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Inspector General

Office of the Inspector General

California State Prison, Corcoran
Medical Inspection Results
Cycle 4

November 2016

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

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EXECUTIVE SUMMARY

Pursuant to 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 California State Prison, Corcoran (COR).

The OIG performed its Cycle 4 medical inspection at COR from March to May 2016. The inspection included in-depth reviews of 80 inmate-patient files conducted by clinicians, as well as reviews of documents from 451 inmate-patient files, covering 94 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 COR using 14 health care quality indicators applicable to the institution, made up of 12 primary clinical indicators and 2 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 policy compliance. Of the 12 primary indicators, 7 were rated by both case review clinicians and compliance inspectors, 3 were rated by case review clinicians only, and 2 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 COR was ***inadequate***.

Health Care Quality Indicators

Fourteen Primary Indicators (Clinical)	All Institutions–Applicability	COR 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**	**COR 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: Inadequate

Overall Assessment Rating:

Inadequate

Based on the clinical case reviews and compliance testing, the OIG's overall assessment rating for COR was *inadequate.* Of the 12 primary (clinical) quality indicators applicable to COR, the OIG found 3 *adequate* and 9 *inadequate*. Of the two secondary (administrative) quality indicators, the OIG found both *inadequate*. To determine the overall assessment for COR, 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 COR.

Clinical Case Review and OIG Clinician Inspection Results

The clinicians' case reviews sampled patients with high medical needs and included a review of 1,231 patient care events.[1] Of the 12 primary indicators applicable to COR, 10 were evaluated by clinician case review; none was *proficient,* six were *adequate,* and four were *inadequate.* When determining the 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 on site 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

COR provided adequate emergency services. The triage and treatment area (TTA) nursing staff provided well-coordinated emergency services to patients. Nursing assessments and treatments were generally appropriate and well documented.

Program Weaknesses — Clinical

- The provider assessments and treatment plans were frequently poor and contributed to the *inadequate* rating for the institution. The high number and the severity of the deficiencies covered a wide spectrum, including emergency care, chronic care, hospital returns, and specialty services.

- The patient care in specialized medical housing was inadequate. Patients admitted to the correctional treatment center (CTC) were acutely ill and required continuous and effective nursing and provider care. The continuity of care was poor with multiple providers involved.

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

There was inadequate communication among the providers assigned to the CTC. Some hospital discharge summaries and specialty reports were not reviewed and signed by the providers, and hospital recommendations and diagnoses were not addressed by the providers.

- Specialty reports were frequently missing, which delayed specialty appointments and hindered patient care.

Compliance Testing Results

Of the 14 health care indicators applicable to COR, 11 were evaluated by compliance inspectors.[2] There were 94 individual compliance questions within those 11 indicators, generating 1,381 data points, that tested COR's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[3] Those 94 questions are detailed in *Appendix A — Compliance Test Results*. The institution's inspection scores in the 11 applicable indicators ranged from 53.1 percent to 70.2 percent, with the primary indicator *Inter- and Intra-System Transfers* receiving the lowest score, and the primary indicator *Health Care Environment* receiving the highest. Of the nine primary indicators applicable to compliance testing, the OIG rated all nine *inadequate*. Of the two secondary indicators, which involve administrative health care functions, both were also rated *inadequate*.

Program Strengths — Compliance

As the *COR Executive Summary Table* on page *vii* indicates, all of the indicators' compliance ratings were *inadequate*, scoring below 75 percent. However, the following are some of COR's strengths based on its compliance scores on individual questions in all the primary health care indicators:

- Patients had a standardized process to obtain and submit request forms for health care services, and nursing staff timely completed face-to-face visits with patients after the requests were reviewed.

- Patients' radiology, laboratory, and pathology services were timely provided.

- Health records staff timely scanned initial health screening forms, health service request forms, handwritten progress notes, specialty reports, and medication administration records into patients' electronic medical records.

- Nursing staff ensured patients transferred from COR to other institutions with complete transfer packets and all applicable medications.

[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.

- The institution timely offered or provided influenza vaccinations to all patients sampled.

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

- The Quality Management Committee (QMC) met monthly, evaluated program performance, and took action when improvement opportunities were identified; the QMC also took adequate steps to ensure the accuracy of its Dashboard data reporting.

- All nursing staff hired within the last year received timely new employee orientation training.

Program Weaknesses — Compliance

The institution received ratings of *inadequate*, scoring below 75 percent, in all nine primary indicators and in both secondary indicators. The following are some of the weaknesses identified by COR's compliance scores on individual questions in all the primary health care indicators:

- Providers did not conduct timely appointments with many patients the OIG sampled. This included those who required a follow-up visit for chronic care conditions or after receiving a specialty service, those who had been referred for a follow-up visit by a provider, and those who had been referred to a provider by nursing staff due to the patient's request for service or upon the patient's transfer to COR from another institution.

- The institution's providers did not properly evidence their review of hospital discharge reports, radiology reports, and pathology reports; and did not communicate corresponding pathology results to patients.

- Health records staff did not always timely scan transcribed documents into patients' electronic health records, and they did not always properly label or file documents into patients' electronic health records.

- Most clinics were lacking some essential equipment and supplies in exam rooms and common areas, and many clinics had exam rooms that did not have an adequate environment conducive to providing medical services.

- The institution did not conduct monthly inventories of its emergency response bags.

- For patients received from another institution, nursing staff did not answer all required questions or timely complete their initial health screening form.

- For most sampled patients who transferred out of COR with approved pending specialty service appointments, the institution did not identify the approved services on their health care transfer forms.

- For many patients sampled, nursing staff did not timely deliver or administer prescribed medications. This included sampled patients who suffered with chronic care conditions, those who returned to the institution from a community hospital, and those who were en route to other CDCR institutions.

- Clinical staff did not employ strong security controls over narcotic medications assigned to clinical areas and did not follow proper protocols for storing non-narcotic medications.

- The main pharmacy did not have a process to store refrigerated medications until restocked, did not properly account for narcotics, and did not follow key medication error reporting protocols.

- Nursing staff did not follow required protocols for administering and reading patients' annual tuberculosis skin tests, and did not properly monitor patients on tuberculosis medications.

- Patients at the highest risk of contracting valley fever were not timely transferred out of the institution.

- Providers did not complete timely assessments for patients admitted to the outpatient housing unit (OHU) and CTC.

- Providers did not timely review patients' high-priority and routine specialty services reports; the institution did not timely deny provider requests for specialty services.

- Many sampled patients who transferred into COR from other institutions with previously approved or scheduled specialty service appointments, received their appointment late or did not receive it at all.

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

- Emergency Medical Response Review Committee incident review packages and emergency response drill packages lacked required documentation.

- Clinical supervisors did not complete structured performance appraisals of providers and appropriate periodic reviews of nursing staff.

The *COR 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.

COR Executive Summary Table

Primary Indicators (Clinical)	Case Review Rating	Compliance Rating	Overall Indicator Rating
Access to Care	*Adequate*	*Inadequate*	*Inadequate*
Diagnostic Services	*Adequate*	*Inadequate*	*Adequate*
Emergency Services	*Adequate*	Not applicable	*Adequate*
Health Information Management (Medical Records)	*Inadequate*	*Inadequate*	*Inadequate*
Health Care Environment	Not applicable	*Inadequate*	*Inadequate*
Inter- and Intra-System Transfers	*Adequate*	*Inadequate*	*Inadequate*
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	*Inadequate*	Not applicable	*Inadequate*
Specialized Medical Housing (OHU, CTC, SNF, Hospice)	*Inadequate*	*Inadequate*	*Inadequate*
Specialty Services	*Inadequate*	*Inadequate*	*Inadequate*

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

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

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

In general, COR performed adequately as measured by population-based metrics. In three of the five comprehensive diabetes care measures, the institution outperformed other State and national organizations. This included Medi-Cal, Kaiser Permanente (typically one of the highest scoring health organizations in California), Medicaid, Medicare, commercial entities, and the United States Department of Veterans Affairs (VA). For blood pressure control of diabetics, COR performed lower than Kaiser (both North and South regions) and similar to the VA; for diabetic patient dilated eye exams, COR scored lower than Kaiser's South region and lower than the VA.

With regard to immunization measures, the institution's scores were mixed, scoring lower than the other entities that reported data for administering influenza shots to younger adults, but scoring higher for administering influenza shots to older adults. With regard to administering pneumococcal vaccines to older adults, COR scored higher than Medicare but lower than the VA. The institution's rates for colorectal cancer screening were lower than all health care organizations that reported data. COR routinely offered patients their required immunizations and cancer screenings, but many of them refused the offers; these refusals adversely affected the institution's scores.

Overall, COR's performance demonstrated by population-based metrics indicates that comprehensive diabetes care and immunizations for older adults were adequate in comparison to statewide and national health care organizations. The institution could improve its scores in immunizations and cancer screenings by making interventions to reduce patient refusals.

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.

California State Prison, Corcoran (COR), was the 24th 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

California State Prison, Corcoran (COR), is a complex, multi-mission institution comprised of the following facilities: general population housing (from low- to high-security), an administrative segregation unit, a security housing unit, a protective housing unit, long-term restricted housing, an enhanced programming facility, and a fully licensed correctional treatment center.

The institution operates nine clinics where staff members handle non-urgent requests for medical services, including eight facility clinics and a specialty clinic. COR also conducts screenings in its receiving and release clinical area (R&R); treats patients needing urgent or emergency care in its triage and treatment area (TTA); treats inmate-patients requiring inpatient health services in three correctional treatment centers (CTC); and treats patients who require assistance with the activities of daily living, but who do not require a higher level of inpatient care, in its outpatient housing unit (OHU). California Correctional Health Care Services (CCHCS) has designated COR 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 limited specialty medical services and consultation for a generally healthy inmate-patient population.

On August 16, 2015, the institution received national accreditation from the Commission on Accreditation for Corrections. This accreditation program is a professional peer review process based on national standards set by the American Correctional Association.

Based on staffing data the OIG obtained from the institution, COR's vacancy rate among medical managers, providers, nursing supervisors, and non-supervisory nurses was 13 percent in February 2016, with the highest vacancy percentages among providers. Due to difficulty recruiting and retaining providers, the chief executive officer (CEO) has pursued the recruitment of mid-level providers form nearby institutions (existing State employees) to work part time at the clinics on weekends. The CEO also reported that in February 2016, there were 12 staff members under disciplinary review, none of whom were redirected to non-patient-care settings.

More recently, and as discussed in the *Quality of Provider Performance* indicator, by May 2016, COR had only two provider vacancies, indicating that the recruitment problem was diminishing.

COR Health Care Staffing Resources as of February 2016

	Management		Providers		Nursing Supervisors		Nursing Staff		Totals	
Description	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Authorized Positions	4	2%	11	6%	16	8%	161.6	84%	192.6	100%
Filled Positions	3	75%	6	55%	14	87%	144.1	89%	167.1	87%
Vacancies	1	25%	5	45%	2	13%	17.5	11%	25.5	13%
Recent Hires (within 12 months)	0	0%	2	33%	5	36%	16	11%	23	14%
Staff Utilized from Registry	0	0%	1	17%	0	0%	33	23%	34	20%
Redirected Staff (to Non-Patient Care Areas)	0	0%	0	0%	0	0%	0	0%	0	0%
Staff on Long-term Medical Leave	0	0%	0	0%	1	7%	12	8%	13	8%

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

As of February 29, 2016, the Master Registry for COR showed that the institution had a total population of 4,155. Within that total population, 2.0 percent were designated as high medical risk, Priority 1 (High 1), and 5.1 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.

COR Master Registry Data as of February 29, 2016

Medical Risk Level	# of Inmate-Patients	Percentage
High 1	82	2.0%
High 2	214	5.1%
Medium	2,264	54.5%
Low	1,595	38.4%
Total	**4,155**	**100.0%**

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 2 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 COR, 14 of the quality indicators were applicable, consisting of 12 primary clinical indicators and two secondary administrative indicators. Of the 12 primary indicators, 7 were rated by both case review clinicians and compliance inspectors, 3 were rated by case review clinicians only, and 2 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 institution's 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 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: COR Sample Sets*, the OIG clinicians evaluated medical charts for 80 unique inmate-patients. *Appendix B, Table B–4: COR Case Review Sample Summary*, clarifies that both nurses and physicians reviewed charts for 17 of those patients, for 97 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 50 inmate-patients. These generated 1,231 clinical events for review (*Appendix B, Table B–3: COR Event-Program*). The inspection tool provides details on whether the encounter was adequate or had significant deficiencies, and identifies deficiencies by programs and processes to help the institution focus on improvement areas.

While the sample method specifically pulled only six chronic care patient records, i.e., three diabetes patients and three anticoagulation patients (*Appendix B, Table B–1: COR Sample Sets*), the 80 unique inmate-patients sampled included patients with 264 chronic care diagnoses, including 15 additional patients with diabetes (for a total of 18) (*Appendix B, Table B–2: COR 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 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 COR *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 attained answers to 94 objective medical inspection test (MIT) questions designed to assess the institution's compliance with critical policies and procedures applicable to the delivery of medical care. To conduct most tests, inspectors randomly selected samples of 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 451 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 14, 2016, field inspectors conducted a detailed onsite inspection of COR's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,381 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 COR's plant infrastructure, protocols for tracking medical appeals and local operating procedures, and staffing resources.

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

SCORING OF COMPLIANCE TESTING RESULTS

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

- Primary indicators: *Access to Care, Diagnostic Services, Health Information Management (Medical Records), Health Care Environment, Inter- and Intra-System Transfers, Pharmacy and Medication Management, Preventive Services, Specialized Medical Housing (OHU, CTC, SNF, Hospice),* and *Specialty Services.*

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

After compiling the answers to the 94 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. The OIG has removed the Dashboard comparisons 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 COR, the OIG reviewed some of the compliance testing results, randomly sampled additional inmate-patients' records, and obtained COR 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 COR. 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 *COR Executive Summary Table* on page *vii* shows the case review and 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 COR. Of these ten indicators, OIG clinicians rated none *proficient*, six *adequate*, and four *inadequate*.

The OIG physicians rated the overall adequacy of care for each of the 30 detailed case reviews they conducted. Of these 30 cases, none were *proficient*, 20 were *adequate*, and 10 were *inadequate*. In the 1,231 events reviewed, there were 323 deficiencies, of which 63 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 unsafe condition or sentinel events identified in the case reviews at COR.

Summary of Compliance Results: The compliance component assessed 9 of the 12 primary (clinical) indicators applicable to COR. Of these nine indicators, OIG inspectors rated all nine *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:
Inadequate
(68.9%)

Overall Rating:
Inadequate

In this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance 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.* The low scores identified in the compliance review, combined with the provider appointment backlog, which caused most of the case review deficiencies, warranted the overall *inadequate* rating.

Case Review Results

The OIG clinicians reviewed 691 provider and nursing encounters and identified 18 deficiencies relating to *Access to Care*. Of those 18 deficiencies, eight were significant. The case review rating for this indicator was *adequate*.

Nurse-to-Provider Referrals

- In case 6, a nurse performed the initial health screening and referred the patient with multiple chronic care illnesses for a provider appointment within 72 hours. The appointment occurred three weeks later.
- In case 17, a nurse referred the patient for a routine provider appointment (within two weeks) for medical equipment accommodations. The appointment occurred almost one month later.
- In case 57, a nurse requested a routine provider appointment to assess a rash, but the appointment did not occur.

Nursing Follow-up Appointments

There were two deficiencies in nursing follow-up:

- In case 70, TTA staff evaluated a patient for dizziness and a fall. A provider ordered a two-day follow-up appointment with nursing staff, but the appointment did not occur.
- In case 74, a nurse treated the patient for a rash. The requested one-week follow-up appointment did not occur.

Provider-to-Provider Follow-up Appointments

COR performed poorly with provider-ordered follow-up appointments. These appointments are important elements of the *Access to Care* indicator. The OIG clinicians identified the following deficiencies:

- In case 27, a provider evaluated the patient in the warfarin clinic and requested a two-week follow-up. The appointment occurred more than one month later.
- In case 32, the patient had new-onset diabetes with a severely high blood sugar average. The provider ordered a follow-up as soon as possible. The appointment occurred more than one month later.
- In case 34, after an ophthalmology evaluation for glaucoma and macular edema, a provider requested a three- to five-day follow-up. The appointment occurred 12 days later.
- In case 34, the patient had poorly controlled hypertension. The provider ordered a patient follow-up in 14 days. The appointment occurred 22 days later.
- In case 36, after an ophthalmology treatment for diabetic retinopathy (a condition that predisposes the eye to hemorrhage), a provider requested a three- to five-day follow-up. The appointment occurred more than six weeks later.
- In case 58, a nurse evaluated the patient for coughing and a sore throat. A provider was consulted and ordered an urgent chest x-ray, which was done on the same day. A different provider reviewed the chest x-ray report and requested a provider follow-up to discuss the chest x-ray results. The follow-up did not occur.

Specialty Service Appointments

COR performed poorly with specialty service appointments. The OIG identified the following deficiencies:

- In case 26, the patient was admitted to a community hospital for impaired bladder function, nerve impairment, and foot weakness. The hospital neurosurgeon, after managing the

patient's conditions with steroid medications, recommended a patient follow-up in one week. This follow-up appointment did not occur.

- In case 28, the patient returned from a hospitalization after repair of a hip fracture, with recommendation to follow up with the orthopedic surgeon in two weeks. A provider ordered a one- to two-week follow-up, but the follow-up occurred six weeks later.

- In case 35, the patient had a kidney tumor. The provider ordered an urgent urology consultation, which did not occur until 19 days later.

- In case 36, the patient had diabetic retinopathy and macular edema (swelling of the eye's greatest visual acuity area); an ophthalmologist injected aflibercept (antibody medication to reduce bleeding) to one eye and requested follow-ups in two and four weeks for more injections in both eyes. The first appointment occurred more than ten weeks later.

Provider Follow-up after Hospitalization

Forty-seven hospital or outside emergency department events were reviewed. The providers timely assessed all patients returning from the higher level of care.

Specialized Medical Housing

The providers saw patients in the correctional treatment center (CTC) and the outpatient housing unit (OHU) appropriately and timely, with the exception of the following:

- In case 37, the patient resided in the OHU, and on two occasions the providers failed to evaluate the patient within the required 14 days. The appointments occurred in 38 and 26 days.

Onsite Inspection

During the onsite visit, clinic nurses reported seeing eight to ten patients each day on the nurse lines and having no backlogs. However, there were backlogs of 495 provider appointments among three clinics. The providers usually saw 14 to 18 scheduled patients each day, and there were provider appointments on the weekends to help alleviate some of the backlogs.

The clinic office technicians attended clinic huddles, and maintained a tracking process to ensure provider chronic care and follow-up appointments were completed.

Compliance Testing Results

The institution received an *inadequate* compliance score of 68.9 percent in the *Access to Care* indicator, scoring in the *inadequate* range in the following five areas:

- Among 25 patients sampled who had transferred into COR from another institution and had been referred to a provider based on nursing staff's initial health care screening, only 6 (24 percent) were seen timely. For 18 patients, appointments were held between 7 and 19 days late, and there was no evidence that one patient had an appointment at all (MIT 1.002).

- Of the five patients sampled whom nursing staff referred to a provider and for whom the provider subsequently ordered a follow-up appointment, only two (40 percent) received their follow-up appointments timely. One patient received his follow-up appointment seven days late, and inspectors found no evidence that the appointments occurred at all for two other patients (MIT 1.006).

- Inspectors also sampled 20 patients who received a specialty service; 13 of them (65 percent) were offered a timely provider follow-up appointment and either received or refused it. For the remaining seven patients, inspectors identified the following deficiencies (MIT 1.008):

    - For two patients who received high-priority specialty services, their appointments were one and nine days late.

    - For one patient who received a high-priority specialty service, there was no evidence that a follow-up appointment occurred at all.

    - For two patients who received routine specialty services, their appointments were 4 and 19 days late.

    - For two patients who received routine specialty services, there was no evidence that a follow-up appointment occurred.

- Among the 30 sampled patients who suffered from one or more chronic care conditions, only 21 (70 percent) received timely provider follow-up appointments. Five patients received chronic care follow-up appointments from 3 to 24 days late; one patient received his follow-up appointment over four months late. For the remaining three patients, there was no evidence the appointments occurred at all (MIT 1.001).

- For the 21 Health Care Services Request forms (CDCR Form 7362) sampled on which nursing staff referred the patient for a provider appointment, 15 of the patients (71 percent) received a timely appointment. Four patients received their appointment from 3 to 15 days late; two other patients did not receive an appointment at all (MIT 1.005).

The institution performed in either the *adequate* or the *proficient* range in the following tests:

- Inspectors sampled 45 requests for health care services submitted by patients across all facility clinics. Nursing staff reviewed 34 of the 45 patients' request forms on the same day they were received (76 percent). Seven patients' request forms were reviewed from one to two days late; four other patients' request forms were not dated and the inspectors were unable to ascertain if the form was reviewed the same day it was received (MIT 1.003). In addition, nursing staff timely completed a face-to-face triage encounter for 44 of those 45 patients (98 percent). The nurse conducted one patient's visit one day late (MIT 1.004).
- Of the 30 sampled patients who had been discharged from a community hospital, 23 (77 percent) either received a timely follow-up appointment with a provider upon their return to COR or were timely offered the follow-up visit and refused. Three patients received a provider follow-up appointment one day late. There was no evidence that four other patients received provider follow-up appointments at all (MIT 1.007).
- Inmates had access to health care services request forms at all six housing units the OIG inspected (MIT 1.101).

Recommendations

No specific recommendations.

DIAGNOSTIC SERVICES

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(69.1%)

Overall Rating:
Adequate

This indicator addresses several types of diagnostic services. Specifically, it addresses whether radiology and laboratory services were timely provided to inmate-patients, whether the 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 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.

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 *adequate.* Although the compliance scores were affected by the lack of provider signatures indicating review of the diagnostic reports, the case review showed that the providers documented awareness of the diagnostic reports in their progress notes. The lack of the providers' signatures on the diagnostic reports did not affect patient care, so the case review rating of *adequate* outweighed the compliance score

Case Review Results

The OIG clinicians reviewed 151 events in diagnostic services and found 12 deficiencies, 2 of which were significant (cases 10 and 25). Most reviewed tests were performed as ordered, reviewed timely by providers, and relayed quickly to patients. The case review rating for *Diagnostic Services* was *adequate.*

Staff performed most laboratory tests, x-rays, and EKGs as ordered, with one significant exception:

- In case 25, the patient underwent an evaluation for a fever in the TTA. The provider ordered a urinalysis, but it was not done.

Health information management contributed to three deficiencies, with three diagnostic reports not retrieved or scanned into the eUHR:

- In case 10, this complex diabetes patient had been ill for four days. An urgent lab report was not retrieved or scanned into the eUHR with the results of a complete blood count and chemistry.
- In cases 29 and 33, a chest x-ray report was not retrieved or scanned into the eUHR.

The OIG also identified eight diagnostic reports scanned into the eUHR without a provider signature.

Compliance Testing Results

The institution received an *inadequate* compliance score of 69.1 percent in the *Diagnostic Services* indicator, which encompasses radiology, laboratory, and pathology services. For clarity, each type of diagnostic service is discussed separately:

Radiology Services

- All ten of the radiology services sampled were timely performed (MIT 2.001). Providers properly evidenced their review of radiology results for only four of the ten patients (40 percent). For five patients' reports, the provider signed or included a name stamp but did not date the report to evidence when it was reviewed; one patient's radiology report was not scanned into his eUHR (MIT 2.002). Providers communicated the radiology results timely to nine of the ten patients (90 percent); there was no evidence the provider communicated the results to one patient (MIT 2.003).

Laboratory Services

- Laboratory services were completed within the time frame specified in the provider's order for nine of ten patients sampled (90 percent); one patient's laboratory test was performed 12 days late (MIT 2.004). Providers properly evidenced their review of the laboratory test results for nine of those ten patients (90 percent); one report was initialed by the provider but did not include the date reviewed (MIT 2.005). Providers timely communicated laboratory test results to seven of the ten patients (70 percent). For three patients, inspectors did not find evidence in the eUHR that the patient received any notification of the test results (MIT 2.006).

Pathology Services

- For all ten pathology services sampled, COR timely received the patient's final diagnostic report (MIT 2.007). Providers timely reviewed only two of the ten reports (20 percent). Providers did not document evidence of their review on six of the final reports, reviewed another report four days late, and did not date one report to indicate when it was reviewed (MIT 2.008). Providers communicated pathology results timely to only two of the nine applicable patients who remained at the institution (22 percent). For four of those patients, the provider communicated the results from 2 to 30 days late; for three other patients, inspectors did not find evidence that the patients received notification of the test results (MIT 2.009).

Recommendations

No specific recommendations**.**

EMERGENCY SERVICES

Case Review Rating:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

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

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

Case Review Results

The OIG clinicians reviewed 41 urgent or emergent events and found 29 deficiencies, with five significant deficiencies (cases 6, 10, and 25, and twice in case 26). The OIG rated *Emergency Services* at COR *adequate.*

Provider Performance

The OIG identified five provider deficiencies in emergency services, two of which were significant (cases 6 and 26), which are also described in the *Quality of Provider Performance* indicator:

- In case 6, the patient had coronary artery disease with stent placement and presented to the TTA with left-sided chest pain suggestive of angina. The provider failed to order aspirin, and failed to record a progress note documenting this emergent event.
- In case 17, the patient with chest pain was evaluated by TTA staff, who then consulted a provider. The provider failed to record a progress note of this emergent event.
- In case 18, a provider was consulted for a patient with left-sided chest pain in the TTA. The provider failed to address the patient's elevated blood pressure and failed to record a progress note.
- In another TTA encounter in case 18, a provider evaluated the patient again for left-sided chest pain. The provider's general diagnosis was non-cardiac chest pain, but the provider did not give a specific diagnosis or a clear treatment plan. The provider also failed to address an elevated blood pressure.

- In case 26, the patient had a psychiatric disorder and history of swallowing objects, and presented to the TTA with abdominal pains after swallowing paper clips. TTA staff consulted a provider, who ordered that the patient be admitted to the psychiatric unit for risk of self-harm. The provider failed to record a progress note documenting this emergent event, and failed to completely evaluate the patient with an x-ray of the abdomen.

Nursing Performance

Emergency nursing care was generally adequate. However, several case examples clearly demonstrated areas for improvement. The TTA nurse failed to reassess the patient's pain or vital signs when required in cases 8 and 26. Nurses sometimes failed to reassess patients after administering medications, before transferring them to an outside hospital, or upon returning patients to their housing units, as illustrated in the following examples:

- In case 23, the patient was seen for a painful, infected arm abscess. The nurse did not assess the size or appearance of the abscess or apply a clean dressing for transport to the community hospital.

- In case 25, the patient with a colostomy was seen in the TTA for two days of nausea and vomiting. In the TTA, the patient had severe pain. The nurse only assessed the patient's pain level once during his three-hour wait in the TTA, even though the nurse gave the patient methadone for pain several minutes prior to his departure to a community hospital.

- In case 26, the patient was seen in the TTA for chest pain. Oxygen, aspirin, and nitroglycerin were not administered as they should have been per the CCHCS chest pain nursing protocol. After the patient arrived in the TTA, there was a 20-minute delay in assessing the patient's vital signs, and a 40-minute delay in contacting the provider. The patient was sent out to a community hospital for a possible pulmonary embolism (blood clot in the lung).

- In case 6, the nurse did not use the chest pain protocol for chest pain.

Diagnostic Services

There were two serious diagnostic services deficiencies:

- In case 10, a provider evaluated a diabetic patient in the TTA for reportedly feeling sick and not taking his insulin, and ordered a stat (immediate) lab test for a complete blood count and chemistry panel. A nurse documented that stat labs were drawn; however, the report was not retrieved, reviewed by a provider, or timely scanned into the eUHR. The patient transferred to another institution before the provider reviewed the lab results. Fortunately, the lab results were normal.

- In case 25, the provider ordered a urinalysis, but it was not done.

Emergency Medical Response Review Committee (EMRRC)

The OIG agreed with the findings of the EMRRC on the cases reviewed.

Clinical Inspection

COR had a well-equipped TTA. The TTA was readily accessible and staffed with two nurses each shift. There was one provider during business hours. The emergency bags had an attached pouch containing naloxone, glucagon, and other emergency supplies.

Conclusion

The OIG rated *Emergency Services* at COR *adequate.* The TTA nursing staff provided well-coordinated emergency services to their patients. Nursing assessments and treatments were generally appropriate and well documented.

Recommendations

No specific recommendations.

HEALTH INFORMATION MANAGEMENT (MEDICAL RECORDS)

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(65.8%)

Overall Rating:
Inadequate

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 identified 78 *Health Information Management* deficiencies, ten of which were significant (three in case 10, two each in cases 18 and 20, and one each in cases 11, 28, and 34). The case review rating of the *Health Information Management* processes was *inadequate.*

Hospital Records

Deficiencies in processing of hospital discharge summaries occurred frequently, as 17 hospital discharge summaries were not properly reviewed and signed by a provider. Most hospital records were timely retrieved, reviewed, and scanned into the eUHR, but there were a few deficiencies; for example, in case 8, a hospital discharge summary was not retrieved or scanned into the eUHR.

Specialty Reports

The most severe deficiencies occurred when specialty reports were not retrieved or scanned into the eUHR, which occurred eight times. The OIG also identified 24 specialty reports not properly reviewed and signed by the providers prior to scanning into the eUHR. Also, in case 28, an oncology consultation report was not retrieved or scanned into the eUHR, even after a provider requested the report.

Diagnostic Reports

The OIG clinicians found four diagnostic reports not retrieved or scanned into the eUHR, and eight diagnostic reports not properly reviewed and signed by the providers.

Missing Documents (Progress Notes and Forms)

The OIG clinicians identified seven missing documents. In case 11, the nursing OHU care records were not found in the eUHR, just prior to the patient's transfer to an outside community hospital for a serious bone and muscle infection.

Scanning Performance

There were three misfiled documents, and in case 18, a medical record of a different patient was scanned into the eUHR.

Legibility

Most provider documentation was transcribed. However, the OIG found illegible nursing progress notes, signatures, and initials. Illegible documentation poses a significant medical risk to patients, especially when other staff must review the medical care or when there is a transfer of care to another team.

Compliance Testing Results

The institution received an *inadequate* compliance score of 65.8 percent in the *Health Information Management (Medical Records)* indicator, scoring in the *inadequate* range on the following four tests:

- The institution scored zero in its labeling and filing of documents scanned into patients' electronic unit health records. The most common errors were incorrectly labeled documents and documents scanned under the wrong date. For example, two Physician Orders (CDCR Form 7221) were incorrectly labeled as pathology results and a Non-formulary Drug Request (CDCR Form 7374). For this test, once the OIG identifies 12 mislabeled or misfiled documents, the maximum points are lost and the resulting score is zero. During the COR medical inspection, inspectors identified a total of 20 documents with filing errors, eight more than the maximum allowable number (MIT 4.006).

- The OIG reviewed hospital discharge records for 30 sampled patients whom the institution sent to an outside hospital for a higher level of care. For 11 of the 30 patients (37 percent), the discharge summary reports were complete and timely reviewed by COR providers. For 11 patients, providers reviewed the hospital discharge summary reports one to three days late. For eight other patients, there was no evidence that a COR provider reviewed the discharge report at all (MIT 4.008).

- Inspectors tested seven provider-dictated progress notes to determine if institution staff scanned the documents within five calendar days of the patient encounter date; only four documents (57 percent) were scanned timely. Staff had scanned three dictated progress notes from two to seven days late (MIT 4.002).

- When the OIG reviewed various medical documents such as hospital discharge reports, initial health screening forms, certain medication administration records (MARs), and specialty service reports to ensure that clinical staff legibly documented their names on the forms, only 20 of 32 samples (63 percent) showed compliance. Twelve of the samples did not include clinician name stamps and the signatures were illegible (MIT 4.007).

The institution performed in either the *proficient* or the *adequate* range in the following tests:

- COR staff scanned all 20 sampled specialty service consultant reports into the patient's eUHR file within five calendar days of the date the specialty service was performed (MIT 4.003).
- Health records administrative staff timely scanned 19 of 20 miscellaneous documents, such as non-dictated providers' progress notes, initial health screening forms, and patients' requests for health care services, within three calendar days of the patient's encounter (95 percent). The only exception was a health care services request form scanned five days late (MIT 4.001).
- COR staff timely scanned 18 of 20 sampled MARs into the patient's eUHR files (90 percent). Two MARs were scanned one and two days late (MIT 4.005).
- Health records administrative staff timely scanned community hospital discharge records into the patients' eUHR for 17 of the 20 sampled records (85 percent); three records each were scanned one day late (MIT 4.004).

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:
Inadequate
(70.2%)

Overall Rating:
Inadequate

Clinician Comments

Although the OIG clinicians did not rate the health care environment at COR, they obtained the following information during their onsite visit:

- The TTA had two beds and adequate space for patient evaluation, with working areas for both nurses and providers. The TTA also had ample lighting and was stocked adequately with medications and medical equipment, such as an automated external defibrillator (AED) and an emergency crash cart.

- Morning huddles were attended by providers, clinic and medication nurses, care coordinators, office technicians, and custody. These meetings were productive as pertinent matters of the nurse and provider lines, as well as any custody issues related to access to care, were discussed.

- With clinical areas undergoing construction, the medication pass pill lines were conducted in the clinic area while provider, nurse, and dental lines were in progress at the same time. For example, in Yard 3B, the medication administration nursing staff had been relocated to the custody staff office; nurses brought medication carts into that office when they conducted their medication passes. These temporary clinics tended to become congested with the clinics and medication lines in progress simultaneously. Additionally, the area used by the nurses in Yard 3B for patient exams had windows surrounding the examination areas and no privacy screens. The nurses' patient examination areas were shared with other staff, and did not allow for confidentiality during patient exams.

Compliance Testing Results

The institution received an *inadequate* compliance score of 70.2 percent in the *Health Care Environment* indicator; 4 of the 11 test areas scored in the *inadequate* range, as described below:

- Although staff on each watch conducted daily inventories of emergency response bags, the institution lacked a process to conduct monthly inventories of the bags, scoring zero on this

test. One bag's oxygen tank was not properly pressurized; another bag had two glucose tubes that had expired almost one year earlier (MIT 5.111).

- Only 4 of the 15 clinic common areas and exam rooms (27 percent) had all essential core medical equipment and supplies; the remaining 11 clinics had one or more deficiencies. Seven clinics lacked a Snellen eye chart or an established distance line on the floor for the chart. Five clinics had core equipment items that lacked evidence of current calibration, such as a weight scale, a nebulization unit, or a vital sign machine; four clinics lacked a nebulization unit; three clinics lacked a glucometer or a peak flow meter. Exam rooms in five clinics lacked an otoscope and tips, lacked an oto-ophthalmoscope, or the oto-ophthalmoscope was not in working order or not currently calibrated. In both the receiving and release (R&R) clinical area and the administrative segregation unit (ASU) nurse exam area, there was no exam table. Two exam areas lacked a biohazard waste receptacle or adequate disposal process, one of them also lacked tongue depressors and disposable paper for the exam table (MIT 5.108).

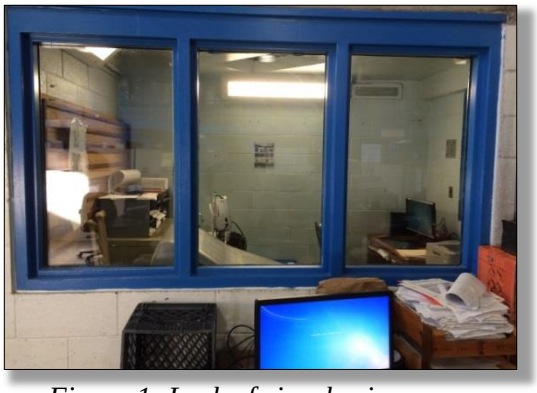

Figure 1: Lack of visual privacy, no privacy screen available

- The OIG inspected various exam rooms in each of COR's 15 clinics, observing patient encounters and interviewing clinical staff, to determine if they had appropriate space, configuration, supplies, and equipment to allow clinicians to perform a proper exam. Exam areas were adequate in only eight clinics (53 percent). Seven clinics had exam areas that were unacceptable for a variety of reasons. For example, seven clinics' exam rooms lacked visual patient privacy because there were no privacy screens available to cover windows; one exam area also lacked auditory privacy for patients during clinical encounters (*Figure 1*). Placement of exam tables in four exam rooms prevented the patient from fully extending on the exam table (*Figure 2*); in two of those exam rooms, the table placement or the size of the room was too small to allow for adequate patient examinations, and one exam table's vinyl cover was worn, cracked, and visibly stained, which could harbor infectious agents if not adequately disinfected. Also, two clinics' supply cabinets were disorganized and the contents were not properly labeled. At two other clinics, the shred box containing confidential patient medical information was not emptied nightly; in one of those clinics, inspectors found confidential patient medical information in a garbage can along with gloves and trash (MIT 5.110).

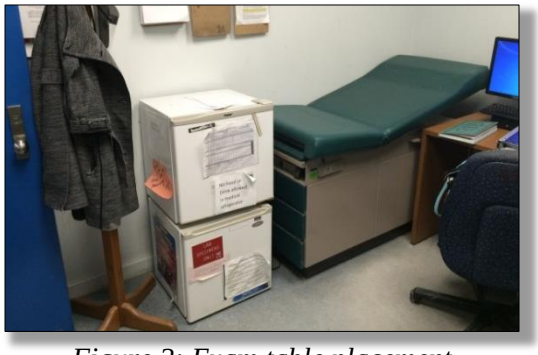

Figure 2: Exam table placement preventing patient from fully extending on the exam table

- Eleven of the 15 clinics (73 percent) had operable sinks and sufficient quantities of hand hygiene supplies. Two clinics' inmate restrooms did not have functioning sinks or antiseptic hand soap and disposable towels. At two other clinics, providers did not have access to a sink in the exam area and stated that it was difficult to maintain good hand hygiene (MIT 5.103).

The institution performed adequately in the two areas below:

- Clinicians adhered to universal hand hygiene precautions in 12 of the 15 clinics (80 percent). At three clinics, nursing staff failed to wash their hands or put on gloves prior to intentional physical contact with patients (MIT 5.104).

- OIG inspectors observed that 12 of the 15 clinics (80 percent) followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste. Two clinics did not have a sharps container in the nurse exam rooms. In the third clinic, nursing staff stated that they had no access to disinfectant wipes or cleaning supplies and lacked access to personal protective equipment (PPE); the nearest PPE was located in an entirely different clinic across the facility (MIT 5.105).

The institution received a *proficient* score in the following five tests:

- Based on OIG's inspection of the institution's non-clinic storage areas for bulk medical supplies, and responses received from the warehouse manager and the CEO, the medical supply management process supported the needs of the medical health care program. As a result, the institution scored 100 percent on this test (MIT 5.106).

- Fourteen of the 15 clinics examined (93 percent) were appropriately disinfected, cleaned, and sanitary. The remaining clinic did not have an adequate cleaning program, evidenced by the lack of clinic cleaning logs and visible dust, dirt, and debris on the floors and equipment (MIT 5.101).

- Among 14 clinics examined, 13 (93 percent) followed adequate medical supply storage and management protocols. At the remaining clinic, bulk medical supplies in the storage room were disorganized and not clearly labeled for identification; also, the storage cabinet had a broken door that could not be secured (MIT 5.107).

- Clinic common areas at 13 of the 15 clinics (87 percent) had an environment conducive to providing medical services. Two clinic triage areas compromised patients' visual and auditory privacy (MIT 5.109).

- Clinical health care staff at 12 of the 14 applicable clinics (86 percent) ensured that reusable invasive and non-invasive medical equipment was properly sterilized or disinfected. At one clinic, inspectors determined that various equipment items designated as sterilized and ready for use were either not properly sterilized or not stored in properly sealed packaging, or the

sterilization packages were not date stamped. Nursing staff at a second clinic indicated they had no access to disinfectant wipes or cleaning supplies for exam tables (MIT 5.102).

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. The OIG did not score this question. When OIG inspectors interviewed the CEO, he identified one concern related to needed roof repairs for clinical areas. At the time of the inspection, the institution had a master infrastructure project budgeted and underway that included renovation of COR's existing clinics in Facilities 3A, 3B, 3C, 4A, and 4B, and the central health services building. The project was on track with completion dates targeted through August 2017. However, the CEO indicated new roofs, which were not included in the current budget, were needed to ensure renovated clinical areas were protected from contamination due to leaks.

The OIG followed up with the CDCR project director, who indicated that CDCR would move forward with the roof repairs once the additional scope and budget was approved (MIT 5.999).

Recommendation 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, TTAs, R&Rs, and inpatient units.

Recommendations for COR

The OIG recommends that COR develop local operating procedures that ensure the following:

- All clinical areas maintain a full complement of core medical equipment that includes a Snellen vision chart with a permanent distance marker, nebulizers with kits and tubing, glucometer, peak flow meter, and personal protective equipment; and all exam rooms have an exam table in the immediate area, an oto-ophthalmoscope, otoscope and tips, sharps container, biohazard waste receptacle, disposable paper for the exam table, and tongue depressors.
- Staff members regularly monitor medical equipment to ensure applicable equipment is in working order and currently calibrated, and torn or worn areas on vinyl-covered exam tables are repaired or the tables are replaced.
- In all exam settings, the room is arranged so that a patient can lie fully extended on the exam table, and clinicians have unimpeded access to the patient.
- Reusable invasive medical equipment is properly sterilized.

- Clinics are cleaned each day they are operational, and all floor surfaces, equipment, and environmental areas are regularly cleaned; all clinic restrooms have functioning sinks and are stocked with antiseptic hand soap and disposable paper towels, and staff have access to sinks and hand hygiene supplies.

INTER- AND INTRA-SYSTEM TRANSFERS

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(53.1%)

Overall Rating:
Inadequate

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 COR 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.

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*. The significantly low scores for the nurses' completion of the Initial Health Screening form (CDCR Form 7277) were a key factor; specifically, nurses did not answer many questions on the form or timely complete the assessment and disposition section of the form. This pattern of errors rendered the compliance score of *inadequate* the more appropriate overall rating.

Case Review Results

Clinicians reviewed 67 encounters relating to the *Inter- and Intra-System Transfers* indicator, including information from both the sending and the receiving institutions. These included 47 hospitalization events, each of which resulted in a transfer back to the institution. In general, the inter- and intra-system transfer processes at COR were *adequate*, with the majority of transferring inmates receiving timely continuity of health care services. The OIG identified 38 deficiencies, three of which were significant, all three in case 10. Seventeen of the deficiencies involved the process of scanning hospital discharge records into the eUHR without a provider's signature.

Transfers In

There were some deficiencies related to the process in place for appointment referrals for new arrivals transferring into COR from other CDCR institutions:

- In case 13, the patient arrived from another institution with a history of blood clots and was taking warfarin (blood thinner); the screening nurse did not refer the patient to the provider or to the warfarin clinic. Fortunately, another nurse made these referrals two days later. In addition, upon arrival at COR, the patient requested mental health services for feeling depressed due to recently received bad news. Neither nurse made a referral for mental health evaluation.

Transfers Out

The OIG found deficiencies for patients transferring out of COR. There were incomplete transfer records, and necessary medications and medical supplies were lacking as the patients transferred to another institution.

- In case 10, a provider evaluated a diabetic patient the day after he was seen in the TTA for reportedly feeling sick for four days. The provider noted that urgent complete blood count and chemistry labs from the previous day were not back. The provider failed to place a medical hold on the patient's transfer to another institution until lab results were reviewed. The provider also failed to address an elevated heart rate. This case is also discussed in the *Diagnostic Services*, *Emergency Services*, and *Quality of Provider Performance* indicators.

- In case 14, the transfer nurse did not provide the patient's tracheostomy supplies and latest MAR to the receiving institution.

- In case 16, the transfer nurse did not provide the patient's medications for transfer to the receiving institution per CCHCS policy requirement, and did not document the pending dietary consult on the patient's transfer information form.

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. At COR, hospital return patients were processed back into the institution by the TTA nurse, who appropriately reviewed the discharge medications and discharge recommendations for plan of care, and obtained physician orders to implement the plan of care. Most discharge summaries were appropriately received from community hospitals and scanned into the eUHR within acceptable time frames, but contained no evidence of review by a provider (this is also discussed in the *Health Information Management* indicator*).* The patients received follow-ups with a provider within appropriate time frames. This process worked well for the majority of hospitalization events.

Onsite Inspection

The nurse in the receiving and release (R&R) area was knowledgeable about current CCHCS transfer policies and processes. The clinical workspace was organized with adequate equipment for conducting physical screening examinations, and there was an Omnicell (electronic medication storage) providing necessary medications as needed. The TTA nurses assessed patients returning after hospitalization and followed appropriate processes for reconciling provider orders and medications, and follow-up appointments were timely processed.

Compliance Testing Results

The institution obtained an *inadequate* compliance score of 53.1 percent in the *Inter- and Intra-System Transfers* indicator, and has an opportunity for improvement in the four areas below:

- The OIG reviewed the Initial Health Screening forms (CDCR Form 7277) for 29 patients who transferred into COR from another CDCR institution to determine if nursing staff completed the assessment and disposition sections of the form on the same day staff completed an initial screening of the patient. Nursing staff properly completed the documents for only two of the patients sampled (7 percent). For the remaining 27 patients, the assessment and disposition sections of the form were completed one to four days late (MIT 6.002).

- Inspectors tested 20 patients who transferred out of COR to another CDCR institution to determine whether their scheduled specialty service appointments were listed on the Health Care Transfer Information form (CDCR Form 7371). Staff had identified the scheduled appointments on the transfer forms of only 7 of the 20 patients sampled (35 percent) (MIT 6.004).

- Among 30 sampled patients who transferred into COR from another CDCR institution, nursing staff completed an initial health screening assessment form on the same day of the patient's arrival for 15 (50 percent). For the 15 remaining patients, nursing staff neglected to answer one or more of the screening form questions on the patient's initial health screening form (MIT 6.001).

- Of 19 sampled patients who transferred into COR with an existing medication order, 14 (74 percent) received their medications without interruption upon arriving at COR. Five patients did not receive scheduled doses of one or more DOT medications (MIT 6.003).

The institution scored in the *proficient* range in the following area:

- COR scored 100 percent when the OIG tested six patients who transferred out of the institution during the onsite inspection to determine whether their transfer packages included the required medications and related documentation. Although nine inmates transferred out on the testing day, only six were prescribed medications (MIT 6.101).

Recommendations

No specific recommendations.

PHARMACY AND MEDICATION MANAGEMENT

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(59.1%)

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 prescribing provider, 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.* Case reviews focused on medication administration, while compliance reviewers considered medication administration as well as medication storage, pharmacy protocols, and other factors to arrive at a rating for this indicator. 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 evaluated *Pharmacy and Medication Management* as it relates to the quality of clinical care provided. In this indicator, the clinicians identified nine deficiencies, one of which was significant (case 20). The case review rating for *Pharmacy and Medication Management* was *adequate*.

New Prescriptions

In the majority of cases, patients received their medications timely and as prescribed. However, in two cases, prescriptions were not processed:

- In case 20, a provider diagnosed the patient with a Helicobacter pylori infection, which can cause stomach ulcers and cancer. The prescribed antibiotics were not filled.
- In case 26, a provider ordered ibuprofen for a patient with back pain, given as directly observed therapy (DOT). The medications were not given.

There was a delay in receiving medications:

- In case 21, the TTA staff evaluated a patient for coughing and a sore throat. A provider prescribed benzonatate (cough suppressant) and chlorpheniramine (allergy medication). The medications were not filled until seven days later.

Chronic Care Medication Continuity

COR performed well in delivering chronic care medications.

Intra-System and Intra-Facility Transfers and Medication Continuity

Medication continuity was maintained in the reviewed transfer cases.

Medication Administration

- In case 19, a provider prescribed lactulose (used as a laxative) as a keep-on-person (KOP) medication; however, the patient was receiving the medication as a DOT medication.
- In case 19, one MAR for cyclobenzaprine (muscle relaxant) was not found in the eUHR.
- In case 22, on four occasions, the patient refused anti-fungal and pain medications; nursing staff did not document the reason for his refusal, and did not complete a Refusal of Examination and/or Treatment form (CDCR Form 7225).
- In case 22, on another encounter, a nurse did not document whether communication occurred regarding medication refusal.
- In case 25, there was no nursing documentation of the patient taking levofloxacin (antibiotic) for a severe urinary tract infection.
- In case 26, the patient refused three consecutive doses of cephalexin (antibiotic), and nursing staff did not complete a referral to inform the provider of the refusal.

Onsite Inspection

At the time of the clinicians' onsite visit in May 2016, the staff had not yet implemented the new 2016 medication management policy. The medication nurses at one clinic stated that they had not received any training on the new policies. The medication nurses also stated that they did not report "near misses" as medication errors.

The OIG discussed the role of the nurse educator for the new medication management policies. The nurse educator indicated that this specific medication management policy was outside of his appointed areas on which to educate other staff, and the institution had not updated its local operating policy (LOP). He stated that once the LOP was updated, the staff training would occur.

Compliance Testing Results

The institution received an *inadequate* compliance score of 59.1 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 *inadequate* average score of 70 percent. The institution performed poorly in the following three areas:

- When the OIG sampled ten patients who were in transit to another institution and were temporarily laid over at COR, only five (50 percent) received their medications without interruption. For three patients, there was no evidence that the patient received one or more of his KOP medications; one of those patients also received the wrong dose of another KOP medication. One other patient did not receive all doses of his DOT medication; for another patient, there was inadequate evidence of whether or not he had refused a dose of his DOT medication (MIT 7.006).

- Clinical staff timely provided new and previously prescribed medications to only 17 of 30 sampled patients upon their return to the institution from a community hospital (57 percent). Identified deficiencies included the following (MIT 7.003):

    - Ten patients received their KOP or DOT discharge medications one to six days late.

    - There was no evidence that two patients received their KOP discharge medications at all.

    - One patient did not receive his DOT medication that was originally ordered for chronic neuropathic (nerve) pain, discontinued, then reordered by a COR provider.

    - Another patient only received a single dose of a medication that should have been administered four times daily; he did not receive the four required doses until two days later.

- The institution timely dispensed chronic care medications to 15 of 23 patients sampled (65 percent). Inspectors found the following deficiencies (MIT 7.001):

    - Three patients did not receive one month of their KOP medications during the OIG's three-month testing period.

    - Inspectors identified exceptions for three patients who were prescribed NA/DOT medications because the MAR date was blank, the MAR was not initialed by the nurse, or the nurse failed to include an explanation for the patient's refusal.

- One patient did not receive refills of two KOP medications; one was not received for one month, and the other, for two months. For one of the medications, nursing staff gave the patient an extra monthly supply of the medication only nine days after giving him the prior monthly supply.

- One other patient did not receive one month of his KOP medication during the OIG's three-month testing period, and inspectors were unable to determine if he received two doses of his insulin medication because the nurse failed to initial the MAR or initialed the MAR but did not indicate the dosage and location of injection.

The institution scored in the *proficient* range in the following two medication administration areas:

- Of the 30 sampled patients at COR who had transferred from one housing unit to another, 27 (90 percent) received their prescribed medications without interruption. Three patients did not receive their medication by the next dosing interval after the transfer occurred (MIT 7.005).

- The institution timely administered or delivered new medication orders to 26 of the 30 patients sampled (87 percent); three patients received their medication from one to seven days late. For one patient, MARs indicated he received a medication twice in one day; the two doses were administered by two different nurses (MIT 7.002).

Observed Medication Practices and Storage Controls

In this sub-indicator, the institution received an average score of 59 percent, scoring in the *inadequate* range in the following five tests:

- The OIG inspected 12 clinics and medication line storage locations and found that none of the them had a designated area to place used medications that required refrigeration for return to pharmacy, resulting in a score of zero. Additionally, the refrigerator temperature logs in the ASU clinic had three missing entries within the last 30 days, and the institution was not able to provide temperature logs for the previous two months (MIT 7.103).

- The OIG inspected 19 clinics and medication line storage locations. Non-narcotic medications that did not require refrigeration were properly stored at only eight locations (42 percent). Eleven locations lacked a designated area to store unused and partially used medication pending return to the pharmacy. At two of those locations, inspectors found discarded full packages of medications that clinical staff had placed in a bin labeled "For Incineration Only," rather than returning the medications to the pharmacy for processing; one of the medication packages still had the patient's full name on it. Other exceptions found at 2 of the 11 locations included medications, saline solution, and sterile water that were expired, and both internal and external medications stored together (MIT 7.102).

- The OIG interviewed nursing staff and inspected narcotics storage areas at 12 applicable locations to assess whether strong narcotics security controls existed; 8 of the 12 areas (67 percent) were adequately controlled. At four locations, nursing staff did not update the narcotics logbook when removing patients' medications from the narcotics locker and instead updated the logbook after the entire medication pass was completed. Also, the narcotics logbook was not counter-signed by two nursing staff at every shift change. Lastly, on the day of the inspection, a narcotics discrepancy was identified at one location; the OIG inspector reported the discrepancy to the supervising registered nurse (MIT 7.101).

- Nursing staff at only five of seven sampled medication preparation and administration locations (71 percent) followed proper hand hygiene contamination control protocols during the medication preparation and administration processes. At two locations, nursing staff failed to sanitize their hands during glove changes (MIT 7.104).

- Nursing staff followed appropriate administrative controls when distributing medications to patients at only five of seven applicable medication preparation and administrative locations, resulting in a score of 71 percent on this test. At one location, a nurse failed to visually confirm if a patient swallowed his medication. At another location, a licensed psychiatric technician did not crush and float medication per the providers' orders for two patients (MIT 7.106).

The institution scored in the *proficient* range on the following test:

- Nursing staff at all seven of the sampled medication preparation and administration locations employed appropriate administrative controls and protocols when preparing patients' medication (MIT 7.105).

Pharmacy Protocols

For this sub-indicator, the institution received an average score of 49 percent, comprised of scores received at the institution's main pharmacy. COR scored in the *inadequate* range with scores of zero on two of the three tests:

- The institution's main pharmacy did not properly store refrigerated or frozen medications. More specifically, the pharmacy did not have a verifiable process in place to properly segregate medications returned from clinical units for restocking and reuse (MIT 7.109).

- At the time of the inspection, COR was operating a licensed pharmacy without a licensed pharmacist in charge (PIC). Nursing staff investigated narcotics discrepancies in the absence of the PIC; however, there were no documents indicating discrepancies were referred to the appropriate committees (MIT 7.110).

- COR followed required medication error reporting protocols for only 13 of the 29 medication error reports and related monthly statistical reports reviewed (45 percent). The

pharmacist in charge completed the follow-up report for 11 of the medication error reports between 5 and 54 days late. For none of the five related monthly statistical reports was there evidence of timely submission to the Pharmacy and Therapeutics Committee or CCHCS's chief of pharmacy services (MIT 7.111).

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

- The institution's main pharmacy employed and followed general security, organization, and cleanliness management protocols (MIT 7.107).
- The main pharmacy at COR properly stored non-refrigerated medications (MIT 7.108).

Non-Scored Tests

- In addition to testing reported medication errors, OIG inspectors follow up on any significant medication errors found during the case reviews or compliance testing to determine whether the errors were properly identified and reported. The OIG provides those results for information purposes only; at COR, the OIG did not find any applicable medication errors subject to this test (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. Of the 60 applicable patients, 54 had possession of their rescue medication. Medical staff immediately issued or returned rescue medication to the six inmates who did not have their medication in their possession (MIT 7.999).

Recommendations

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
(68.6%)

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 received an *inadequate* compliance score of 68.6 percent in the *Preventive Services* indicator, receiving low scores in three of seven test areas:

- Although COR timely conducted annual tuberculosis (TB) screenings within the prior year for all 30 patients sampled, nursing staff conducted those screenings adequately for only 2 of those patients (7 percent). Nurses properly screened only 2 of the 15 patients classified as Code 22 (requiring a skin test in addition to screening of signs and symptoms); for 11 of the 15 Code 22 patient screenings, a licensed vocation nurse or psychiatric technician, rather than a registered nurse, public health nurse, or provider, read the test results. On two additional forms, the reviewer signatures were illegible, so it was impossible to confirm who read the tests. Inspectors also sampled 15 patients classified as Code 34 (those who had previously tested positive for TB and did not receive a skin test). For all patients, nursing staff did not complete the history section of the Tuberculin Testing/Evaluation Report (CDCR Form 7331) (MIT 9.003).

- Although COR conducted weekly or monthly monitoring of 17 sampled patients who received TB medications, the institution was in compliance for only nine of those patients (53 percent). Seven patients' required TB monitoring assessment forms were completed but were not timely scanned into their eUHR after each monitoring visit. For one other patient, the monthly monitoring form did not include his weight and weight change (MIT 9.002).

- The OIG sampled 15 patients at high risk for contracting the coccidioidomycosis infection (valley fever), identified as medically restricted and ineligible to reside at COR, to determine if the patients were transferred out of the institution within 60 days from the time they were determined ineligible. COR was compliant for 9 of the 15 patients sampled, scoring 60 percent (MIT 9.009):

- Two patients were transferred out of the institution 68 and 77 days after they had been identified as ineligible to reside there, meaning they were transferred out 8 and 17 days late.

- Two patients with previous medical holds on file who were released from the medical hold, and updated to outpatient and ready for transfer, did not transfer out of COR until 14 and 50 days later. CCHCS's current health care transfer policy does not address the window of time allowed to transfer a patient after release from a medical hold.

- As of July 1, 2016, two patients determined medically restricted and ineligible to reside at the institution were still housed at COR after they were identified as ineligible; one had been there for six months since the determination, and the other, ten months.

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

- COR scored 76 percent for timely administering TB medications to patients with TB. Of 17 patients sampled, 13 received all required doses of their medication during the three-month test period. Two patients missed one or more medication doses, one patient received a medication two days late, and the remaining patient received an extra dose and also missed the final dose of his medication (MIT 9.001).

The institution scored in the *proficient* range in the following three areas:

- The institution was compliant in offering annual influenza vaccinations to all 30 sampled patients for the most recent influenza season (MIT 9.004).

- The OIG tests whether the patients who suffered from a chronic care condition were offered vaccinations for influenza, pneumonia, and hepatitis. At COR, 15 of 16 patients sampled (94 percent) received all recommended vaccinations at the required interval. One patient had no record of ever being offered or receiving the recommended pneumonia vaccination (MIT 9.008).

- Twenty-seven of 30 patients sampled (90 percent) either had a normal colonoscopy within the last ten years or were offered a colorectal cancer screening within the previous 12 months. Two patients neither received a normal colonoscopy within ten years nor were offered the cancer screening in the prior 12 months; a third patient did not receive a repeat colonoscopy within five years, as ordered, after receiving an abnormal colonoscopy (MIT 9.005).

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 OHU, correctional treatment center (CTC), or other inpatient units are reported under the *Specialized Medical Housing* indicator. Nursing services provided in the triage and treatment area (TTA) or related to emergency medical responses are reported under *Emergency Services*.

Case Review Results

The OIG clinicians reviewed 243 outpatient nursing encounters and identified 56 deficiencies in the quality of nursing care, 12 of which were significant deficiencies. The minor deficiencies, although unlikely to cause patient harm, were in areas clearly established in CCHCS policy as requirements for nursing practice, and were, therefore, subject to monitoring and appropriate quality improvement strategies. The outpatient nursing services provided to patients at COR were *adequate*.

Nursing Sick Call Assessment and Documentation

Many nurses at COR appropriately assessed patient complaints and symptoms, and provided necessary interventions for patients presenting in the outpatient nurse clinics. However, several patterns of deficiencies were found related to inadequate nursing assessment, failure to implement appropriate interventions, and incomplete documentation. The following demonstrate the patterns of significant deficiencies identified in the sick call processes at COR:

In cases 19, 20, and 77, the sick call nurse referred the patient with medical symptoms to a provider without assessing the patient, as required by CCHCS policy.

- In case 17, the nurse did not conduct a face-to-face assessment on a patient requesting increased clozapine (antipsychotic medication) because auditory hallucinations were still troubling him. Although the nurse appropriately referred the patient to the psychiatrist, the nurse should have assessed the patient regarding the nature of the auditory hallucinations and potential need for urgent referral.

In cases 20, 34, and 36, the nurse failed to check blood pressures as ordered.

- In case 18, the provider ordered weekly blood pressure checks for two months. However, there were no blood pressure checks done in January and February 2016.

In cases 3, 18, 26, 39, 60, and 70, the nurse did not assess all of the patient's complaints as required by CCHCS policy.

- In case 59, the nurse did not assess the patient with chest pain on the same day the sick call form was reviewed. The nurse assessed the patient for hip and leg pain on the following day, but again failed to assess for chest pain.

Other significant deficiencies were found in the following encounters:

- In case 8, the nurse did not complete a physical assessment of a patient with painful urination and problems emptying his bladder. In addition, urine lab testing to check for urinary tract infection was not done. The nurse left the management of the patient to a provider appointment in about three weeks. This patient should have been referred sooner.

- In case 25, the patient submitted a sick call form for hip and nerve pain, and the nurse referred him for a routine provider appointment without a nursing assessment. Additionally, this patient missed clinic appointments with the nurse and another with the provider, as the patient did not have a clinic pass and was not called in for the appointment.

- In case 63, the nurse identified the removal of basal cell cancer growth two years previously, and failed to refer the patient to a provider for evaluation of a skin lesion in the same area. The patient was not seen by a provider until two months later at which time he was referred to dermatology for evaluation of the skin lesion.

Medication Administration

Medication administration was generally timely and reliable. Specific findings are discussed in the *Pharmacy and Medication Management* indicator.

Emergency Care

This is further discussed in the *Emergency Services* indicator.

Inter- and Intra-System Transfers

Although there were few major nursing issues found in the cases reviewed, various deficiencies in nursing services related to patients returning from hospital discharge, which are further discussed in the *Inter- and Intra-System Transfers* and *Diagnostic Services* indicators.

Specialized Medical Housing

See the *Specialized Medical Housing* indicator for specific findings.

Onsite Inspection

During the onsite visit in May 2016, the OIG clinicians found nurses in outpatient clinic settings at COR to be active participants in the primary care team morning huddles. The huddles started and ended on time, and were attended well in all clinics by the providers, sick call nurses, nurse case coordinators, medication line nurses, schedulers, and supervising nurses. Sick-call nurses facilitated morning report and discussions about currently hospitalized and newly-discharged patients, TTA visits, physician-on-call reports, mental health concerns, and any other issues related to current patient issues and the day's clinic. All staff members had the opportunity to participate in the team discussions.

During walking rounds, the outpatient nurse and LVN staff generally verbalized having no major barriers with initiating communication with providers, custody officers, and their immediate nursing supervisors regarding patient care needs and providing nursing services to patients. Although there were backlogs for provider visits in all clinics, there were no sick call nurse line backlogs. Nurses see approximately 8 to 14 patients daily for sick call and follow-up visits. Nurses also described the recently implemented process of scanning orders to pharmacy, which improved communication and timeliness of medication orders. However, although nurses reported less mandatory overtime hours, numerous nurses verbalized frustration about miscommunication issues between supervising nurses. The issue was discussed with the CNE, and the topic will be discussed with staff in the future.

Nursing supervisors reported that 214 inmates refused their annual TB skin tests in April 2016. Ongoing interventions were underway to screen, educate, and refer these inmates to providers. At the time of the onsite visit, nursing administrators were in the process of collecting data on the remaining uncompleted TB skin tests.

Recommendations

The OIG recommends improvement strategies to educate, monitor, and ensure that sick call nurses do the following:

- Conduct a face-to-face nursing assessment of every patient with a medical complaint.
- Conduct a focused subjective and objective nursing assessment that is based on both the patient's current complaints and his health history.

- Assess or address each medical complaint.
- Complete a focused physical assessment of each complaint.

QUALITY OF PROVIDER PERFORMANCE

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

Case Review Rating:
Inadequate
Compliance Score:
Not Applicable

Overall Rating:
Inadequate

Case Review Results

The OIG clinicians reviewed 313 medical provider encounters and identified 107 deficiencies in provider performance, 20 of which were significant. As a whole, COR provider performance was *inadequate*.

Assessment and Decision-Making

The following eight significant deficiencies in provider encounters demonstrated inadequate medical assessment and decision-making:

- In case 6, a provider evaluated a patient with known coronary artery disease and stent placement. The provider failed to prescribe daily aspirin and a statin (cholesterol-lowering medication), which placed the patient at risk for cardiovascular events. At another encounter, the same provider later prescribed aspirin, but inappropriately prescribed it as "as needed for pain," not as a daily preventive measure.

- In case 10, a provider evaluated a diabetic patient who reportedly was feeling sick and not taking his insulin. The provider ordered urgent blood tests. On the following day, a different provider evaluating the patient noted the lab results were not back. Without checking on those lab results, the provider inappropriately cleared the patient for transfer to another facility that same day. This placed the patient at risk of harm. The provider should have contacted diagnostic services directly to follow up on the results. The provider also failed to evaluate the patient's rapid heart rate of 115 beats per minute.

- In case 18, a provider reviewed a heart scan result, but failed to address a finding suggesting a previous myocardial infarction (heart attack). The provider should have assessed the patient's cardiovascular risk and started the patient on a statin. Based on the patient's history, examination results, and lab results, the patient had a 9.9 percent calculated ten-year risk of heart disease or stroke. This was an indication for treatment with a moderate-intensity statin.

- In case 20, the patient did not receive two of the antibiotics needed to treat stomach inflammation from an infection (Helicobacter). Also, during a follow-up visit for the infection, the provider failed to check the MAR to confirm that the antibiotics were filled. The failure to treat this condition placed the patient at risk for development of peptic ulcer disease and gastric cancer.

- In case 27, a nurse consulted a provider for the patient's critically high blood glucose (545 mg/dL), which can quickly lead to diabetic ketoacidosis and hyperosmolar state (life-threatening conditions). The provider should have had the patient follow up with a provider on the following day.

- In case 28, for a patient with prior colon cancer, the provider failed to address a lung nodule seen on a computed tomography (CT) scan.

- In case 31, the patient had a critically high blood glucose (477 mg/dL). When the nurse alerted the provider of the result, the provider failed to have the patient follow up for assessment of diabetes.

- In case 80, a provider failed to address the patient's tachycardia (fast heart rate) of 130 beats per minute. The patient was taking the atypical antipsychotic, olanzapine, which can cause tachycardia and other electrical heart problems (prolonged QTc interval and altered cardiac conduction), which could lead to fatal arrhythmias. The provider should have obtained an EKG and consulted with a psychiatrist.

The following minor deficiencies were also identified:

- In case 37, a paraplegic patient with liver cirrhosis and thrombocytopenia (low platelet count) had esophageal varices (enlarged fragile blood vessels) and erosive gastritis (bleeding stomach). The provider inappropriately prescribed a nonsteroidal anti-inflammatory drug (NSAID), naproxen. This medication further increased the risk of bleeding in this already high-risk patient. Fortunately, the medication was discontinued ten days later.

- In case 78, a lab showed an elevated white blood cell count suggestive of an infection. The providers did not address the abnormal lab result on the subsequent visit. This is also discussed in the *Specialized Medical Housing* indicator.

Emergency Care

Providers generally made appropriate triage decisions when patients presented emergently to the TTA, and generally were available for consultation with the TTA nursing staff. However, there was one significant deficiency in the TTA (case 26) and one minor deficiency (cases 18), both of which are further discussed in the *Emergency Services* indicator. The remaining minor deficiency was in case 29, which is discussed in the *Specialized Medical Housing* indicator.

- In case 26, the patient, who had a psychiatric disorder and history of swallowing foreign bodies requiring endoscopic retrieval, presented to the TTA complaining of severe abdominal pains after swallowing paper clips. A provider was consulted and ordered the patient admitted to the psychiatric unit for risk of self-harm. The provider should have obtained an abdominal x-ray. Furthermore, there was no provider progress note documenting an emergent event.

- In case 18, the provider evaluated the patient for left-sided chest pain and concluded that it was non-cardiac chest pain. However, the provider did not formulate a specific diagnosis for the chest pain or a clear treatment plan. The provider also failed to address an elevated blood pressure of 155/89 mmHg.

- In case 29, the patient with known cardiomyopathy (weak heart prone to failure) and coronary artery disease presented to the TTA with chest pain. The provider failed to order an EKG for a possible acute cardiovascular event.

Hospital Return

COR providers did not properly review and sign several hospital discharge summaries, so it was impossible to know if the providers reviewed them and addressed all recommendations. The OIG found two significant deficiencies:

- In case 23, a patient with an arm Streptococcal cellulitis (skin infection) and abscess was admitted to a community hospital for surgical care and antibiotics. The hospital consultant advised intravenous antibiotics for seven days, followed by oral antibiotics for an additional seven days. However, the provider mistakenly prescribed both antibiotics together for seven days. This placed the patient at risk for harm.

- In case 28, a patient returned from hospitalization after surgery for a hip fracture and elbow laceration. The hospital consultant advised an antibiotic for a wound infection. The provider prescribed an ineffectively low dose of the antibiotic.

The following deficiency was also identified:

- In case 6, the patient had a negative heart scan stress test during a hospitalization, and was scheduled for another stress test a month later. The provider failed to provide an indication for the repeat procedure. This unnecessary procedure, which carries a small risk of serious harm from the test itself, placed the patient at unwarranted risk of harm.

Chronic Care

COR providers performed poorly in managing chronic medical conditions and in providing continuity of care for chronic patients. Diabetic care displayed five significant deficiencies:

- In case 30, there were two significant deficiencies. For this patient with well-controlled diabetes, the provider inappropriately discontinued all regular insulin before meals. Subsequently, his blood glucose readings were elevated. Two weeks later, a different provider saw the patient and failed to recognize that the discontinuation of pre-meal regular insulin had contributed to the poor glucose control. Three weeks later, the patient was seen again by the provider with an elevated average fasting glucose. The provider failed to adjust his insulin. The continuity of care was poor with five different providers managing this patient's diabetes.

- In case 31, the patient had poorly controlled diabetes with high average fasting glucose. During three months of the OIG record review, the providers evaluated the patient four times, each time failing to recognize and manage the poorly controlled diabetes. After four months, a provider acknowledged the poor glycemic control and increased basal insulin. However, the provider failed to have the patient follow up in a timely manner for further insulin adjustment.

- In case 32, there were two significant deficiencies: one in the diagnosis of diabetes, and one in its treatment. It took almost three months for the patient with elevated blood glucose to receive treatment and a new diagnosis of diabetes. When the provider finally diagnosed the diabetes, the average glucose was extremely high (HbA1c of 12.9%). The provider also failed to start the patient on insulin treatment, which is the recommended treatment for patients at this high level.

Hypertension and elevated cholesterol were also poorly managed, with two significant deficiencies:

- In case 18, the patient had poorly controlled hypertension with elevated blood pressures on seven of his last eight provider encounters. The provider failed to adjust his blood pressure medications. Uncontrolled hypertension and untreated high cholesterol placed the patient at risk for cardiovascular events.

- In case 29, the patient had an acute esophageal variceal bleed (enlarged fragile blood vessel) requiring emergent surgical band placement and a blood transfusion. The gastroenterologist recommended adjusting the patient's beta-blocker medication to target blood pressure and heart rate goals to lower the risk of bleeding. However, the providers did not acknowledge or address the recommendations. Subsequently, the patient had a pulmonary embolism and required anticoagulation with a blood thinner for three months. This further increased the risk of bleeding from inadequately managed esophageal varices. During these three months, on nine occasions, the providers documented a blood pressure that was higher than advised by the gastroenterologist and guidelines.

The following minor deficiencies were also identified:

- In case 17, the provider ordered blood pressure checks twice weekly for four weeks. The blood pressure log showed elevated blood pressure on all readings. The same provider evaluated the patient later, but failed to address the elevated blood pressure readings.

- In case 27, a provider reviewed the patient's recent lab results but failed to address the elevated cholesterol. Based on the patient's age and diabetic condition, the provider should have prescribed a statin.

- In case 32, the diabetic patient had an elevated triglyceride level due to poor diabetes control. The provider inappropriately prescribed gemfibrozil for treatment. Gemfibrozil was not indicated for treatment of mild to moderate hypertriglyceridemia, as the medication has the risk of side effects such as pancreatitis. Thus, the provider placed the patient at unnecessary risk. Based on the patient's age and diagnosis of diabetes, the provider should have prescribed a statin instead.

The OIG clinicians also identified the following deficiencies in provider chronic care delivery:

- In case 8, the patient had a seizure and a low level of phenytoin (anti-seizure medication). The provider should have increased the phenytoin dose and rechecked the level. The provider failed to do this; two weeks later, the patient had another seizure and an inappropriately low medication level.

- In case 18, a provider saw the patient for chronic care, and then cancelled a future chronic care appointment. However, the provider did not assess any of the patient's chronic diagnoses of hypertension, asthma, chronic back pain, renal cystic mass, and a rotator cuff tear. The provider also failed to address the patient's elevated blood pressure.

- In case 29, the provider excessively increased the warfarin (blood thinner) by 40 percent (INR level of 1.6). This placed the patient at risk of over anticoagulation and bleeding, especially in this high-risk patient who had had a recent esophageal variceal bleed that required a blood transfusion and surgical placement of bands on the varices.

Specialty Services

COR providers generally referred patients appropriately and reviewed the specialty reports timely; however, not all the reports were properly reviewed and signed by the providers, and the providers failed to address all recommendations. One significant deficiency was identified:

- In case 33, a provider referred the patient to optometry. The optometrist suspected glaucoma and macular arterial occlusion (blocked blood flow to the eye), and recommended an ophthalmology referral for further evaluation. The provider, however, failed to address the optometrist's recommendation on subsequent visits.

The following minor deficiencies were also identified:

- In case 18, an orthopedic surgeon evaluated the patient after performing rotator cuff repair and advised physical therapy as soon as possible. The patient's provider failed to address the surgeon's recommendation on the subsequent visit. Four weeks later, the orthopedic surgeon evaluated the patient and documented "it is imperative that patient begin therapy as soon as possible." The physical therapy was delayed by one month.

- In case 29, a gastroenterologist recommended a liver ultrasound with ultrasound of the blood vessels and a lab for a tumor marker alpha-fetoprotein every six months. The providers did not acknowledge these recommendations on subsequent visits with the patient.

- In case 51, a nephrologist recommended discontinuing fludrocortisone (steroid), which had contributed to the patient's leg swelling. On the follow-up visit, a provider documented "recommendations are being followed" and inappropriately prescribed fludrocortisone for three months.

Health Information Management

The providers generally documented outpatient, TTA, and CTC encounters on the day they occurred. Most progress notes were dictated and legible.

Onsite Inspection

At the time of the OIG clinicians' onsite inspection in May 2016, there were four mid-level providers, including three nurse practitioners, one of whom was only recently hired, and a physician assistant; there were five physicians, including one telemedicine physician. There were two provider vacancies. One of the five physicians was on administrative leave. Continuity of care was poor, and there was a backlog of 495 appointments for the three main yard clinics. To reduce the backlog, mid-level providers from nearby facilities were seeing COR patients on the weekends.

The chief medical executive (CME) position was not filled. The chief physician and surgeon (CP&S) was acting as both CME and CP&S. The CP&S supervised the mid-level providers and performed annual evaluations for all the providers. The providers met weekly for training and

discussion of pain management cases. The morning huddles were productive, led by providers and attended by nurses, the care coordinator, custody staff, and an office technician. They discussed significant TTA encounters and hospital returns that occurred the previous day.

Conclusion

With the high number and severity of the deficiencies in provider performance, the OIG rated the *Quality of Provider Performance* indicator *inadequate*.

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. COR's specialized medical housing units are the correctional treatment center (CTC) and the outpatient housing unit (OHU).

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(70.0%)

Overall Rating:
Inadequate

Case Review Results

At the time of the OIG's inspection, the CTC at California State Prison, Corcoran, contained 50 beds and its OHU contained 14 beds. The OIG reviewed 151 provider encounters in the CTC and OHU and identified 41 deficiencies, three of which were significant. The patients in the CTC were more complex than those housed in the OHU, and had the majority of deficiencies. There were 91 nursing events reviewed with 21 deficiencies identified, eight of which were significant. The OIG clinicians rated this indicator *inadequate.*

Provider Performance

The provider performance was inadequate. There were deficiencies in addressing hospital and specialist recommendations and managing acute medical conditions. These deficiencies are also described in the *Quality of Provider Performance* indicator:

- In case 8, the patient returned from a local emergency department after management of a seizure. The cause of the seizure was a low medication level of phenytoin (anti-seizure medication). The provider failed to increase the patient's regular phenytoin dose and recheck the level. Two weeks later, the patient had another seizure episode as the medication had not been adjusted.

- In case 23, the patient with a skin infection and abscess was admitted to a community hospital for surgical care and antibiotics. The hospital consultant recommended giving intravenous antibiotics for seven days, then oral antibiotics for another seven days. However, the CTC provider mistakenly prescribed both antibiotics together for seven days. The provider failed to provide the recommended 14 days of antibiotic coverage, which placed the patient at risk of harm.

- In case 24, the patient was in the CTC for treatment of cellulitis and abscesses in both arms. The CTC provider did not complete a discharge summary.

- In case 28, the patient returned from a hospitalization after surgery for a hip fracture and an elbow laceration. The hospital-recommended antibiotic was inappropriately lowered to an inadequate dose for treating wound infections.

- Also in case 28, for this patient with prior colon cancer, the provider failed to address a lung nodule seen on a CT scan. Subsequently, an oncologist noted the abnormal finding. The provider, again, failed to note on follow-up visits the abnormal lung nodule the oncologist identified.

- In case 29, the patient had an acute esophageal variceal (enlarged fragile blood vessel) bleed requiring emergency surgical band placement and blood transfusion. The provider failed to follow the gastroenterologist's recommended medication adjustments to lower the risk of bleeding.

- In addition, in case 29, the patient required anticoagulation. The provider excessively increased the warfarin (blood thinner) on one encounter, and placed this very high-risk patient at further risk of over anticoagulation and bleeding.

- In case 33, on two encounters, the provider progress note lacked a signature.

- In case 37, a paraplegic patient with liver cirrhosis and thrombocytopenia (low platelet count) was residing in the CTC. An endoscopy showed esophageal varices and erosive gastritis (bleeding from the stomach). A provider inappropriately prescribed the nonsteroidal anti-inflammatory drug naproxen. This placed the patient at much higher risk for gastrointestinal bleeding. Fortunately, the medication was discontinued ten days later.

- In case 78, a provider did not address a very fast heart rate (140 beats per minute) and an elevated blood pressure. During another encounter, a different provider did not address a lab with an elevated white blood cell count suggestive of a possible infection.

- In case 80, the medical provider failed to record a progress note documenting the patient encounter for a spider bite.

Nursing Performance

Nursing care in the CTC was inadequate. There were several patterns of deficiencies that placed patients at risk of serious harm. First, nursing staff often did not timely contact the providers or notify higher-level nursing staff when acute situations occurred. Nurses also did not implement a nursing care plan or develop a comprehensive care plan that included the patient's significant medical problems.

- In case 2, the patient had difficulty breathing and congestion that required repositioning and suctioning. The nursing staff did not recheck his markedly abnormal vital signs for more than two hours. In addition, the nurse failed to notify the medical provider for several hours

that the patient required transfer to a community hospital intensive care unit for aspiration pneumonia.

- In case 9, the nurses failed to initiate a care plan upon the patient's admission to the CTC.
- In case 11, the nurse did not administer insulin as ordered for the patient with a high blood glucose level. The nurse also failed to document the reason for holding the insulin and whether the provider was contacted about the elevated blood glucose. On another occasion, the patient vomited material suggestive of blood twice within three hours. However, the nurse did not test for blood and failed to contact the provider urgently. The provider was not aware of the vomiting until seven hours later. Subsequently, the patient was admitted to a community hospital for a gastrointestinal bleed requiring a blood transfusion.
- In case 21, the patient's blood pressure was 156/100 mmHg upon discharge from the CTC. The nurse did not recheck the blood pressure and failed to notify a provider of the elevated blood pressure.
- In case 78, the patient had a decubitus ulcer (bedsore) on his hip upon his admission to the CTC. Two weeks later, the nurses documented a new bedsore on his back, but failed to initiate a care plan to prevent further skin breakdown. On another occasion, the nurse did not notify a provider regarding the patient's low blood pressure. The nurse also failed to recheck his blood pressure. Another nurse failed to adequately assess the patient when he was close to an expected death from cancer. At that time, the nurse inappropriately administered medication by mouth, even though other nurses had documented the patient lacked a gag reflex. This placed the patient at risk of choking.
- In case 80, the licensed psychiatric technician (LPT) assessed and documented a possible skin infection on the patient's leg. However, the LPT did not contact the nurse regarding the need for nursing assessment of the wound.

Onsite Inspection

The CTC had 50 medical beds, 24 of which were occupied during the OIG's onsite visit. There were two negative pressure rooms (designed to minimize the spread of airborne infections). A physician and a mid-level provider were assigned as the primary providers for COR's specialized medical housing, and other providers were also involved in patient care. During the OIG's onsite visit, the nurse instructor discussed plans to review expectations and methodology for developing nursing care plans with the CTC nursing staff.

Conclusion

The OIG clinicians found specialized medical housing *inadequate*, mainly due to poor provider performance in the CTC. Patients admitted to the CTC were acutely ill and required continuous and effective provider care. The continuity of care was poor, as multiple providers were involved and there was poor communication among the providers assigned to the CTC. Some hospital discharge summaries and specialty reports were not properly reviewed by the providers, and their recommendations and diagnoses were not addressed by the providers. The nursing care plans were often incomplete, and nurses often failed to update them based on the patient's changing condition and care needs. The nurse educator verified that CTC nursing staff had not received any recent formal training on documentation of nursing care plans.

Compliance Testing Results

The institution received an *inadequate* compliance score of 70.0 percent in the *Specialized Medical Housing* indicator, which focused on the institution's CTC and OHU. The institution received an *inadequate* score in the following areas:

- Providers completed their Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes at required intervals (three-day interval for the CTC, 14-day interval for the OHU) for only 5 of the 13 sampled patients (38 percent). For six patients admitted to the CTC, some providers' notes were one or two days late or not completed; for two patients admitted to the OHU, some providers' notes were two to ten days late or not completed (MIT 13.004).

- Inspectors tested the working order of COR's OHU and CTC patient room call buttons. They were all in good working condition. According to staff interviewed who regularly worked in the specialized housing units, during an emergent event, custody staff and clinicians were able to expeditiously access and enter a patient's locked room when an emergent event occurred. However, staff did not provide a daily log for call light testing as required for the OHU, resulting in a score of 50 percent (MIT 13.101).

The institution scored in the *adequate* range in the following two areas:

- Providers completed a history and physical (H&P) within 72 hours of admission for 10 of the 13 sampled patients (77 percent). For one patient admitted to the CTC and two patients admitted to the OHU, no evidence was found in the eUHR that an H&P was completed at all (MIT 13.003).

- COR physicians evaluated 11 of the 13 sampled patients within 24 hours of admission (85 percent); one CTC patient's evaluation occurred one day late, and there was no evidence that one OHU patient's evaluation occurred at all (MIT 13.002).

COR received a *proficient* score in the following area:

- For all 13 patients sampled, nursing staff timely completed an initial assessment on the day the patient was admitted to specialized housing (MIT 13.001).

Recommendations

No specific recommendations.

SPECIALTY SERVICES

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(64.2%)

Overall Rating:
Inadequate

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

Case Review Results

The OIG clinicians reviewed 99 events related to S*pecialty Services*. There were 41 deficiencies, eight of which were significant deficiencies. Examples of three significant deficiencies are discussed below. These related to the retrieving of specialty reports and the scheduling of specialty appointments. The case review rating for *Specialty Services* was *inadequate.*

Provider Performance

Case review showed that providers generally referred patients to specialists appropriately. The providers addressed specialists' recommendations, except on four occasions. These episodes are discussed further in the indicator *Quality of Provider Performance*.

Specialty Access

For two patients, specialty services follow-up appointments did not occur timely. These are also discussed in the *Access to Care* indicator.

- In case 28, the patient returned from hospitalization after repairs of a hip fracture. The orthopedic surgeon recommended a follow-up in two weeks, but the follow-up occurred six weeks later.
- In case 36, the patient had diabetic retinopathy and macular edema. The ophthalmologist injected aflibercept (a medication to lower the risk of bleeding in the eye). Important follow-up visits and repeat treatments at two weeks and four weeks were delayed until ten weeks later.

Health Information Management

The OIG identified 24 specialty reports not properly reviewed and signed by the providers prior to being scanning into the eUHR. The OIG also identified eight specialty reports that were not retrieved or scanned into the eUHR:

- In case 28, an oncology consultation report was not retrieved or scanned into the eUHR, even after a provider requested the report be retrieved.

Onsite Inspection

At the time of the OIG inspection, there was one nurse recently assigned to offsite specialty services for the most recent three months. The nurse scheduled specialty appointments, retrieved and reviewed specialty reports, and made the necessary orders and referrals. A tracking process had been recently established to ensure that patients received their appointments. As only one nurse was familiar with these work processes, there was concern about adequate continuity of services in the event of any future absence of this nurse.

Conclusion

The OIG clinicians rated the *Specialty Services* indicator at COR *inadequate* because the missing specialty reports and the delay of specialty appointments hindered patient care.

Compliance Testing Results

The institution received an *inadequate* compliance score of 64.2 percent in the *Specialty Services* indicator. COR scored in the *inadequate* range in the following test areas:

- Providers received and reviewed only 3 of the 14 sampled specialists' reports for patients who received a routine specialty service (21 percent). Providers reviewed five specialty services reports from one to 23 days late; for five patients, there was no evidence the provider reviewed the report results at all. For the remaining patient, the provider's review was delayed because the report was received four days late (MIT 14.004).

- Providers timely received and reviewed the specialists' reports for only 6 of 12 sampled patients who received a high-priority specialty service (50 percent). For three patients, there was no evidence the provider reviewed the report results at all. Providers reviewed two specialty services reports two and four days late. For one remaining patient, the provider's review was delayed because the report was received seven days late (MIT 14.002).

- When patients are approved or scheduled for specialty service appointments at one institution and then transfer to another institution, policy requires that the receiving institution timely schedule and hold the patient's appointment. Eleven of the 20 patients sampled who transferred to COR with an approved specialty service appointment (55 percent) received it within the required time frame. Four patients received their specialty

service appointment from 8 to 79 days late, and there was no evidence that a specialty service appointment occurred at all for five patients (MIT 14.005).

- The institution timely denied providers' specialty service requests for 12 of 20 patients sampled (60 percent). Eight of the specialty services requests were denied from one to 26 days late (MIT 14.006).

- Eleven of 15 sampled patients' high-priority specialty service appointments (73 percent) occurred within 14 calendar days of the provider's order. Three patients received their appointment from 2 to 16 days late, and there was no evidence that another patient received the specialty service at all (MIT 14.001).

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

- COR provided routine specialty service appointments to all 15 patients tested within the required time frame (MIT 14.003).

- Among 19 patients sampled who had a specialty service denied by COR's health care management, 17 (89 percent) received timely notification of the denied service, including the provider meeting with the patient within 30 days to discuss alternate treatment strategies. One patient met with another provider, who did not discuss the denial. Another patient was offered an appointment to discuss the denial two days late; the patient refused the appointment (MIT 14.007).

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 does not score several questions. Instead, the OIG presents the findings for informational purposes only. For example, the OIG describes certain local processes in place at COR.

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 COR 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 both *inadequate*. The test questions used to assess compliance for each indicator are detailed in *Appendix A.*

INTERNAL MONITORING, QUALITY IMPROVEMENT, AND ADMINISTRATIVE OPERATIONS

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(65.8%)

Overall Rating:
Inadequate

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 within the *inadequate* range in this indicator, receiving a compliance score of 65.8 percent, showing need for improvement in the following three areas:

- The OIG reviewed documentation for 12 emergency medical response incidents addressed by the institution's Emergency Medical Response Review Committee (EMRRC) during the prior six-month period and found that the required EMRRC Event Checklist forms were not fully completed for any of them. The "Clinical Review" portions, evaluating such areas as the appropriateness of clinical decisions, method of transporting, and adherence to nursing protocol and TTA procedures, were left blank. As a result, COR received a score of zero on this test (MIT 15.007).

- Emergency response drill packages for three medical emergency response drills conducted in the prior quarter did not include required documentation; none of the three drill packages contained a Crime/Incident Report (CDCR Form 837). As a result, COR received a score of zero on this test (MIT 15.101).

- COR improved or reached targeted performance objectives for only one of the five quality improvement initiatives identified in its 2015 Performance Improvement Work Plan, resulting in a score of 20 percent. For the other four initiatives, the work plan did not include sufficient progress information to demonstrate that the institution either improved or reached the targeted level for each of its performance objectives (MIT 15.005).

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

- The OIG reviewed data from the institution to determine if COR timely processed at least 95 percent of its monthly inmate medical appeals during the 12-month period ending January 2016. For each of the first ten months of that 12-month period, COR timely processed all of its medical appeals (83 percent). For December 2015 and January 2016, the institution reported that 6 percent and 11 percent of its appeals were overdue (MIT 15.001).

With scores of 100 percent in all but one, the institution performed at the *proficient* level in the following test areas:

- The institution's Quality Management Committee (QMC) met monthly, evaluated program performance, and took action when staff identified improvement opportunities (MIT 15.003). COR also took adequate steps to ensure the accuracy of its Dashboard data reporting (MIT 15.004).

- COR's local governing body (LGB) met quarterly during the most recent 12-month period, and all meeting minutes provided a detailed narrative of the LGB's general management and planning of patient health care (MIT 15.006).

- Inspectors sampled ten second-level medical appeals; the institution's responses addressed all of the patients' appealed issues (MIT 15.102).

- Medical staff promptly submitted the Initial Inmate Death Report (CDCR Form 7229A) to CCHCS's Death Review Unit for eight of the nine cases tested that occurred at COR in the prior 12-month period (89 percent); the remaining report was less than three hours late (MIT 15.103).

Other Information Obtained from Non-Scored Areas

- The OIG gathered non-scored data regarding the completion of death review reports. CCHCS's Death Review Committee timely completed its death review summary for only one of the nine inmate deaths that occurred during the testing period. For any inmate deaths that occurred prior to November 1, 2015, the CCHCS Death Review Committee (DRC) was required to complete a death review summary within 30 business days of the death and submit it to the institution's chief executive officer (CEO) five business days later. The DRC completed seven summary reports between 9 and 70 days late (54 to 115 calendar days after the death); the DRC did not timely submit any of those summary results to the institution's CEO. For an expected death of an inmate that occurred after November 1, 2015, the DRC is required to complete a death review summary within 30 calendar days and submit it to the CEO seven calendar days later. For the only death that occurred after November 1, 2015, the DRC completed its review 22 days late, or 52 calendar days after the death; the CEO was notified of the results 16 days later (MIT 15.996).

- Inspectors met with the institution's CEO to inquire about COR's protocols for tracking appeals. The health care appeals coordinator provided weekly appeals summary reports to the chief support executive (CSE), who provided the reports to the appropriate management staff. The reports addressed statistics on appeals filed and their status, overdue appeals, and appealed issues listed by category and (clinic) location. Management discussed issues at the Quality Management Committee meetings, and evaluated trends and followed-up on issues. According to management at COR, the appeals primarily related to inmate disagreements with treatment, staff, and referrals (MIT 15.997).

- Non-scored data regarding the institution's practices for implementing local operating procedures (LOPs) indicated that the institution had an effective process in place for revising existing LOPs and developing new ones. When new or revised policies and procedures were received from CCHCS, the health program specialist (HPS) distributed them to appropriate management or the Quality Management sub-committee. Once drafted, the new or revised LOPs were finalized and approved at the QMC and subsequently signed by the warden. Following approval, the LOPs were provided to the administrative assistant/public information officer, who scanned them and posted them to COR's shared network so all staff could access them. Also, healthcare staff were trained as needed. At the time of the OIG's inspection in March 2016, COR had implemented, or was developing, 43 of the 49 stakeholder-recommended LOPs (88 percent) (MIT 15.998).

The OIG discusses the institution's health care staffing resources in the *About the Institution* section of this report (MIT 15.999).

Recommendations

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:
Inadequate
(64.6%)

Overall Rating:
Inadequate

Compliance Testing Results

The institution received an *inadequate* compliance score of 64.6 percent in the *Job Performance, Training, Licensing, and Certifications* indicator. The following four areas displayed opportunities for improvement:

- The OIG inspected records from January 2016 for five nurses, to determine if their nursing supervisors properly completed monthly performance reviews. Although the supervisor discussed the results of the monthly reviews with the subordinate nurse, for all five nurses the supervisor did not complete the required number of reviews. As a result, COR scored zero on this test (MIT 16.101).

- None of the institution's six providers who required a structured clinical performance appraisal appropriately received one. Inspectors found the following deficiencies (MIT 16.103):

  - None of the six providers received timely appraisals. Four had never received an annual performance appraisal, while two others received an appraisal two months late and over four years late.

  - Four providers' most recent performance appraisal package lacked a 360-Degree evaluation.

  - Three providers' performance appraisal packages lacked required Unit Health Record Clinical Appraisals.

  - One provider did not receive a Core Competency-Based Evaluation.

- The OIG tested provider, nursing, and custody staff records to determine if the institution ensured that those staff members had current emergency response certifications. The institution's provider and nursing staff were compliant, but custody managers were not. While the California Penal Code exempts custody managers who primarily perform managerial duties from medical emergency response certification training, CCHCS policy

does not allow for such an exemption. As a result, the institution received a score of 67 percent in this inspection area (MIT 16.104).

- Seven of the ten nurses sampled (70 percent) were current with their clinical competency validations; three nurses did not receive a clinical competency validation within the required time frame (MIT 16.102).

COR received an *adequate* score on the following test:

- The OIG reviewed the currency of professional licenses and certifications for five categories of staff, including nursing staff and the pharmacist in charge (PIC). While all nursing staff were current with their professional licenses and certification requirements, the acting PIC was not. As a result, the institution received a score of 80 percent on this test. The pharmacist in charge (PIC) position was vacant from March 1, 2016, until April 12, 2016. The CEO was the acting PIC, but he did not possess a professional license or certification (MIT 16.105).

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

- All providers were current with their professional licenses (MIT 16.001).
- The institution's pharmacy and providers who prescribed controlled substances were current with their Drug Enforcement Agency registrations (MIT 16.106).
- All nursing staff hired within the last year timely received new employee orientation training (MIT 16.107).

Recommendations

No specific recommendations.

POPULATION-BASED METRICS

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

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

Methodology

For population-based metrics, the OIG used a subset of HEDIS measures applicable to the CDCR patient population. Selection of the measures was based on the availability, reliability, and feasibility of the data required for performing the measurement. The OIG collected data utilizing various information sources, including the 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 California State Prison, Corcoran, nine HEDIS measures were selected and are listed in the following *COR 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. COR outperformed all other entities in three of the five diabetic measures selected, but scored lower than some of the other entities in blood pressure control and conducting required dilated eye exams for diabetic patients.

When compared statewide, COR outperformed Medi-Cal in all five diabetic measures. The institution also outperformed Kaiser Permanente in three of the five measures, scoring lower than Kaiser, both North and South regions, in diabetic blood pressure control, and lower than Kaiser South for diabetic eye exams. When compared nationally, COR outperformed Medicaid, Medicare, and commercial health plans (based on data obtained from health maintenance organizations) in each of the five diabetic measures. COR outperformed or closely matched the U.S. Department of Veterans Affairs (VA) in all applicable measures except diabetic eye exams, for which it scored 13 percentage points lower than the VA. However, inspectors noted that 9 percent of COR's sampled patients were offered the eye exams but refused the offers; these refusals adversely affected the institution's score in this measure.

Immunizations

Comparative data for immunizations was only fully available for the VA and partially available for Kaiser, commercial plans, and Medicare. With respect to administering influenza shots to younger adults, COR's score was lower than that of each of the other entities that reported data; however, for influenza shots to older adults, the institution scored higher than both Medicare and the VA. With regard to administering pneumococcal vaccines to older adults, COR scored higher than Medicare but lower than the VA. For all three immunization measures, COR routinely offered patients these preventive services but many of them refused the offers; these refusals significantly affected COR's immunization scores.

Cancer Screening

Comparative data for colorectal cancer screening was available for Kaiser, commercial entities, Medicare, and the VA. COR scored lower than all those entities in this measure, but similar to the immunization measures, patient refusals significantly affected the institution's score. Specifically, 30 percent of COR's patients sampled were timely offered the cancer screening but refused it.

Summary

The population-based metrics performance of California State Prison, Corcoran, reflects an adequate chronic care program. For diabetic patient dilated eye exams and all immunization measures, the institution has an opportunity to improve its scores by placing an emphasis on educating patients regarding their refusals of these preventive services.

COR Results Compared to State and National HEDIS Scores

Clinical Measures	California				National			
	COR Cycle 4 Results[1]	HEDIS Medi-Cal 2015[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%**	86%	95%	94%	86%	91%	93%	99%
Poor HbA1c Control (>9.0%) [6,7]	**12%**	39%	18%	24%	44%	31%	25%	19%
HbA1c Control (<8.0%) [6]	**79%**	49%	70%	62%	47%	58%	65%	-
Blood Pressure Control (<140/90)	**77%**	63%	84%	85%	62%	65%	65%	78%
Eye Exams	**77%**	53%	69%	81%	54%	56%	69%	90%
Immunizations								
Influenza Shots - Adults (18–64)	**44%**	-	54%	55%	-	50%	-	58%
Influenza Shots - Adults (65+)	**77%**	-	-	-	-	-	72%	76%
Immunizations: Pneumococcal	**82%**	-	-	-	-	-	70%	93%
Cancer Screening								
Colorectal Cancer Screening	**63%**	-	80%	82%	-	64%	67%	82%

1. Unless otherwise stated, data was collected in February 2016 by reviewing medical records from a sample of COR'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 *2015 HEDIS Aggregate Report for Medi-Cal Managed Care*.
3. Data was obtained from Kaiser Permanente November 2015 reports for the Northern and Southern California regions.
4. National HEDIS data for Medicaid, commercial plans, and Medicare was obtained from the 2015 *State of Health Care Quality Report*, available on the NCQA website: www.ncqa.org. The results for commercial plans were based on data received from various health maintenance organizations.
5. The Department of Veterans Affairs (VA) data was obtained from the VA's website, www.va.gov. For the Immunizations: Pneumococcal measure only, the data was obtained from the *VHA Facility Quality and Safety Report - Fiscal Year 2012 Data*.
6. For this indicator, the entire applicable COR population was tested.
7. For this measure only, a lower score is better. For Kaiser, the OIG derived the Poor HbA1c Control indicator using the reported data for the <9.0% HbA1c control indicator.

APPENDIX A — COMPLIANCE TEST RESULTS

California State Prison, Corcoran Range of Summary Scores: 53.12% - 70.17%	
Indicator	**Compliance Score (Yes %)**
Access to Care	68.94%
Diagnostic Services	69.14%
Emergency Services	Not Applicable
Health Information Management (Medical Records)	65.79%
Health Care Environment	70.17%
Inter- and Intra-System Transfers	53.12%
Pharmacy and Medication Management	59.06%
Prenatal and Post-Delivery Services	Not Applicable
Preventive Services	68.55%
Quality of Nursing Performance	Not Applicable
Quality of Provider Performance	Not Applicable
Reception Center Arrivals	Not Applicable
Specialized Medical Housing (OHU, CTC, SNF, Hospice)	70.00%
Specialty Services	64.18%
Internal Monitoring, Quality Improvement, and Administrative Operations	65.80%
Job Performance, Training, Licensing, and Certifications	64.58%

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?	21	9	30	70.00%	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?	6	19	25	24.00%	5
1.003	**Clinical appointments:** Did a registered nurse review the inmate-patient's request for service the same day it was received?	34	11	45	75.56%	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?	44	1	45	97.78%	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	6	21	71.43%	24
1.006	**Sick call follow-up appointments:** If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified?	2	3	5	40.00%	40
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?	23	7	30	76.67%	0
1.008	**Specialty service follow-up appointments:** Do specialty service primary care physician follow-up visits occur within required time frames?	13	7	20	65.00%	10
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:					**68.94%**	

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?	4	6	10	40.00%	0
2.003	**Radiology:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	9	1	10	90.00%	0
2.004	**Laboratory:** Was the laboratory service provided within the time frame specified in the provider's order?	9	1	10	90.00%	0
2.005	**Laboratory:** Did the primary care provider review and initial the diagnostic report within specified time frames?	9	1	10	90.00%	0
2.006	**Laboratory:** Did the primary care provider communicate the results of the diagnostic study to the 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?	10	0	10	100.00%	0
2.008	**Pathology:** Did the primary care provider review and initial the diagnostic report within specified time frames?	2	8	10	20.00%	0
2.009	**Pathology:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	2	7	9	22.22%	1
Overall percentage:					**69.14%**	

Emergency Services	Scored Answers
Assesses reaction times and responses to emergency situations. The OIG RN clinicians will use detailed information obtained from the institution's incident packages to perform focused case reviews.	**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?	4	3	7	57.14%	0
4.003	Are specialty documents scanned into the eUHR within the required time frame?	20	0	20	100.00%	0
4.004	Are community hospital discharge documents scanned into the eUHR within three calendar days of the inmate-patient date of hospital discharge?	17	3	20	85.00%	0
4.005	Are medication administration records (MARs) scanned into the eUHR within the required time frames?	18	2	20	90.00%	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?	20	12	32	62.50%	0
4.008	**For inmate-patients discharged from a community hospital:** Did the preliminary hospital discharge report include key elements and did a provider review the report within three calendar days of discharge?	11	19	30	36.67%	0
Overall percentage:					**65.79%**	

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?	14	1	15	93.33%	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?	12	2	14	85.71%	1
5.103	**Infection Control:** Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	11	4	15	73.33%	0
5.104	**Infection control:** Does clinical health care staff adhere to universal hand hygiene precautions?	12	3	15	80.00%	0
5.105	**Infection control:** Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	12	3	15	80.00%	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?	13	1	14	92.86%	1
5.108	**Clinical areas:** Do clinic common areas and exam rooms have essential core medical equipment and supplies?	4	11	15	26.67%	0
5.109	**Clinical areas:** Do clinic common areas have an adequate environment conducive to providing medical services?	13	2	15	86.67%	0
5.110	**Clinical areas:** Do clinic exam rooms have an adequate environment conducive to providing medical services?	8	7	15	53.33%	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?	0	13	13	0.00%	2
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:					**70.17%**	

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?	15	15	30	50.00%	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?	2	27	29	6.90%	1
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?	14	5	19	73.68%	11
6.004	**For inmate-patients transferred out of the facility:** Were scheduled specialty service appointments identified on the Health Care Transfer Information Form 7371?	7	13	20	35.00%	0
6.101	**For inmate-patients transferred out of the facility:** Do medication transfer packages include required medications along with the corresponding Medication Administration Record (MAR) and Medication Reconciliation?	6	0	6	100.00%	3
Overall percentage:					**53.12%**	

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?	15	8	23	65.22%	7
7.002	Did health care staff administer or deliver new order prescription medications to the inmate-patient within the required time frames?	26	4	30	86.67%	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?	17	13	30	56.67%	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?	27	3	30	90.00%	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?	5	5	10	50.00%	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?	8	4	12	66.67%	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?	8	11	19	42.11%	2
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	12	12	0.00%	9
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	2	7	71.43%	14
7.105	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when preparing medications for inmate-patients?	7	0	7	100.00%	14
7.106	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when distributing medications to inmate-patients?	5	2	7	71.43%	14
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?	0	1	1	0.00%	0
7.110	**Pharmacy:** Does the institution's pharmacy properly account for narcotic medications?	0	1	1	0.00%	0
7.111	**Pharmacy:** Does the institution follow key medication error reporting protocols?	13	16	29	44.83%	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:						**59.06%**

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?	13	4	17	76.47%	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?	9	8	17	52.94%	0
9.003	**Annual TB Screening:** Was the inmate-patient screened for TB within the last year?	2	28	30	6.67%	0
9.004	Were all inmate-patients offered an influenza vaccination for the most recent influenza season?	30	0	30	100.00%	0
9.005	**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?	15	1	16	93.75%	14
9.009	Are inmate-patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	9	6	15	60.00%	0
Overall percentage:					**68.55%**	

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?	13	0	13	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?	11	2	13	84.62%	0
13.003	**For OHU, CTC, & SNF only:** Was a written history and physical examination completed within 72 hours of admission?	10	3	13	76.92%	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?	5	8	13	38.46%	0
13.101	**For OHU and CTC Only:** Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter inmate-patient's cells?	1	1	2	50.00%	0
Overall percentage:					**70.00%**	

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 provider order?	11	4	15	73.33%	0
14.002	Did the provider review the high priority specialty service consultant report within the required time frame?	6	6	12	50.00%	3
14.003	Did the inmate-patient receive the routine specialty service within 90 calendar days of the provider order?	15	0	15	100.00%	0
14.004	Did the provider review the routine specialty service consultant report within the required time frame?	3	11	14	21.43%	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?	11	9	20	55.00%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	12	8	20	60.00%	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?	17	2	19	89.47%	1
Overall percentage:					**64.18%**	

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?	10	2	12	83.33%	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)?	1	4	5	20.00%	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?	4	0	4	100.00%	0
15.007	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	0	12	12	0.00%	0
15.101	Did the institution complete a medical emergency response drill for each watch and include participation of health care and custody staff during the most recent full quarter?	0	3	3	0.00%	0
15.102	Did the institution's second level medical appeal response address all of the inmate-patient's appealed issues?	10	0	10	100.00%	0
15.103	Did the institution's medical staff review and submit the initial inmate death report to the Death Review Unit in a timely manner?	8	1	9	88.89%	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:					**65.80%**	

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?	16	0	16	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?	7	3	10	70.00%	0
16.103	Are structured clinical performance appraisals completed timely?	0	6	6	0.00%	1
16.104	Are staff current with required medical emergency response certifications?	2	1	3	66.67%	0
16.105	Are nursing staff and the pharmacist in charge current with their professional licenses and certifications?	4	1	5	80.00%	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:					**64.58%**	

APPENDIX B — CLINICAL DATA

Table B-1: COR Sample Sets	
Sample Set	**Total**
Anticoagulation	3
Death Review/Sentinel Events	4
Diabetes	3
Emergency Services – CPR	4
Emergency Services – Non-CPR	5
High Risk	5
Hospitalization	5
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	40
Specialty Services	5
	80

Table B-2: COR Chronic Care Diagnoses	
Diagnosis	**Total**
Anemia	1
Anticoagulation	3
Arthritis/Degenerative Joint Disease	7
Asthma	19
COPD	6
Cancer	6
Cardiovascular Disease	15
Chronic Kidney Disease	3
Chronic Pain	31
Cirrhosis/End-Stage Liver Disease	4
Coccidioidomycosis	1
DVT/PE	1
Deep Vein Thrombosis/Pulmonary Embolism	4
Diabetes	18
Diagnosis	16
Gastroesophageal Reflux Disease	13
Gastrointestinal Bleed	1
Hepatitis C	29
Hyperlipidemia	13
Hypertension	41
Mental Health	21
Migraine Headaches	1
Seizure Disorder	8
Sleep Apnea	1
Thyroid Disease	1
	264

Table B-3: COR Event — Program	
Program	**Total**
Diagnostic Services	152
Emergency Care	51
Hospitalization	69
Intra-System Transfers In	12
Intra-System Transfers Out	6
Not Specified	8
Outpatient Care	519
Specialized Medical Housing	312
Specialty Services	102
	1,231

Table B-4: COR Case Review Sample Summary	
	Total
MD Reviews, Detailed	30
MD Reviews, Focused	0
RN Reviews, Detailed	17
RN Reviews, Focused	50
Total Reviews	97
Total Unique Cases	80
Overlapping Reviews (MD & RN)	17

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

California State Prison, Corcoran			
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 (30)	OIG Q: 6.001	• See ***Intra-system Transfers***
MITs 1.003-006	Nursing Sick Call (5 per clinic) (45)	MedSATS	• Clinic (each clinic tested) • Appointment date (2–9 months) • **Randomize**
MIT 1.007	Returns from Community Hospital (30)	OIG Q: 4.008	• See ***Health Information Management (Medical Records)*** (returns from community hospital)
MIT 1.008	Specialty Services Follow-up (30)	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	(7)	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	(20)	OIG Q: 4.008	• Community hospital discharge documents • First 20 IPs selected
MIT 4.005	(20)	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 (30)	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 5.101-105 MIT 5.107-111	Clinical Areas (15)	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 (9)	OIG inspector onsite review	• R&R IP transfers with medication

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Pharmacy and Medication Management			
MIT 7.001	Chronic Care Medication (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 (30)	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 (10)	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 (varies by test)	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 (29)	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 (60)	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 samples)	Data Source	Filters
Preventive Services			
MITs 9.001–002	TB Medications (17)	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) (15)	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 samples)	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	CTC (10) OHU (3)	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 CTC/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 (20)	InterQual	• Review date (3–9 months) • **Randomize**
	(0)	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • **Randomize**

Quality Indicator	Sample Category (number of samples)	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) (5)	Institution PIWP	• PIWP with updates (12 months) • Medical initiatives
MIT 15.006	LGB (4)	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 (9)	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.996	Death Review Committee (9)	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 (16)	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 (7)	OIG Q:16.001	• All required performance evaluation documents
MIT 16.104	Medical Emergency Response Certifications (all)	Onsite certification tracking logs	• All staff o Providers (ACLS) o Nursing (BLS/CPR) o 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

November 14, 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 California State Prison, Corcoran (COR) 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,

for

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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Roy Wesley, Chief Deputy Inspector General, OIG
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