Onsite Inspection

The onsite inspection provided insight into the workflow of Calipatria State Prison. The physicians were pleased with the workload and access to specialists. The providers felt supported by the executive staff and by their colleagues, and they helped each other as necessary to meet the medical needs of the facility. Complex cases and pain management were discussed during the weekly meetings. Huddles were efficient and informative. At the time of the onsite inspection, the acting chief medical executive (CME) was present because the former was leaving. The CME seemed enthusiastic and well liked by colleagues.

Conclusion

The CAL medical providers were a conscientious group of physicians who worked toward the common goal of providing quality care to the inmate population. Medical management was performed well at CAL. Despite two medical areas needing improvement: the chest pain and diabetic management, the care provided by CAL medical providers was *adequate*.

Recommendations

No specific recommendations.

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

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

Case Review Rating:
Proficient
Compliance Score:
Proficient
(98.0%)

Overall Rating:
Proficient

Case Review Results

The OIG clinicians reviewed 309 events in the OHU and found 34 deficiencies. Four deficiencies were significant, and involved the care of the same patient (case 17, discussed below). Case 68 had 18 minor deficiencies when the nurse failed to complete documentation when administering Tylenol and codeine for pain on 18 different days. Other than these few deficiencies, the nurses in the OHU extensively monitored and charted findings on every shift regarding patients' conditions. Therefore, the OIG rated the *Specialized Medical Housing* indicator at CAL *proficient*.

- In case 17, the provider did not document the abnormalities on the computerized tomography (CT) scan that included cardiomegaly with small bilateral pleural effusions. At another encounter, the provider did not address the concern of the rectal polyp that was awaiting a surgical removal. Finally, after this patient had an altered level of consciousness, nurses failed to perform neurologic checks every four hours as ordered on two days.

Compliance Testing Results

The institution received a *proficient* compliance score of 98.0 percent in the *Specialized Medical Housing* indicator, which focused on the institution's outpatient housing unit (OHU). The institution scored in the *proficient* range for all of the indicator's test areas, which includes the following:

- When the OIG tested the working order of call buttons in OHU patient rooms, all inspected call buttons were working properly, and the staff maintained a call-system-testing log for the OHU call buttons. In addition, according to staff interviews, custody officers and clinicians were able to efficiently respond and access patients' rooms within one minute when an emergent event occurred (MIT 13.101).

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

- Among a sample of ten applicable patients, providers evaluated nine patients (90 percent) within 24 hours of the patient's admission to the OHU and, for all ten patients, completed a history and physical within 72 hours (MIT 13.002, 13.003).

- Providers completed their subjective, objective, assessment, plan, and education (SOAPE) notes at required 14-day intervals for all six applicable patients (MIT 13.004).

Recommendations

No specific recommendations.

SPECIALTY SERVICES

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

Overall Rating:
Adequate

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

In this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance review resulting in a *proficient* score. The OIG's internal review process considered those factors that led to both scores and ultimately rated this indicator *adequate*. The key factor warranting the lower rating was that the case reviews revealed seven significant deficiencies. As a result, the case review rating of *adequate* was deemed a more appropriate reflection of the overall indicator rating.

Case Review Results

The OIG clinicians reviewed 144 events related to *Specialty Services*, the majority of which were specialty consultations and procedures. Sixteen deficiencies were found in this category, with seven significant deficiencies. The OIG clinicians rated the *Specialty Services* indicator *adequate.*

Access to Specialty Services

- In case 8, the provider ordered a follow-up appointment to be held within 14 days after a colonoscopy. The patient was not seen by a primary care provider for three months.
- In case 12, the patient did not receive an appointment with the primary care provider after a neurology consult within two weeks as recommended. The patient had progressive arm weakness and altered sensation. The patient was evaluated six weeks later by the primary care physician.
- In case 24, optometry recommended follow-up for visual field testing and a glaucoma evaluation in one to two weeks. This was delayed over two months. This is also discussed in the *Access to Care* indicator.
- In case 25, follow-up evaluation with the primary care physician was delayed nearly four months after an endocrinology consult for diabetes.

Nursing Performance

There were no significant deficiencies in this area.

Provider Performance

- In case 17, specialty services failed to schedule a surgical procedure to remove a rectal tumor. Despite many follow-up appointments, the provider failed to recognize the surgical procedure had not been scheduled for more than nine months. This is also discussed in the *Access to Care* indicator.

- In addition, in case 17, the provider had scheduled the patient for many specialty consults, but the most important consults were inappropriately rescheduled for lower-priority consults. The neurology consult was delayed for a physical therapy session, and recurrent seizures led to several hospitalizations. The physical therapy was being provided despite the patient performing vigorous exercise. This is also discussed in the *Quality of Provider Performance* indicator.

Health Information Management

- In case 3, the orthopedic physician evaluated the patient, but dictated the consult note almost two months later. The primary care provider reviewed the note another week later, more than two months after the evaluation. This is also discussed in the *Health Information Management* indicator.

Clinician Onsite Inspection

The medical providers reported that they had good access to telemedicine and outside specialists. The patient backlog was minimal within each yard, and there was no backlog for the specialty clinics. The providers and the ancillary staff were confident in their ability to provide accessible and timely specialty care.

Compliance Testing Results

The institution received a *proficient* compliance score of 85.6 percent in the *Specialty Services* indicator. CAL scored in the *proficient* range in the following five tests:

- For all 15 patients sampled, their high-priority specialty service appointment occurred within 14 calendar days of the provider's order. In addition, 15 other patients sampled also received their routine specialty services appointment within 90 calendar days of the provider's order (MIT 14.001, 14.003).

- The institution timely denied providers' specialty service requests for all 20 sampled patients (MIT 14.006).

- Providers received and reviewed the specialists' reports within the required time frame for 14 of 15 sampled patients who received a high-priority specialty service (93 percent). For one patient, the provider reviewed the specialty service report three days late (MIT 14.002).

- For 12 of 14 patients sampled (86 percent), the institution received and providers reviewed the specialty services report timely. For two patients, providers reviewed the report 8 and 52 days late (MIT 14.004).

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

- Among 20 patients sampled who had a specialty service denied by the institution's health care management, 16 patients (80 percent) received timely notification of the denied service that included the provider meeting with the patient within 30 days to discuss alternative treatment strategies. For four patients sampled, the provider follow-up visits informing the patients of the denials were from 46 to 187 days late (MIT 14.007).

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

- When a patient at one institution has an approved pending or scheduled specialty services appointment and then transfers to a different institution, policy requires that the receiving institution reschedule or provide the patient's appointment within the required time frame. Of 20 sampled patients who transferred to CAL with an approved pending specialty service appointment, only 8 patients (40 percent) timely received their specialty services upon arrival. Of those 12 patients who did not receive their services timely, six patients did not receive the service at all. One patient refused the specialty service, but the refusal was 47 days late. One other patient had his specialty service discontinued by the provider, but the provider's order was 13 days late. Four other sampled patients received their specialty services from 15 to 76 days late (MIT 14.005).

Recommendations

No specific recommendations.

SECONDARY (ADMINISTRATIVE) QUALITY INDICATORS OF HEALTH CARE

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

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

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

INTERNAL MONITORING, QUALITY IMPROVEMENT, AND ADMINISTRATIVE OPERATIONS

Case Review Rating:
Not Applicable
Compliance Score:
Adequate
(75.0%)

Overall Rating:
Adequate

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

Compliance Testing Results

The institution scored in the *adequate* range in the *Internal Monitoring, Quality Improvement, and Administrative Operations* indicator, receiving a compliance score of 75.0 percent. CAL scored 100 percent in the following six test areas:

- The institution promptly processed all inmate medical appeals in each of the most recent 12 months (MIT 15.001). In addition, based on a sample of ten second-level medical appeals, the institution's responses addressed all of the patients' appealed issues (MIT 15.102).

- CAL's QMC met monthly, evaluated program performance, and took action when improvement opportunities were identified (MIT 15.003). Additionally, the institution scored 100 percent for taking adequate steps to ensure the accuracy of its Dashboard data reporting (MIT 15.004).

- Medical staff promptly submitted the Initial Inmate Death Report (CDCR Form 7229A) to CCHCS's Death Review Unit for the two applicable deaths that occurred at CAL in the prior 12-month period (MIT 15.103).

- The OIG inspected documentation for 12 emergency medical response incidents reviewed by CAL's Emergency Medical Response Review Committee (EMRRC) during the prior six-month period, and found that all incident packages complied with policy (MIT 15.007).

The following test areas received scores in the *inadequate* range:

- CAL improved or reached targeted performance objectives for zero of the five quality improvement initiatives identified in its 2015 Performance Improvement Work Plan. The

institution failed to monitor the performance objectives after March 2015, which resulted in the poor score on this test (MIT 15.005).

- Inspectors reviewed the summary reports and related documentation for three medical emergency response drills conducted in the prior quarter. Documentation provided from the first, second, and third watches' response drills lacked the inclusion of required forms. Therefore, the institution received a score of zero on this test (MIT 15.101).

Other Information Obtained from Non-Scored Areas

- The OIG gathered non-scored data regarding the completion of death review reports and found that CCHCS's Death Review Committee (DRC) did not timely complete its death review summary for the two deaths that occurred during the testing period. The CCHCS Death Review Committee is required to complete a death review summary within 30 business days of the death and submit it to the institution's CEO. However, the DRC completed its death review summary 13 and 22 days late (or 55 and 69 calendar days after the deaths) and submitted the summary to the CEO 12 and 35 days late, respectively (MIT 15.996).

- Inspectors met with the institution's CEO to inquire about CAL's protocols for tracking appeals. According to the CEO, the health care appeals coordinator reported monthly and on an ongoing, real-time basis. Executive staff used summary reports that came from headquarters on a monthly basis and standard printouts from the appeals tracking system to identify all subjects and issues at the staff meetings and to monitor the status of current appeals. The CEO reported there were no critical issues related to inmate appeals within the most recent six months (MIT 15.997).

- The institution had an ineffective process in place for developing local operating procedures (LOPs). The institution's health program specialist responsible for LOP modification reported that 26 of the 30 health care LOPs had expired. While the institution had implemented 61 percent of the total recommended and applicable health care LOPs, 87 percent of them had expired (MIT 15.998).

- The OIG discusses the institution's health care staffing resources in the *About the Institution* section on page *2* (MIT 15.999).

Recommendations

No specific recommendations.

JOB PERFORMANCE, TRAINING, LICENSING, AND CERTIFICATIONS

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

Case Review Rating:
Not Applicable
Compliance Score:
Proficient
(87.5%)

Overall Rating:
Proficient

Compliance Testing Results

The institution received a *proficient* compliance score of 87.5 percent in the *Job Performance, Training, Licensing, and Certifications* indicator. The institution scored 100 percent in seven of the indicator's eight tests, as follows:

- All providers were current with their professional licenses, and nursing staff and the pharmacist in charge were current with their professional licenses and certification requirements (MIT 16.001, 16.105).
- All ten reviewed nursing staff members who administered medications possessed current clinical competency validations, and all nursing staff hired within the last year timely received new employee orientation training (MIT 16.102, 16.107).
- The OIG reviewed performance evaluation packets of seven of the institution's applicable providers; the institution met all performance review requirements for all seven (MIT 16.103).
- All applicable providers, nursing staff, and custody staff were current with their emergency response certifications (MIT 16.104).
- The institution's pharmacy and providers who prescribed controlled substances were current with their Drug Enforcement Agency registrations (MIT 16.106).

The institution scored zero in the following area:

- None of the five supervising registered nurses sampled performed and documented the required number of reviews on subordinate nursing staff (MIT 16.101).

Recommendations

No specific recommendations.

POPULATION-BASED METRICS

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

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

Methodology

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

Comparison of Population-Based Metrics

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

Results of Population-Based Metric Comparison

Comprehensive Diabetes Care

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

When compared statewide, CAL significantly outperformed Medi-Cal in all five diabetic measures selected. CAL also outperformed Kaiser in four of the five diabetic measures. However, CAL's scores were lower than Kaiser's, for both the North and South regions, for diabetic patients' blood pressure control by 6 and 7 percentage points, respectively.

When compared nationally, CAL significantly outperformed Medicaid, Medicare, and commercial health plans (based on data obtained from health maintenance organizations) in all five of the diabetic measures listed. In addition, CAL performed better than the U.S. Department of Veterans Affairs (VA) in three of the four applicable diabetic measures, and matched the VA for diabetic patients' blood pressure control.

Immunizations

Comparative data for immunizations was only fully available for the VA and partially available for Kaiser Permanente and commercial plans. For influenza shots for younger adults, CAL scored much lower than Kaiser, commercial plans, and the VA. However, this is primarily due to the high number of patient refusals; 64 percent of the patients sampled refused the influenza vaccination. The institution only had two patients over the age of 65. As a result, no comparative data was presented for adults aged 65 and older for influenza and pneumococcal vaccinations.

Cancer Screening

For colorectal cancer screening, CAL was comparable to or better than all other entities that reported data (Kaiser, commercial plans, Medicare, and the VA). Statewide, CAL scored 1 percentage point higher than Kaiser North, and 1 percentage point lower than Kaiser South. Nationally, CAL outperformed commercial and Medicare plans, but scored 1 percentage point lower than the VA. If not for the 16 percent refusal rate among the sampled patients, CAL would have outperformed all statewide and national plans.

Summary

Overall, CAL's HEDIS performance reflects an adequately performing chronic care program, further corroborated by the institution's *adequate* score in the *Access to Care*, *Quality of Nursing Performance*, and *Quality of Provider Performance* indicators, for diabetic and colorectal cancer screening, but has room for improvement for influenza immunizations. The institution can improve performance for immunizations and colorectal cancer screenings by making interventions to lower patient refusals.

CAL Results Compared to State and National HEDIS Scores

Clinical Measures	California				National			
	CAL Cycle 4 Results[1]	HEDIS Medi-Cal 2014[2]	Kaiser (No.CA) HEDIS Scores 2015[3]	Kaiser (So.CA) HEDIS Scores 2015[3]	HEDIS Medicaid 2015[4]	HEDIS Com-mercial 2015[4]	HEDIS Medicare 2015[4]	VA Average 2014[5]
Comprehensive Diabetes Care								
HbA1c Testing (Monitoring)	**100%**	83%	95%	94%	86%	91%	93%	99%
Poor HbA1c Control (>9.0%)[6,7]	**3%**	44%	18%	24%	44%	31%	25%	19%
HbA1c Control (<8.0%)[6]	**83%**	47%	70%	62%	47%	58%	65%	-
Blood Pressure Control (<140/90)	**78%**	60%	84%	85%	62%	65%	65%	78%
Eye Exams	**91%**	51%	69%	81%	54%	56%	69%	90%
Immunizations								
Influenza Shots – Adults (18–64)	**36%**	-	54%	55%	-	50%	-	58%
Influenza Shots – Adults (65+)[8]	-	-	-	-	-	-	72%	76%
Immunizations: Pneumococcal[8]	-	-	-	-	-	-	70%	93%
Cancer Screening								
Colorectal Cancer Screening	**81%**	-	80%	82%	-	64%	67%	82%

1. Unless otherwise stated, data was collected in March 2016 by reviewing medical records from a sample of CAL's population of applicable inmate-patients. These random statistical sample sizes were based on a 95 percent confidence level with a 15 percent maximum margin of error.
2. HEDIS Medi-Cal data was obtained from the California Department of Health Care Services 2014 *HEDIS Aggregate Report for the Medi-Cal Managed Care Program*.
3. Data was obtained from Kaiser Permanente November 2015 reports for the Northern and Southern California regions.
4. National HEDIS data for Medicaid, commercial, and Medicare was obtained from the 2015 *State of Health Care Quality Report*, available on the NCQA website: www.ncqa.org. The results for commercial 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.
6. For this indicator, the entire applicable CAL 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. Population limited to only two inmate-patients over the age of 65; therefore, the OIG omitted the sample from the comparative analysis.

APPENDIX A — COMPLIANCE TEST RESULTS

Calipatria State Prison Range of Summary Scores: 63.24% – 98.00%	
Indicator	**Compliance Score (Yes %)**
Access to Care	88.74%
Diagnostic Services	85.56%
Emergency Services	Not Applicable
Health Information Management (Medical Records)	81.56%
Health Care Environment	80.91%
Inter- and Intra-System Transfers	80.73%
Pharmacy and Medication Management	71.41%
Prenatal and Post-Delivery Services	Not Applicable
Preventive Services	63.24%
Quality of Nursing Performance	Not Applicable
Quality of Provider Performance	Not Applicable
Reception Center Arrivals	Not Applicable
Specialized Medical Housing (OHU, CTC, SNF, Hospice)	98.00%
Specialty Services	85.58%
Internal Monitoring, Quality Improvement, and Administrative Operations	75.00%
Job Performance, Training, Licensing, and Certifications	87.50%

Reference Number	*Access to Care*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
1.001	**Chronic care follow-up appointments:** Was the inmate-patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter?	25	5	30	83.33%	0
1.002	**For endorsed inmate-patients received from another CDCR institution:** If the nurse referred the inmate-patient to a provider during the initial health screening, was the inmate-patient seen within the required time frame?	13	12	25	52.00%	5
1.003	**Clinical appointments:** Did a registered nurse review the inmate-patient's request for service the same day it was received?	29	1	30	96.67%	0
1.004	**Clinical appointments:** Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed?	30	0	30	100.00%	0
1.005	**Clinical appointments:** If the registered nurse determined a referral to a primary care provider was necessary, was the inmate-patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter?	15	0	15	100.00%	15
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?	6	0	6	100.00%	24
1.007	**Upon the inmate-patient's discharge from the community hospital:** Did the inmate-patient receive a follow-up appointment within the required time frame?	8	0	8	100.00%	0
1.008	**Specialty service follow-up appointments:** Do specialty service primary care physician follow-up visits occur within required time frames?	16	8	24	66.67%	6
1.101	**Clinical appointments:** Do inmate-patients have a standardized process to obtain and submit health care services request forms?	6	0	6	100.00%	0
Overall percentage:					**88.74%**	

Reference Number	*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	100.00%	0
2.002	**Radiology:** Did the primary care provider review and initial the diagnostic report within specified time frames?	10	0	10	100.00%	0
2.003	**Radiology:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	10	0	10	100.00%	0
2.004	**Laboratory:** Was the laboratory service provided within the time frame specified in the provider's order?	10	0	10	100.00%	0
2.005	**Laboratory:** Did the primary care provider review and initial the diagnostic report within specified time frames?	7	3	10	70.00%	0
2.006	**Laboratory:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	7	3	10	70.00%	0
2.007	**Pathology:** Did the institution receive the final diagnostic report within the required time frames?	9	1	10	90.00%	0
2.008	**Pathology:** Did the primary care provider review and initial the diagnostic report within specified time frames?	8	2	10	80.00%	0
2.009	**Pathology:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	6	4	10	60.00%	0
Overall percentage:					**85.56%**	

Emergency Services	Scored Answers
Assesses reaction times and responses to emergency situations.	**Not Applicable**

Reference Number	*Health Information Management (Medical Records)*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated progress notes, initial health screening forms, and health care service request forms scanned into the eUHR within three calendar days of the inmate-patient encounter date?	19	1	20	95.00%	0
4.002	Are dictated / transcribed documents scanned into the eUHR within five calendar days of the inmate-patient encounter date?	5	0	5	100.00%	0
4.003	Are specialty documents scanned into the eUHR within the required time frame?	19	1	20	95.00%	0
4.004	Are community hospital discharge documents scanned into the eUHR within three calendar days of the inmate-patient date of hospital discharge?	6	2	8	75.00%	0
4.005	Are medication administration records (MARs) scanned into the eUHR within the required time frames?	11	0	11	100.00%	0
4.006	During the eUHR review, did the OIG find that documents were correctly labeled and included in the correct inmate-patient's file?	0	12	12	0.00%	0
4.007	Did clinical staff legibly sign health care records, when required?	32	0	32	100.00%	0
4.008	**For inmate-patients discharged from a community hospital:** Did the preliminary hospital discharge report include key elements and did a PCP review the report within three calendar days of discharge?	7	1	8	87.50%	0
Overall percentage:					**81.56%**	

Reference Number	*Health Care Environment*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
5.101	**Infection Control:** Are clinical health care areas appropriately disinfected, cleaned and sanitary?	10	0	10	100.00%	0
5.102	**Infection control:** Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	9	0	9	100.00%	1
5.103	**Infection Control:** Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	7	3	10	70.00%	0
5.104	**Infection control:** Does clinical health care staff adhere to universal hand hygiene precautions?	4	4	8	50.00%	2
5.105	**Infection control:** Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	10	0	10	100.00%	0
5.106	**Warehouse, Conex and other non-clinic storage areas:** Does the medical supply management process adequately support the needs of the medical health care program?	1	0	1	100.00%	0
5.107	**Clinical areas:** Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	10	0	10	100.00%	0
5.108	**Clinical areas:** Do clinic common areas and exam rooms have essential core medical equipment and supplies?	4	6	10	40.00%	0
5.109	**Clinical areas:** Do clinic common areas have an adequate environment conducive to providing medical services?	7	3	10	70.00%	0
5.110	**Clinical areas:** Do clinic exam rooms have an adequate environment conducive to providing medical services?	6	4	10	60.00%	0
5.111	**Emergency response bags:** Are TTA and clinic emergency medical response bags inspected daily and inventoried monthly, and do they contain essential items?	7	0	7	100.00%	3
5.999	**For Information Purposes Only:** Does the institution's health care management believe that all clinical areas have physical plant infrastructures sufficient to provide adequate health care services?	Information Only				
Overall percentage:					**80.91%**	

Reference Number	*Inter- and Intra-System Transfers*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
6.001	**For endorsed inmate-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 inmate-patient arrived at the institution?	27	3	30	90.00%	0
6.002	**For endorsed inmate-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 inmate-patient to the TTA, if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening?	30	0	30	100.00%	0
6.003	**For endorsed inmate-patients received from another CDCR institution or COCF:** If the inmate-patient had an existing medication order upon arrival, were medications administered or delivered without interruption?	7	4	11	63.64%	19
6.004	**For inmate-patients transferred out of the facility:** Were scheduled specialty service appointments identified on the Health Care Transfer Information Form 7371?	10	10	20	50.00%	0
6.101	**For inmate-patients transferred out of the facility:** Do medication transfer packages include required medications along with the corresponding Medical Administration Record (MAR) and Medication Reconciliation?	2	0	2	100.00%	8
Overall percentage:					**80.73%**	

Reference Number	*Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.001	Did the inmate-patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows?	6	5	11	54.55%	19
7.002	Did health care staff administer or deliver new order prescription medications to the inmate-patient within the required time frames?	28	2	30	93.33%	0
7.003	**Upon the inmate-patient's discharge from a community hospital:** Were all medications ordered by the institution's primary care provider administered or delivered to the inmate-patient within one calendar day of return?	7	1	8	87.50%	0
7.004	**For inmate-patients received from a county jail:** Were all medications ordered by the institution's reception center provider administered or delivered to the inmate-patient within the required time frames?	Not Applicable				
7.005	**Upon the inmate-patient's transfer from one housing unit to another:** Were medications continued without interruption?	30	0	30	100.00%	0
7.006	**For inmate-patients en route who lay over at the institution:** If the temporarily housed inmate-patient had an existing medication order, were medications administered or delivered without interruption?	4	3	7	57.14%	0
7.101	**All clinical and medication line storage areas for narcotic medications:** Does the institution employ strong medication security controls over narcotic medications assigned to its clinical areas?	0	7	7	0.00%	9
7.102	**All clinical and medication line storage areas for non-narcotic medications:** Does the institution properly store non-narcotic medications that do not require refrigeration in assigned clinical areas?	9	6	15	60.00%	1
7.103	**All clinical and medication line storage areas for non-narcotic medications:** Does the institution properly store non-narcotic medications that require refrigeration in assigned clinical areas?	0	9	9	0.00%	7
7.104	**Medication preparation and administration areas:** Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes?	5	1	6	83.33%	10
7.105	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when preparing medications for inmate-patients?	6	0	6	100.00%	10
7.106	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when distributing medications to inmate-patients?	2	4	6	33.33%	10

7.107	**Pharmacy:** Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and satellite pharmacies?	1	0	1	100.00%	0
7.108	**Pharmacy:** Does the institution's pharmacy properly store non-refrigerated medications?	1	0	1	100.00%	0
7.109	**Pharmacy:** Does the institution's pharmacy properly store refrigerated or frozen medications?	1	0	1	100.00%	0
7.110	**Pharmacy:** Does the institution's pharmacy properly account for narcotic medications?	1	0	1	100.00%	0
7.111	**Pharmacy:** Does the institution follow key medication error reporting protocols?	22	8	30	73.33%	0
7.998	**For Information Purposes Only:** During eUHR compliance testing and case reviews, did the OIG find that medication errors were properly identified and reported by the institution?	Information Only				
7.999	**For Information Purposes Only:** Do inmate-patients in isolation housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications?	Information Only				
Overall percentage:					**71.41%**	

Prenatal and Post-Delivery Services	**Scored Answers**
This indicator is not applicable to this institution.	**Not Applicable**

Reference Number	*Preventive Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
9.001	**Inmate-patients prescribed TB medications:** Did the institution administer the medication to the inmate-patient as prescribed?	14	7	21	66.67%	0
9.002	**Inmate-patients prescribed TB medications:** Did the institution monitor the inmate-patient monthly for the most recent three months he or she was on the medication?	8	13	21	38.10%	0
9.003	**Annual TB Screening:** Was the inmate-patient screened for TB within the last year?	1	29	30	3.33%	0
9.004	Were all inmate-patients offered an influenza vaccination for the most recent influenza season?	28	2	30	93.33%	0
9.005	**All inmate-patients from the age of 50 through the age of 75:** Was the inmate-patient offered colorectal cancer screening?	27	3	30	90.00%	0
9.006	**Female inmate-patients from the age of 50 through the age of 74:** Was the inmate-patient offered a mammogram in compliance with policy?	Not Applicable				
9.007	**Female inmate-patients from the age of 21 through the age of 65:** Was the inmate-patient offered a pap smear in compliance with policy?	Not Applicable				
9.008	Are required immunizations being offered for chronic care inmate-patients?	22	3	25	88.00%	5
9.009	Are inmate-patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	Not Applicable				
Overall percentage:					**63.24%**	

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

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

Reception Center Arrivals	Scored Answers
This indicator is not applicable to this institution.	**Not Applicable**

Reference Number	*Specialized Medical Housing (OHU, CTC, SNF, Hospice)*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	**For all higher-level care facilities:** Did the registered nurse complete an initial assessment of the inmate-patient on the day of admission, or within eight hours of admission to CMF's Hospice?	10	0	10	100.00%	0
13.002	**For OHU, CTC, & SNF only:** Did the primary care provider for OHU or attending physician for a CTC & SNF evaluate the inmate-patient within 24 hours of admission?	9	1	10	90.00%	0
13.003	**For OHU, CTC, & SNF only:** Was a written history and physical examination completed within 72 hours of admission?	10	0	10	100.00%	0
13.004	**For all higher-level care facilities:** Did the primary care provider complete the Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes on the inmate-patient at the minimum intervals required for the type of facility where the inmate-patient was treated?	6	0	6	100.00%	4
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 inmate-patient's cells?	1	0	1	100.00%	0
Overall percentage:					**98.00%**	

Reference Number	*Specialty Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	Did the inmate-patient receive the high-priority specialty service within 14 calendar days of the PCP order?	15	0	15	100.00%	0
14.002	Did the PCP review the high priority specialty service consultant report within the required time frame?	14	1	15	93.33%	0
14.003	Did the inmate-patient receive the routine specialty service within 90 calendar days of the PCP order?	15	0	15	100.00%	0
14.004	Did the PCP review the routine specialty service consultant report within the required time frame?	12	2	14	85.71%	1
14.005	**For endorsed inmate-patients received from another CDCR institution:** If the inmate-patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames?	8	12	20	40.00%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	20	0	20	100.00%	0
14.007	Following the denial of a request for specialty services, was the inmate-patient informed of the denial within the required time frame?	16	4	20	80.00%	0
Overall percentage:					**85.58%**	

Reference Number	*Internal Monitoring, Quality Improvement, and Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.001	Did the institution promptly process inmate medical appeals during the most recent 12 months?	12	0	12	100.00%	0
15.002	Does the institution follow adverse/sentinel event reporting requirements?	Not Applicable				
15.003	Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified?	6	0	6	100.00%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	1	0	1	100.00%	0
15.005	For each initiative in the Performance Improvement Work Plan (PIWP), has the institution performance improved or reached the targeted performance objective(s)?	0	5	5	0.00%	1
15.006	**For institutions with licensed care facilities:** Does the Local Governing Body (LGB), or its equivalent, meet quarterly and exercise its overall responsibilities for the quality management of patient health care?	Not Applicable				
15.007	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	12	0	12	100.00%	0
15.101	Did the institution complete a medical emergency response drill for each watch and include participation of health care and custody staff during the most recent full quarter?	0	3	3	0.00%	0
15.102	Did the institution's second-level medical appeal response address all of the inmate-patient's appealed issues?	10	0	10	100.00%	0
15.103	Did the institution's medical staff review and submit the initial inmate death report to the Death Review Unit in a timely manner?	2	0	2	100.00%	0
15.996	**For Information Purposes Only:** Did the CCHCS Death Review Committee submit its inmate death review summary to the institution timely?	Information Only				
15.997	**For Information Purposes Only:** Identify the institution's protocols for tracking medical appeals.	Information Only				
15.998	**For Information Purposes Only:** Identify the institution's protocols for implementing health care local operating procedures.	Information Only				
15.999	**For Information Purposes Only:** Identify the institution's health care staffing resources.	Information Only				
Overall percentage:					**75.00%**	

Reference Number	*Job Performance, Training, Licensing, and Certifications*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
16.001	Do all providers maintain a current medical license?	8	0	8	100.00%	0
16.101	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	0	5	5	0.00%	0
16.102	Are nursing staff who administer medications current on their clinical competency validation?	10	0	10	100.00%	0
16.103	Are structured clinical performance appraisals completed timely?	7	0	7	100.00%	0
16.104	Are staff current with required medical emergency response certifications?	3	0	3	100.00%	0
16.105	Are nursing staff and the pharmacist in charge current with their professional licenses and certifications?	5	0	5	100.00%	1
16.106	Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	1	0	1	100.00%	0
16.107	Are nursing staff current with required new employee orientation?	1	0	1	100.00%	0
Overall percentage:					**87.50%**	

APPENDIX B — CLINICAL DATA

Table B-1 CAL Sample Sets	
Sample Set	**Total**
CTC/OHU	2
Death Review/Sentinel Events	2
Diabetes	8
Emergency Services – Non-CPR	5
High Risk	5
Hospitalization	5
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	30
Specialty Services	5
	68

Table B-2 CAL Chronic Care Diagnoses	
Diagnosis	**Total**
Anemia	1
Arthritis/Degenerative Joint Disease	2
Asthma	17
COPD	1
Cancer	1
Cardiovascular Disease	2
Chronic Pain	19
Cirrhosis/End-Stage Liver Disease	2
Diabetes	11
Gastroesophageal Reflux Disease	9
Gastrointestinal Bleed	1
Hepatitis C	28
Hyperlipidemia	9
Hypertension	20
Migraine Headaches	3
Seizure Disorder	6
Sleep Apnea	1
Thyroid Disease	3
	136

Table B-3 CAL Event — Program	
Program	**Total**
Diagnostic Services	111
Emergency Care	40
Hospitalization	29
Intra-System Transfers In	15
Intra-System Transfers Out	7
Not Specified	1
Outpatient Care	690
Specialized Medical Housing	304
Specialty Services	144
	1,341

Table B-4 CAL Case Review Sample Summary	
	Total
MD Reviews Detailed	30
MD Reviews Focused	0
RN Reviews Detailed	17
RN Reviews Focused	35
Total Reviews	82
Total Unique Cases	68
Overlapping Reviews (MD & RN)	14

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

Calipatria State Prison			
Quality Indicator	**Sample Category (number of samples)**	**Data Source**	**Filters**
Access to Care			
MIT 1.001	Chronic care patients (30)	Master Registry	• Chronic care conditions (at least one condition per inmate-patient—any risk level) • **Randomize**
MIT 1.002	Nursing Referrals (25)	OIG Q: 6.001	• See ***Intra-System Transfers***
MITs 1.003-006	Nursing sick call (5 per clinic) (30)	MedSATS	• Clinic (each clinic tested) • Appointment date (2–9 months) • **Randomize**
MIT 1.007	Returns from community hospital (8)	OIG Q: 4.008	• See ***Health Information Management (Medical Records)*** (returns from community hospital)
MIT 1.008	Specialty services follow-up (24)	OIG Q: 14.001 & 14.003	• See ***Specialty Services***
MIT 1.101	Availability of health care services request forms (6)	OIG onsite review	• Randomly select one housing unit from each yard
Diagnostic Services			
MITs 2.001–003	Radiology (10)	Radiology Logs	• Appointment date (90 days–9 months) • **Randomize** • Abnormal
MITs 2.004–006	Laboratory (10)	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • **Randomize** • Abnormal
MITs 2.007–009	Pathology (10)	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • **Randomize**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Health Information Management (Medical Records)			
MIT 4.001	Timely scanning (20)	OIG Qs: 1.001, 1.002, & 1.004	• Non-dictated documents • 1st 10 IPs MIT 1.001, 1st 5 IPs MITs 1.002, 1.004
MIT 4.002	(5)	OIG Q: 1.001	• Dictated documents • First 20 IPs selected
MIT 4.003	(20)	OIG Qs: 14.002 & 14.004	• Specialty documents • First 10 IPs for each question
MIT 4.004	(8)	OIG Q: 4.008	• Community hospital discharge documents • First 20 IPs selected
MIT 4.005	(11)	OIG Q: 7.001	• MARs • First 20 IPs selected
MIT 4.006	(12)	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (12 or more = No)
MIT 4.007	Legible signatures & review (32)	OIG Qs: 4.008, 6.001, 6.002, 7.001, 12.001, 12.002 & 14.002	• First 8 IPs sampled • One source document per IP
MIT 4.008	Returns from community hospital (8)	Inpatient claims data	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • **Randomize** (each month individually) • First 5 inmate-patients from each of the 6 months (if not 5 in a month, supplement from another, as needed)
Health Care Environment			
MIT 5.101-111	Clinical areas (10)	OIG inspector onsite review	• Identify and inspect all onsite clinical areas.
Inter- and Intra-System Transfers			
MIT 6.001-003	Intra-system transfers (30)	SOMS	• Arrival date (3–9 months) • Arrived from (another CDCR facility) • Rx count • **Randomize**
MIT 6.004	Specialty services send-outs (20)	MedSATS	• Date of transfer (3–9 months) • **Randomize**
MIT 6.101	Transfers out (2)	OIG inspector onsite review	• R&R IP transfers with medication

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
Pharmacy and Medication Management			
MIT 7.001	Chronic care medication (30)	OIG Q: 1.001	*See* ***Access to Care*** • At least one condition per inmate-patient—any risk level • **Randomize**
MIT 7.002	New Medication Orders (30)	Master Registry	• Rx count • **Randomize** • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns from Community Hospital (8)	OIG Q: 4.008	• See ***Health Information Management (Medical Records)*** *(returns from community hospital)*
MIT 7.004	RC arrivals – medication orders *N/A at this institution*	OIG Q: 12.001	• See ***Reception Center Arrivals***
MIT 7.005	Intra-facility moves (30)	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • **Randomize**
MIT 7.006	En Route (7)	SOMS	• Date of transfer (2–8 months) • Sending institution (another CDCR facility) • **Randomize** • NA/DOT meds
MITs 7.101-103	Medication storage areas (varies by test)	OIG inspector onsite review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–106	Medication Preparation and Administration Areas (6)	OIG inspector onsite review	• Identify and inspect onsite clinical areas that prepare and administer medications
MITs 7.107-110	Pharmacy (1)	OIG inspector onsite review	• Identify & inspect all onsite pharmacies
MIT 7.111	Medication error reporting (30)	Monthly medication error reports	• All monthly statistic reports with Level 4 or higher • Select a total of 5 months
MIT 7.999	Isolation unit KOP medications (2)	Onsite active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in isolation units
Prenatal and Post-Delivery Services			
MIT 8.001-007	Recent Deliveries *N/A at this institution*	OB Roster	• Delivery date (2–12 months) • **Most recent** deliveries (within date range)
	Pregnant Arrivals *N/A at this institution*	OB Roster	• Arrival date (2–12 months) • **Earliest** arrivals (within date range)

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
Preventive Services			
MITs 9.001–002	TB medications (21)	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • **Randomize**
MIT 9.003	TB Code 22, annual TST (15)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (22) • **Randomize**
	TB Code 34, annual screening (15)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (34) • **Randomize**
MIT 9.004	Influenza vaccinations (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • **Randomize** • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal cancer screening (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • **Randomize**
MIT 9.006	Mammogram *N/A at this institution*	SOMS	• Arrival date (at least 2 yrs prior to inspection) • Date of birth (age 52–74) • **Randomize**
MIT 9.007	Pap smear *N/A at this institution*	SOMS	• Arrival date (at least three yrs prior to inspection) • Date of birth (age 24–53) • **Randomize**
MIT 9.008	Chronic care vaccinations (30)	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • **Randomize** • Condition must require vaccination(s)
MIT 9.009	Valley fever (number will vary) *N/A at this institution*	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • **All**

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
Reception Center Arrivals			
MITs 12.001–008	RC *N/A at this institution*	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • **Randomize**
Specialized Medical Housing			
MITs 13.001–004	OHU (10)	CADDIS	• Admit date (1–6 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • **Randomize**
MIT 13.101	Call buttons OHU (all)	OIG inspector onsite review	• Review by location
Specialty Services Access			
MITs 14.001–002	High-priority (15)	MedSATS	• Approval date (3–9 months) • **Randomize**
MITs 14.003–004	Routine (15)	MedSATS	• Approval date (3–9 months) • Remove optometry, physical therapy or podiatry • **Randomize**
MIT 14.005	Specialty services arrivals (20)	MedSATS	• Arrived from (other CDCR institution) • Date of transfer (3–9 months) • **Randomize**
MIT 14.006-007	Denials (10)	InterQual	• Review date (3–9 months) • **Randomize**
	(10)	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • **Randomize**

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
Internal Monitoring, Quality Improvement, & Administrative Operations			
MIT 15.001	Medical appeals (all)	Monthly medical appeals reports	• Medical appeals (12 months)
MIT 15.002	Adverse/sentinel events (0)	Adverse/sentinel events report	• Adverse/sentinel events (2–8 months)
MITs 15.003–004	QMC Meetings (6)	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.005	Performance improvement work plans (PIWP) (6)	Institution PIWP	• PIWP with updates (12 months) • Medical initiatives
MIT 15.006	LGB (0)	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.007	EMRRC (12)	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.101	Medical emergency response drills (3)	Onsite summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	2nd level medical appeals (10)	Onsite list of appeals/closed appeals files	• Medical appeals denied (6 months)
MIT 15.103	Death Reports (2)	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.996	Death Review Committee (2)	OIG summary log – deaths	• Between 35 business days & 12 months prior • CCHCS death reviews
MIT 15.998	Local operating procedures (LOPs) (all)	Institution LOPs	• All LOPs

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Job Performance, Training, Licensing, and Certifications			
MIT 16.001	Provider licenses (8)	Current provider listing (at start of inspection)	• Review all
MIT 16.101	RN Review Evaluations (5)	Onsite supervisor periodic RN reviews	• RNs who worked in clinic or emergency setting six or more days in sampled month • **Randomize**
MIT 16.102	Nursing Staff Validations (10)	Onsite nursing education files	• On duty one or more years • Nurse administers medications • **Randomize**
MIT 16.103	Provider Annual Evaluation Packets (all)	OIG Q:16.001	• All required performance evaluation documents

MIT 16.104	Medical Emergency Response Certifications
	(all)
		Onsite certification tracking logs	• All staff
			  ○ Providers (ACLS)
			  ○ Nursing (BLS/CPR)
			  ○ Custody (CPR/BLS)

MIT 16.105	Nursing staff and Pharmacist in Charge Professional Licenses and Certifications (all)	Onsite tracking system, logs, or employee files	• All required licenses and certifications
MIT 16.106	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations (all)	Onsite listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 16.107	Nursing Staff New Employee Orientations (all)	Nursing staff training logs	• New employees (hired within last 12 months)

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

September 15, 2016

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

Dear Mr. Barton:

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

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

Sincerely,

Janet Lewis

JANET LEWIS
Deputy Director
Policy and Risk Management Services
California Correctional Health Care Services

cc: Clark Kelso, Receiver
Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
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