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Office of the Inspector General

Richard J. Donovan Correctional Facility Medical Inspection Results Cycle 4

January 2017

Fairness ◆ Integrity ◆ Respect ◆ Service ◆ Transparency

Office of the Inspector General
RICHARD J. DONOVAN CORRECTIONAL FACILITY
Medical Inspection Results
Cycle 4

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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 Richard J. Donovan Correctional Facility (RJD).

The OIG performed its Cycle 4 medical inspection at RJD from June to August 2016. The inspection included in-depth reviews of 66 inmate-patient files conducted by clinicians, as well as reviews of documents from 420 inmate-patient files, covering 93 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 RJD 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 RJD was ***adequate***.

Health Care Quality Indicators

Fourteen Primary Indicators (Clinical)	All Institutions–Applicability	RJD 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**	**RJD Applicability**
15–Internal Monitoring, Quality Improvement, and Administrative Operations	All institutions	Compliance only
16–Job Performance, Training, Licensing, and Certifications	All institutions	Compliance only

Overall Assessment: Adequate

Overall Assessment Rating:

Adequate

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

Clinical Case Review and OIG Clinician Inspection Results

The clinicians' case reviews sampled patients with high medical needs and included a review of 2,117 patient care events.[1] Of the 12 primary indicators applicable to RJD, 10 were evaluated by clinician case review; one was *proficient*, five were *adequate*, and four were *inadequate*. When determining the overall adequacy of care, the OIG paid particular attention to the clinical nursing and provider quality indicators, as adequate health care staff can sometimes overcome suboptimal processes and programs. However, the opposite is not true; inadequate health care staff cannot provide adequate care, even though the established processes and programs onsite may be adequate. The OIG clinicians identify inadequate medical care based on the risk of significant harm to the patient, not the actual outcome.

Program Strengths — Clinical

- Strong medical leadership at RJD was evident, and this was voiced by the medical providers.
- The daily provider morning report meetings and morning huddles in the clinics were informative, pertinent, and effective in relaying necessary information.
- The pharmacy staff effectively managed the anticoagulation clinic, which allowed providers more time for other medical issues and care.
- Continuous quality improvement in RJD's emergency medical response reviews and transfer process was evidenced by RJD's own recognition of problems with these processes and its implementation of solutions.
- The orientation to correctional medicine at RJD for new providers was comprehensive.

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

Program Weaknesses — Clinical

- Emergency services at RJD were inadequate due to poor nursing assessment and documentation.
- Health information management at RJD was inadequate, mainly due to delays in the retrieval and review of hospital, specialty, and diagnostic reports.
- The inter- and intra-system transfer processes at RJD were inadequate.
- Pharmacy and medication management at RJD was inadequate.
- Nursing performance was subpar as it related to specialized medical housing.
- The quality of provider performance was only borderline adequate. Providers sometimes conducted poor review of medical records and used legacy, "cloned," progress notes, which resulted in patients' conditions being incorrectly described in progress notes.

Compliance Testing Results

Of the 14 health care indicators applicable to RJD, 11 were evaluated by compliance inspectors.[2] There were 93 individual compliance questions within those 11 indicators, generating 1,335 data points that tested RJD's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[3] Those 93 questions are detailed in *Appendix A — Compliance Test Results*. The institution's inspection scores in the 11 applicable indicators ranged from 58.3 percent to 92.0 percent, with the secondary (administrative) indicator *Internal Monitoring, Quality Improvement, and Administrative Operations* receiving the lowest score, and the primary indicator *Specialized Medical Housing (OHU, CTC, SNF, Hospice)* receiving the highest. Of the nine primary indicators applicable to compliance testing, the OIG rated three *proficient*, three *adequate,* and three *inadequate.* Of the two secondary indicators, which involve administrative health care functions, both were rated *inadequate*.

[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.

Program Strengths — Compliance

As the *RJD Executive Summary Table* on page *viii* indicates, the institution's compliance ratings were *proficient*, scoring above 85 percent, in the following three primary indicators: *Access to Care*, *Diagnostic Services*, and *Specialized Medical Housing (OHU, CTC, SNF, and Hospice)*. The following are some of RJD'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 reviewed patients' requests and completed face-to-face visits with patients. Both nurse-requested and provider-ordered follow-up appointments were timely.
- Upon discharge from a community hospital, patients received timely follow-up appointments.
- Patients received their radiology, laboratory, and pathology services timely. In addition, providers timely reviewed the diagnostic reports related to radiology and laboratory services and communicated those results to patients.
- Health records staff timely scanned specialty reports into patients' electronic medical records.
- Clinical areas were appropriately disinfected, cleaned, and sanitized. Clinical staff properly controlled exposure to blood-borne pathogens and contaminated waste in health care areas. Clinical staff properly sterilized or disinfected reusable invasive and non-invasive medical equipment.
- Patients received from other institutions had a nurse complete the assessment and disposition section of the Initial Health Screening form (CDCR Form 7277), were referred to the TTA if required, and were assessed the day of their arrival.
- Nursing staff timely administered or delivered newly ordered medications to patients and employed appropriate administrative controls and protocols when preparing medications.
- In its main pharmacy, RJD followed general security, organization, and cleanliness management protocols; properly stored and monitored refrigerated, frozen, and non-refrigerated medications; and properly accounted for narcotic medications.
- RJD timely offered colorectal cancer screenings and influenza vaccinations.
- Nurses timely completed initial patient assessments in the correctional treatment center (CTC), and providers timely evaluated patients upon admission and completed a history and physical exam within 72 hours.

- The institution's specialized medical housing unit had properly working call buttons, and medical staff could timely access and enter patient cells during emergent events.
- Providers timely reviewed high-priority and routine specialty services reports.
- When providers' requests for specialty services were denied, the denials occurred within the required time frame.

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

- The institution promptly processed inmate medical appeals and addressed all of the patients' appealed issues in second-level medical appeals.
- Providers, nursing staff, and the pharmacist in charge were current with their professional licenses; the pharmacy and authorized providers who prescribed controlled substances maintained current Drug Enforcement Agency registrations.
- Medical staff timely reviewed and submitted initial inmate death reports to the CCHCS Death Review Unit.

Program Weaknesses — Compliance

The institution received ratings of *inadequate*, scoring below 75 percent, in the following three primary indicators: *Health Information Management*, *Pharmacy and Medication Management*, and *Preventive Services*. The institution also received an *inadequate* score in both of the two secondary indicators, *Internal Monitoring, Quality Improvement, and Administrative Operations* and *Job Performance, Training, Licensing, and Certifications*. The following are some of the weaknesses identified by RJD's compliance scores on individual questions in all the primary health care indicators:

- Providers did not conduct timely appointments with patients who had been referred by nursing staff following their transfer to RJD from other institutions.
- Providers routinely failed to communicate pathology results to their patients within required time frames.
- Health information management staff did not always properly label documents scanned into patients' electronic health records.
- Clinical staff did not follow universal hand hygiene protocols before or after patient encounters or during medication preparation and administration.
- Most clinics lacked essential medical equipment and supplies.

- For many patients, including those who suffered with chronic care conditions and those who were en route to other CDCR institutions, nursing staff did not timely deliver or administer prescribed medications.
- The institution's clinic and medication line locations did not employ strong medication security controls over narcotic medications. RJD also did not properly store non-narcotic medications, or employ appropriate administrative controls and protocols when distributing medications to patients.
- Patients at RJD did not always timely receive their tuberculosis medications, and the institution's monthly monitoring of these patients was poor. In addition, RJD was subpar in performing annual tuberculosis screenings.
- Providers in RJD's CTC did not always complete subjective, objective, assessment, plan, and education (SOAPE) notes on patients at the required intervals.
- Patients who arrived at RJD from other institutions with pending specialty services appointments did not always receive their appointments within the required time frame.
- Providers did not always timely inform patients of denied requests for specialty services.

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

- Nursing supervisors did not timely conduct periodic reviews of nurses or ensure those passing medications were current on their competency evaluations.
- The institution's Emergency Medical Response Review Committee meeting minutes did not always include all required documentation about discussed incidents.
- The institution did not ensure that recently hired nurses timely completed new employee orientation training.

The *RJD 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.

RJD Executive Summary Table

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

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

Secondary Indicators (Administrative)	Case Review Rating	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, RJD performed well as measured by population-based metrics. In four of the five comprehensive diabetes care measures, RJD outperformed other State and national organizations, including 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). Only for diabetic eye exams did RJD's score was lower than Kaiser's (South region) and the VA's.

With regard to immunization measures, RJD's rates were mixed. RJD outperformed all statewide and national health management organizations for administering influenza vaccinations for younger adults. However, the institution did not perform as well with regard to administering influenza vaccines for older adults when compared to Medicare and the VA, but a high rate of patient refusals negatively affected the institution's score. With regard to administering pneumococcal vaccines to older adults, RJD scored higher than Medicare but lower than the VA. RJD's rates for colorectal cancer screening were better than those of all other reporting entities.

Overall, RJD's performance demonstrated by the population-based metrics indicated that the chronic care program was above average in regard to diabetes care and colorectal cancer screenings. Immunizations were average; however, the institution may improve by making interventions to educate patients to reduce 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.

Richard J. Donovan Correctional Facility (RJD) was the 32nd 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 2 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

Richard J. Donovan Correctional Facility (RJD) is named for the late Assemblyman and Judge Richard J. Donovan, who sponsored legislation to build a State prison facility in Southern California. The facility opened in July 1987. RJD is designated an "intermediate care prison"; these institutions are located in predominantly urban areas close to tertiary care centers and specialty care providers for the most cost-effective care. The facility consists of a correctional treatment center (CTC), general population housing, and special needs yard (SNY) housing. Along with multiple clinics that daily handle non-urgent requests for medical services, RJD has a treatment and triage area (TTA, or standby emergency room) to provide urgent care.

On August 5, 2016, RJD received national accreditation from the Commission on Accreditation for Corrections. The 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, RJD's vacancy rate among medical managers, providers, nursing supervisors, and non-supervisory nurses was 3 percent in May 2016, with the highest vacancy percentages among nursing supervisors. As indicated in the following table, RJD had 144.6 budgeted health care positions, of which 140.5 were filled. Based on its authorized and filled positions, the institution reported 4.1 vacant positions. Lastly, the CEO reported that in May 2016, there were four staff members under CDCR disciplinary review, one of whom was redirected to a non-patient-care setting.

RJD Health Care Staffing Resources as of May 2016

	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff		Totals	
Description	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Authorized Positions	5	3%	12.5	9%	12.5	9%	114.6	79%	144.6	100%
Filled Positions	4	80%	12	96%	11.5	92%	113	99%	140.5	97%
Vacancies	1	20%	0.5	4%	1	8%	1.6	1%	4.1	3%
Recent Hires (Within 12 Months)	0	0%	5	42%	3	26%	53	47%	61	43%
Staff Utilized from Registry	0	0%	0	0%	0	0%	0	0%	0	0%
Redirected Staff (to Non-Patient Care Areas)	0	0%	0	0%	0	0%	1	1%	1	1%
Staff on Long-Term Medical Leave	0	0%	0	0%	0	0%	2	2%	2	1%

Note: RJD's Health Care Staffing Resources data was not validated by the OIG.

As of May 27, 2016, the Master Registry for RJD showed that the institution had a total population of 3,126. Within that total population, 17.4 percent were designated as high medical risk, Priority 1 (High 1), and 19.8 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 laboratory reports 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 are. 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.

RJD Master Registry Data as of May 27, 2016

Medical Risk Level	# of Inmate-Patients	Percentage
High 1	545	17.43%
High 2	618	19.77%
Medium	1,518	48.56%
Low	445	14.24%
Total	**3,126**	**100.00%**

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 RJD, 14 of the quality indicators were applicable, consisting of 12 primary clinical indicators and 2 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 chief executive officer of health care services and requests a status report. Additionally, if the OIG learns of significant departures from community standards, it may report such departures to the institution's chief executive officer or to CCHCS. Because these matters involve confidential medical information protected by State and federal privacy laws, specific identifying details related to any such cases are not included in the OIG's public report.

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

CASE REVIEWS

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

PATIENT SELECTION FOR RETROSPECTIVE CASE REVIEWS

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

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

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

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

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

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

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

BENEFITS AND LIMITATIONS OF TARGETED SUBPOPULATION REVIEW

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

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

Nonetheless, the health care system's response to this subpopulation can be accurately evaluated and yields valuable systems information. In the above example, if the health care system is

providing appropriate diabetic monitoring, medication therapy, and specialty referrals for the high-risk patients reviewed, then it can be reasonably inferred that the health care system is also providing appropriate diabetic services to the entire diabetic subpopulation. However, if these same high-risk patients needing monitoring, medications, and referrals are generally not getting those services, it is likely that the health care system is not providing appropriate diabetic services to the greater diabetic subpopulation.

CASE REVIEWS SAMPLED

As indicated in *Appendix B, Table B–1: RJD Sample Sets*, the OIG clinicians evaluated medical charts for 66 unique inmate-patients. *Appendix B, Table B–4: RJD Case Review Sample Summary* clarifies that both nurses and physicians reviewed charts for 19 of those patients, for 85 reviews in total. Physicians performed detailed reviews of 30 charts, and nurses performed detailed reviews of 19 charts, totaling 49 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 36 inmate-patients. These generated 2,117 clinical events for review (*Appendix B, Table B–3: RJD 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: RJD Sample Sets*), the 66 unique inmate-patients sampled included patients with 299 chronic care diagnoses. This includes 26 additional patients with diabetes (for a total of 29) and two additional anticoagulation patients (for a total of five) (*Appendix B, Table B–2: RJD Chronic Care Diagnoses*). The OIG's sample selection tool allowed evaluation of many chronic care programs because the complex and high-risk patients selected from the different categories often had multiple medical problems. While the OIG did not evaluate every chronic disease or health care staff member, the overall operation of the institution's system and staff were assessed for adequacy. The OIG's case review methodology and sample 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 *RJD 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 June to August 2016, deputy inspectors general and registered nurses attained answers to 93 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 420 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 June 13, 2016, field inspectors conducted a detailed onsite inspection of RJD's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,335 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 RJD'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*, *Emergency Services*, *Health Information Management (Medical Records)*, *Health Care Environment*, *Inter- and Intra-System Transfers*, *Pharmacy and Medication Management*, *Preventive Services*, *Specialized Medical Housing (OHY, CTC, CNF, 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 93 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 unable to be compared. 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 RJD, the OIG reviewed some of the compliance testing results, randomly sampled additional inmate-patients' records, and obtained RJD 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 RJD. Of those 12 indicators, 7 were rated by both the case review and compliance components of the inspection, 3 were rated by the case review component alone, and 2 were rated by the compliance component alone.

The *RJD Executive Summary Table* on page *viii* 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 RJD. Of these ten indicators, OIG clinicians rated one *proficient*, five *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 was *proficient*, 24 were *adequate*, and 6 were *inadequate*. In the 2,117 events reviewed, there were 840 deficiencies, of which 68 were considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

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

There were no adverse event/events identified in the case reviews at RJD.

Summary of Compliance Results: The compliance component assessed 9 of the 12 primary (clinical) indicators applicable to RJD. Of these nine indicators, OIG inspectors rated three *proficient*, three *adequate*, and three *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:
Proficient
Compliance Score:
Proficient
(89.5%)

Overall Rating:
Proficient

Case Review Results

The OIG clinicians reviewed 1,313 provider and nurse encounters and identified 27 deficiencies relating to *Access to Care*. The majority of deficiencies were due to provider follow-up appointments not occurring as ordered and provider follow-up visits after specialty appointments not occurring in a timely manner. The only significant deficiency in this indicator occurred when a newly transferred patient was not seen by a provider in the requested time frame (case 37).

Provider-to-Provider Follow-up Appointments

Provider-ordered follow-up appointments did not occur in the time frame ordered in in five cases.

Nurse Sick Call Access

RJD nurses performed well in addressing sick calls in a timely manner.

Nurse-to-Provider Referrals

Nurse-requested provider follow-up appointments did not occur timely in three cases.

Provider Follow-up After Specialty Services

Provider follow-up appointments after specialty services did not occur timely in six cases.

Intra-System Transfers

- In case 37, a nurse ordered a newly transferred patient with multiple medical problems to be seen in 14 days; he was not seen by a provider for almost three months. This case is discussed further in the *Inter- and Intra-System Transfers* indicator.

Follow-up After Hospitalization

Provider follow-up appointments generally occurred in a timely manner.

Urgent/Emergent Care

Follow-up appointments after urgent or emergent care did not occur timely in three cases.

Specialized Medical Housing

RJD provided patients sufficient access to providers in the correctional treatment center (CTC).

Specialty Access

Access to specialty services is discussed in the *Specialty Services* indicator.

Clinician Summary

RJD performed well with regard to *Access to Care*, so the case review rating was *proficient*.

Compliance Testing Results

The institution received a *proficient* compliance score of 89.5 percent in the *Access to Care* indicator, and scored in the *proficient* range in the following test areas:

- Nursing staff reviewed all 30 sampled health care services request on the same day they were received (MIT 1.003). In addition, nursing staff completed a face-to-face encounter within one business day of reviewing the request for 29 patients (97 percent). The only exception was when a health care services request indicated that a nursing protocol was completed, but it was not located in the eUHR (MIT 1.004).

- Inmates had access to health care services requests at all six housing units inspected (MIT 1.101).

- The OIG tested 30 patients discharged from a community hospital to determine if they received a provider follow-up appointment at RJD within five calendar days of their return to the institution, or earlier if a TTA provider ordered the appointment to occur sooner. Of 30 patients, 28 (93 percent) received a timely provider follow-up appointment. One patient received his follow-up appointment four days late, and another patient refused his follow-up appointment, but it was offered six days late (MIT 1.007).

- Among 12 health care services requests for which nursing staff referred the patient for a provider appointment, 11 patients (92 percent) received timely appointments. One patient received his provider appointment one day late (MIT 1.005). Out of those 12 provider appointments, providers ordered five of the patients to return for a follow-up visit. All five

patients received their follow-up appointments within the provider's ordered time frame (MIT 1.006).

- Inspectors sampled 30 patients who received a specialty service, and found 27 of them (90 percent) received or timely refused a provider follow-up appointment. Three patients received their follow-up appointments from one to 30 days late (MIT 1.008).

RJD performed in the *adequate* range on the following test:

- Routine appointments were timely for 33 of the 40 sampled patients with chronic conditions (83 percent). One patient received his follow-up appointments 11 days late, while four others' were from four months to over one year late. Two patients did not receive a follow-up appointment at all (MIT 1.001).

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

- Primary care provider visits occurred timely for 15 of the 29 sampled patients who transferred into RJD with a pre-existing chronic care provider visit or who, upon arrival, received a new provider referral from the RJD screening nurse (52 percent). Provider visits were from 5 to 44 days late for 13 patients. While one patient refused his provider appointment, it was offered 19 days late (MIT 1.002).

Recommendations

No specific recommendations.

DIAGNOSTIC SERVICES

Case Review Rating:
Adequate
Compliance Score:
Proficient
(88.4%)

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 primary care provider timely reviewed the results, and whether the results were communicated to the inmate-patient within the required time frames. In addition, for pathology services, the OIG determines whether the institution received a final pathology report and whether the provider timely reviewed and communicated the pathology results to the patient. The case reviews also factor in the appropriateness, accuracy, and quality of the diagnostic tests ordered and the clinical response to the results.

In this indicator, the OIG's case review and compliance review processes yielded different results, with case review giving an *adequate* rating and the compliance testing resulting in a *proficient* score. The OIG's internal review process considered those factors that led to both results and ultimately rated this indicator *adequate*. The key factor warranting the lower overall rating was that case review identified a number of missing diagnostic reports in the health record and reports that were not reviewed in a timely manner, which did not support an overall indicator rating higher than *adequate*.

Case Review Results

The OIG clinicians reviewed 338 diagnostic events and found 57 deficiencies, of which 3 were significant. The majority of the deficiencies related to health information management, such as diagnostic reports missing from the health records and diagnostic reports that providers did not properly review and sign in a timely manner. Other deficiencies included diagnostic tests not being performed in the time frame ordered. The following examples are provided for quality improvement purposes:

- In five cases, laboratory results were not retrieved and scanned into the eUHR.
- In eight cases, x-ray reports were not retrieved and scanned into the eUHR.
- In nine cases, providers did not review and sign laboratory reports in a timely manner.

In ten cases, laboratory tests were not completed as ordered. The following three cases contained significant deficiencies that increased the risk of harm to patients.

- In case 8, laboratory results indicating a possible intestinal bleed were not addressed in a timely manner.

- In case 32, an immediate urine test was ordered, but it was not collected until the following day.

- In case 36, clinical staff did not draw laboratory tests to monitor kidney function as ordered for this patient, who had just been discharged from the hospital with a diagnosis of acute kidney injury. The order was for the laboratory tests to be drawn in one to two days, but they were not drawn until one month later, after they were reordered.

Clinician Summary

The vast majority of deficiencies were unlikely to contribute to patient harm. When RJD transitions to the new electronic medical record system in 2017, the number of these deficiencies will likely dramatically decrease. RJD's performance was satisfactory with regard to diagnostic services, and the indicator rating was thus *adequate*.

Compliance Testing Results

The institution received a *proficient* compliance score of 88.4 percent in the *Diagnostic Services* indicator, which encompasses radiology, laboratory, and pathology services. For clarity, each type of diagnostic service is discussed separately, below:

Radiology Services

- All ten of the radiology services sampled were timely performed (MIT 2.001). RJD providers initialed and dated the radiology reports and communicated the results within the required time frame for nine of those patients (90 percent). The provider reviewed the radiology report and communicated the results to one patient one day late (MIT 2.002, 2.003).

Laboratory Services

- RJD performed nine of ten laboratory services sampled within the required time frame (90 percent). For one patient, the laboratory service was provided three days late (MIT 2.004). The institution's providers initialed and dated the laboratory reports and communicated the results within the required time frame for nine of ten sampled patients (90 percent). A provider reviewed and communicated the laboratory results to one patient one day late (MIT 2.005, 2.006).

Pathology Services

- The institution timely received a final pathology report for nine of ten patients sampled (90 percent). For one patient, the institution never received a pathology report (MIT 2.007). Further, for the nine samples where the institution received a final report, providers timely reviewed the results for eight of them (89 percent). For one patient, the OIG could find no evidence in the eUHR that a provider reviewed the pathology report (MIT 2.008). Also, six

of the nine patients for whom the institution received a final pathology report (67 percent) had their pathology results communicated to them by a provider within the required time frame. Providers communicated results to two patients 8 and 14 days late, while another patient never received his result (MIT 2.009).

Recommendation

The OIG recommends that RJD review flow processes to improve the timeliness of diagnostic reports being performed, reviewed, signed by primary care providers, and scanned into patients' charts.

EMERGENCY SERVICES

Case Review Rating:
Inadequate
Compliance Score:
Not Applicable

Overall Rating:
Inadequate

An emergency medical response system is essential to providing effective and timely emergency medical response, assessment, treatment, and transportation 24 hours per day. Provision of urgent/emergent care is based on 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 114 urgent/emergent events and found 94 deficiencies, the majority of which related to nursing performance. There were marked problems with initiation of BLS and airway assessment and management. There were 11 significant deficiencies (two each in cases 12 and 14, and one each in cases 1, 2, 4, 9, 13, 21, and 24).

Provider Performance

The TTA providers generally saw patients timely, made adequate assessments and sound triage decisions, and sent patients to higher levels of care appropriately. There were a few exceptions, also discussed in the *Quality of Provider Performance* indicator. In cases 9 and 14, providers failed to consider cardiac causes for chest pain in patients with cardiac risk factors. In three cases, orders for transfer should have been ACLS instead of BLS. Fortunately, this did not affect the patients' outcomes.

Nursing Performance

On several occasions, nurses failed to perform timely, appropriate interventions.

- In case 1, the first BLS responders failed to initiate CPR immediately on a patient who had collapsed on the yard.
- In case 2, the first medical responders and the TTA nurses failed to timely attach an automated external defibrillator (AED).
- In case 7, the patient had chest pain and difficulty breathing. The emergency response nurse noted respiratory distress and audible wheezing, but the first medical responders did not

administer oxygen or assess vital signs. After the patients' breathing treatment in the TTA, the nurse failed to assess lung sounds and failed to assess prior rescue inhaler use. Additionally, the nurse failed to assess if the rescue inhaler was with the patient.

- In case 12, the patient was unresponsive, was not breathing, and had no pulse. RJD staff initiated CPR and used an AED. Soon thereafter, staff found a pulse and noted agonal breaths, but the nurse failed to initiate rescue breathing.

- In case 14, the patient reported ingesting 20 ibuprofen tablets. He had a weak pulse, labored breathing, and low blood pressure. The TTA nurse did not call 9-1-1 or contact a provider for 33 minutes.

- In four cases, the first responders failed to arrive on scene within the required time frame.

- In case 24, the patient had a prolonged seizure. RJD nursing staff administered seizure medications known to cause low blood pressure and respiratory depression. However, the nurse failed to assess vital signs after administration. Nursing staff failed to timely assess vital signs in three other cases.

Emergency nursing services deficiencies often related to inadequate documentation. Nursing documentation was incomplete and sometimes disorganized.

- In case 7, medical alarms were activated when the patient had difficulty breathing on two separate occasions. The first responders failed to document on-scene arrival times for both events. Failure to document emergency timelines was also identified in four other cases.

- In case 11, transfers via state vehicle for a higher level of care were ordered on two separate occasions. On both occasions, the nurses inappropriately placed the patient in a holding cell and failed to document reassessment and times of departure to the hospital.

Emergency Medical Response Review

In five cases, the medical review process failed to identify nursing deficiencies.

Clinician Onsite Visit

The OIG identified problems with medication changes not implemented upon return to RJD after outside hospitalization. The institution's leadership indicated these issues had been identified, and that they were using quality improvement principles and tools to rectify them. Currently, RJD has one provider assigned to the TTA. In addition to providing urgent or emergent care, this provider is also responsible for ensuring orders were appropriately reconciled for patients returning from the hospital and specialty appointments during business hours. These issues are further discussed in the *Intra- and Inter-System Transfers* indicator.

The Emergency Medical Response Review Committee (EMRRC) had recently modified its processes. RJD reported that reviewing all unscheduled send-outs for emergent care was not practical during the monthly EMRRC meeting due to the high volume. Knowing this resulted in poor reviews, unscheduled send-outs were reviewed weekly by members of the committee, and specific cases with pertinent teaching issues were brought forward to monthly meetings which resulted in better-quality reviews and learning. Leadership also included TTA staff in these processes.

Conclusion

A large number of nursing deficiencies were identified in the *Emergency Services* indicator. Issues with BLS performance, incomplete first medical responder and TTA nursing documentation, and poor nursing assessment resulted in an *inadequate* rating for this indicator.

Recommendations

The OIG recommends that RJD conduct periodic training for providers regarding the appropriateness of ACLS versus BLS transfers.

The OIG recommends that RJD leadership audit documentation and enforce complete, accurate, organized, and timely documentation of urgent and emergent care, compliant with standards.

HEALTH INFORMATION MANAGEMENT (MEDICAL RECORDS)

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(58.6%)

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 noted 99 deficiencies during case review of RJD's health information management. Three deficiencies were significant (cases 8, 21, and 36). The majority of deficiencies were delays in the retrieval and review of hospital, specialty, and diagnostic reports. At times, reports were missing altogether.

Inter-Departmental Transmission

While inter-departmental transmission was generally satisfactory at RJD, there were instances when this was questionable. When diagnostic reports were missing and there were no indications of a review of results, it was questionable as to whether or not they were completed.

Hospital Records

Of the 60 hospitalizations or emergency room visits reviewed resulting in patients returning to RJD, there were eight instances (in seven cases) in which hospital records were not available in a timely manner or were missing altogether.

Specialty Services

Frequent problems with specialty services reports involved delays in the reports being retrieved, reviewed, and signed timely, or staff not scanning reports into the eUHR. This is further discussed in the *Specialty Services* indicator. There were also instances when the specialty services nurse did not provide the specialists with pertinent information, such as diagnostic reports and medications.

Diagnostic Reports

There were several instances of diagnostic reports that were missing from patient health records and providers not reviewing and signing reports timely. This is further discussed in the *Diagnostic Services* indicator.

Urgent/Emergent Records

Health information management as it related to urgent/emergent records was generally satisfactory. There were occasional occurrences when nurses did not properly document their urgent/emergent encounters, and when on-call providers did not document their telephone encounters.

Scanning Performance

Case review found occasional documents misfiled in the wrong patient's record. As noted above, specialty and diagnostic reports were not always available for review in the health records; it was unclear if this was because reports were not retrieved or because of poor scanning performance.

Legibility

Since providers dictated the majority of their progress notes, there were no concerns about legibility. However, nursing notes were difficult to read in cases 6, 12, 13, 17, 21, 24, 31, and 43.

Miscellaneous

There were other occurrences of missing documents, including medication administration records, wound care notes, and nursing and provider notes. On several occasions, providers used legacy (cloned) notes. This is further discussed in the *Quality of Provider Performance* indicator.

Compliance Testing Results

The institution received an *inadequate* compliance score of 58.6 percent in the *Health Information Management (Medical Records)* indicator and scored in the *inadequate* range in the following six tests:

- The institution scored zero in its labeling and filing of documents scanned into patients' electronic unit health records (eUHR); most documents were mislabeled, such as Tuberculosis Patient Plans (CDCR Form 7405) that were commonly mislabeled as Confidential Morbidity Reports (CDCR Form PM-110). 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 RJD medical inspection, inspectors identified a total of 15 documents with scanning errors, three more than the maximum allowable number (MIT 4.006).

- Among 20 sampled provider-dictated progress notes, 6 (30 percent) were scanned within five business days of the patient encounter date. The other 14 were scanned one to nine days late (MIT 4.002).

- RJD timely scanned 11 of the 20 sampled community hospital discharge reports or treatment records into patients' eUHRs (55 percent); nine reports were scanned one to four days late (MIT 4.004).

- RJD staff timely scanned 12 of the 20 sampled medication administration records (MARs) into the patient's eUHR (60 percent). Eight MARs were scanned one to three days late (MIT 4.005).

- The OIG reviewed hospital discharge reports and treatment records for 30 sampled patients whom the institution sent to the hospital for a higher level of care; 20 were complete, included key elements, and were reviewed timely by a RJD provider (67 percent). Providers reviewed six reports one to three days late. Two reports did not include either the discharge date or the admission date. One report included neither admission nor discharge date, and it was one day late. One other report was not found in the eUHR (MIT 4.008).

- When the OIG reviewed various medical documents such as hospital discharge reports, initial health screening forms, certain medication administration records, and specialty services reports to ensure that clinical staff legibly documented their names on the forms, only 23 of 32 samples (72 percent) showed compliance. Nine of the samples tested did not have a legible signature or stamp to identify the clinician (MIT 4.007).

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

- For 19 of 20 specialty service consultant reports sampled, RJD staff scanned the reports into the patient's eUHR file within five calendar days (95 percent). The institution scanned one urgent specialty services report four days late (MIT 4.003).

- Among ten sampled miscellaneous non-dictated documents, including providers' progress notes and patients' initial health screening forms and requests for health care services, the institution timely scanned nine of the documents (90 percent). One initial health screening form was scanned one day late (MIT 4.001).

Recommendations

No specific recommendations.

HEALTH CARE ENVIRONMENT

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

Case Review Rating:
Not Applicable
Compliance Score:
Adequate
(82.6%)

Overall Rating:
Adequate

Compliance Testing Results

The institution received an *adequate* compliance score of 82.6 percent in the *Health Care Environment* indicator with the following four tests receiving scores in the *proficient* range:

- RJD appropriately disinfected, cleaned, and sanitized all 12 clinic locations tested. Specifically, all clinics observed were clean, and cleaning logs were present and completed (MIT 5.101).
- Staff members at all 12 clinic locations followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste (MIT 5.105).
- RJD's non-clinic medical storage areas met the supply management process and support needs of the medical health care program (MIT 5.106).
- Clinical health care staff at 11 of the 12 applicable clinics (92 percent) ensured that reusable invasive and non-invasive medical equipment was properly sterilized or disinfected. The only exception was one clinic in which staff utilized a chemical solution for soaking invasive medical equipment between patient uses, but nursing staff were unable to submit evidence of a current local operating procedure for the chemical sterilization process (MIT 5.102).

RJD performed in the *adequate* range on the following five test areas:

- Ten of the 12 clinics (83 percent) had operable sinks and adequate hand hygiene supplies. At one clinic's patient restroom, there were no disposable towels. In another clinic, staff did not have access to a sink near a blood-draw station (MIT 5.103).
- Inspectors examined emergency response bags to determine if they were inspected daily and inventoried monthly and whether they contained all essential items. Emergency response bags were compliant in seven of the nine clinical locations where bags were stored (78 percent). In one clinic, the inventory log did not match the physical tag on the

emergency response bag. In another clinic, staff on each watch did not conduct the required daily inspections, and the bag was not sealed and properly tagged (MIT 5.111).

- Of the 12 clinics tested, 10 (83 percent) followed adequate medical supply storage and management protocols. Two clinics' storage rooms for bulk medical supplies were not labeled for easy identification, and one of the two clinics had staff's personal belongings stored together with medical supplies (*Figure 1*) (MIT 5.107).

Figure 1: Personal belongings stored with medical supplies

- The clinic common areas at 9 of 12 clinics (75 percent) had an adequate environment conducive to providing medical services. Two clinics did not provide protection for the outside waiting areas from inclement weather. In another clinic, the vital sign station was within audible range of the nurse's exam room, which compromised patients' auditory privacy (MIT 5.109).

- Inspectors examined 12 clinics to determine if appropriate space, configuration, supplies, and equipment allowed clinicians to perform a proper clinical exam. Nine clinic locations (75 percent) were in compliance. At one clinic, oto-ophthalmoscopes were not easily accessible to be used at the exam table, and at another clinic, the RN exam room did not provide visual privacy for patients. One other clinic had a provider's desk in disrepair, an exam table with torn vinyl (*Figure 2*), a supply cabinet/drawer not labeled for easy identification, an RN exam room that did not ensure visual privacy, and a confidential shred bin that was full and easily accessible to inmate-porters (MIT 5.110).

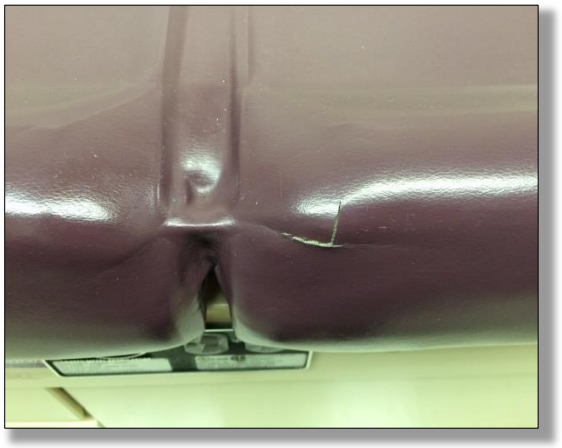

Figure 2: Exam table with ripped vinyl area that could harbor infection

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

- Inspectors observed clinician encounters with patients in nine clinics. Clinicians at five clinic locations (56 percent) followed good hand hygiene practices. Clinicians at four clinics did not routinely sanitize their hands before or after patient contact or before putting on gloves (MIT 5.104).

- Of the 12 clinics inspected, 8 (67 percent) met compliance requirements for essential core medical equipment and supplies. One clinic had a weight scale for wheelchairs and an oto-ophthalmoscope that were not operational, and two other clinics had pulse oximeters and the blood pressure component on the vital sign machines working only intermittently. One other clinic had expired lubricating jelly in a provider exam room (MIT 5.108).

Other Information Obtained from Non-Scored Results

The OIG gathered information to determine if the institution's physical infrastructure was maintained in a manner that supported health care management's ability to provide adequate health care. The OIG did not score this question. When OIG inspectors interviewed health care managers, they did not express concerns about the facility's infrastructure or its effect on staff's ability to provide adequate health care. RJD had a number of significant infrastructure projects underway, including a new administrative segregation primary care clinic, medication distribution room additions at certain housing units, a new pharmacy and dialysis building, primary care clinic renovations on four yards, renovations to the central health services building, and a new health care administration building. These projects started in March 2015, and are expected to be completed by December 2017 (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, TTA, R&R, and inpatient units.

Recommendations for RJD

The OIG recommends that RJD conduct periodic training and refresher courses on proper hand sanitation techniques and protocols for staff to follow when applying and removing protective gloves before, during, and after patient encounters.

The OIG recommends the institution develop local operating procedures that help to ensure that all clinical areas supply a standardized full complement of core equipment. Specifically, clinic areas should include operational weight scales, oto-ophthalmoscopes, pulse oximeters, and vital sign machines, as well as providing lubricating jelly in exam rooms.

INTER- AND INTRA-SYSTEM TRANSFERS

Case Review Rating:
Inadequate
Compliance Score:
Adequate
(81.4%)

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 RJD 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 *inadequate* rating and the compliance testing resulting in an *adequate* score. After considering both case review and compliance testing results, the OIG inspection team determined the final overall rating was *inadequate*. Case review's concerns were related to hospital discharge returns, specifically, the availability of the hospital discharge reports and the reconciliation of hospital discharge medication for patients.

Case Review Results

Clinicians reviewed 210 encounters relating to *Inter- and Intra-System Transfers*, including information from both the sending and receiving institutions. These included 172 hospital-related events, including 69 hospitalizations, 60 of which resulted in a transfer back to RJD (the remaining nine resulted in transfers to other facilities or deaths at the hospital).

Transfers In

OIG clinicians reviewed 22 events relating to patients transferring into RJD and noted 14 deficiencies. Incomplete nursing assessment and inadequate medication continuity were the cause of most patient arrival deficiencies. The following case displayed the only significant deficiency in this category.

- In case 37, the newly arrived patient complained of musculoskeletal pains and worsening depression. The nurse failed to thoroughly assess the patient's complaints, failed to note the

frequency of his use of his rescue asthma-inhaler and self-administered nitroglycerin, and failed to document any recent seizure activity. In this same case, the provider follow-up, ordered to be 14 days, occurred almost three months later.

Transfers Out

OIG clinicians reviewed 16 events relating to transfers out, and 8 minor deficiencies were noted. Nurses failing to thoroughly complete Health Care Transfer Information forms (CDCR Form 7371) contributed to most of the deficiencies for patients transferring out of RJD.

- In case 10, the nurse failed to list the patient's recent hospital visit for seizures and his pending neurology and audiology referrals.
- In case 40, the nurse failed to list the patient's diagnosis of chronic hepatitis C and his pending podiatry follow-up.
- In case 42, the nurse completed a transfer form 13 days prior to the patient's transfer. The nurse failed to document the patient's pending rheumatology appointment and recent arm wound. Also, prior to the patient's transfer and after the transfer form was completed, provider referrals for a podiatry consult and a hepatitis follow-up were not reflected on the transfer documents. Fortunately, the utilization management nurse contacted the receiving facility regarding the pending podiatry appointment.

Hospitalizations

Patients returning from hospitalizations or from outside emergency departments are some of the highest-risk encounters due to two factors. First, these patients are generally hospitalized for a severe illness or injury. Second, they are at risk due to potential lapses in care that can occur during any transfer, such as from the hospital to the institution. Case review highlighted these risks at RJD. OIG clinicians reviewed 172 hospital-related events, including 69 hospitalizations, 60 of which resulted in patients transferring back to RJD. Of the 74 noted deficiencies, 11 were significant and increased the risk of harm to patients.

In several cases, hospital discharge summaries were not always readily available for review. Cases 1, 10, 12, 21, 41, and the cases below illustrate how the lack of attention to detail can result in transfer errors, increasing risk of harm for patients returning from the hospital:

- In case 8, the patient was hospitalized for sepsis, during which time he was diagnosed with possible adrenal insufficiency. Upon the patient's return to RJD, the diagnosis of possible adrenal insufficiency was missed, and the patient did not receive the recommended hormone supplements. Fortunately, no harm occurred to the patient, as he did not have adrenal insufficiency.

- In case 36, hospital discharge recommendations included medications to prevent urinary retention. When these medications were not ordered upon the patient's return to RJD, this resulted in re-hospitalization with acute kidney failure.

In other cases, the medication reconciliation process failed, resulting in patient medications inappropriately prescribed or discontinued. This occurred in cases, 7, 11, 21, 23, 25, 33, and the following:

- In case 2, a RJD provider, anticipating the patient's return from a community hospital, ordered medications. However, when the patient returned to RJD, the hospital recommended discontinuation of a blood pressure medication, but the RJD provider failed to discontinue the medication.

Clinician Onsite Visit

Case review revealed concerns about hospital returns, so the OIG clinicians brought them to the attention of leadership at RJD. The institution's leadership had already identified these concerns, used quality improvement principles and tools to better analyze the issues, and had put processes in place to rectify them. The OIG also learned that community hospital nurses routinely contacted the RJD TTA nurse and performed a "handoff" prior to discharge; however, at the time of the OIG clinical case reviews, documentation of this handoff was not identified in the eUHR.

Statewide Transfer Challenges

In reviewing inter- and intra-system transfers, the OIG acknowledges system wide challenges common to all institutions. Nurses are responsible for accurately communicating pertinent information, identifying health care conditions that need treatment and monitoring, and facilitating continuity of care during the transfer process. While this is sufficient for most CDCR patients, it has not been adequate for patients with complex medical conditions or patients referred for complex specialty care. Often, nurses not familiar with the patient's care or not part of the primary care team initiate the transfer forms. In addition, providers are often left out of the transfer process altogether, and patients are transferred without the provider's knowledge. Without a sending and receiving provider, the risk for lapses in care increase significantly.

Conclusion

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

Compliance Testing Results

The institution earned an *adequate* compliance score of 81.4 percent in the *Inter- and Intra-System Transfers* indicator. RJD performed within the *proficient* range on the following tests:

- Nursing staff properly completed the initial health screening form on the same day the patient arrived for 26 of 30 patients sampled who transferred into the institution (87 percent). For three of the patient screenings, nurses did not answer all of the necessary questions. For one of the other patients screened, the nurse did not complete the initial health screening form on the same day the patient arrived (MIT 6.001). For all of the 30 sampled patients who transferred into the institution, nurses completed the assessment and disposition sections of the screening form on the same day that they performed the initial health screening (MIT 6.002).

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

- Of the 30 sampled patients who transferred into the institution, 19 had an existing medication order that RJD should have administered or delivered without interruption. Of those 19 patients, 15 (79 percent) received their medications timely. Four patients did not receive their medication at the next required dosing interval; all four received their medication one day late (MIT 6.003).

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

- Inspectors sampled 20 patients who transferred out of RJD to another CDCR institution to determine whether RJD listed their scheduled specialty service appointments on the transfer form. RJD nursing staff correctly listed the pending specialty services for 14 of 20 patients sampled (70 percent) (MIT 6.004).

- Among transfer packages of seven patients transferring out of the facility, five (71 percent) included required medications and support documentation. Two of the patients who transferred from RJD to another institution did not have their required KOP medications in their transfer packages (MIT 6.101).

Recommendations

The OIG recommends that medical leadership at RJD continue monitoring the efficacy of processes put in place to ensure RJD medical staff appropriately manages patients upon their return from hospitals.

The OIG recommends that RJD nursing staff document in the medical records the communication with community hospital nurses.

PHARMACY AND MEDICATION MANAGEMENT

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(70.4%)

Overall Rating:
Inadequate

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

Case Review Results

The OIG clinicians evaluate pharmacy and medication management as secondary processes as they relate to the quality of clinical care provided. Compliance testing is a more targeted approach and is heavily relied on for the overall rating for this indicator. During case review, 90 deficiencies were related to pharmacy and medication management, 12 of which were significant and increased the risk for harm to patients.

Medication Administration

There were several occasions of inappropriately managed medications. In some cases, nursing staff dispensed or administered medications late; in other cases, nursing staff did not give medications at all. Minor deficiencies of this nature occurred in eight cases, but four significant deficiencies occurred as follows:

- In case 8, a five-day course of a medication to stimulate growth of white blood cells to help the body fight infections was ordered but not administered to this patient undergoing chemotherapy, which can cause a drop in the white blood cell count. There were also repeated instances of a weekly dose medication not being administered.
- In case 9, the patient requested his medications and eye drops be nurse-administered (NA) as he had trouble remembering to take his medications, and had difficulty self-administering the eye drops. Following this request, it was unclear why the orders for these medications repeatedly oscillated from NA to KOP.
- In case 16, antibiotics ordered "stat," meaning immediately, were not administered for two days.

- In case 20, a provider stopped two medications for heart disease in anticipation of a surgery. Following the surgery, the medications were not restarted for almost two months.

The CTC nursing medication reconciliation process failed to ensure provider medication orders were accurately reflected on medication administration records (MARs). An important example of this failure was rescue inhalers for asthma and chronic obstructive pulmonary disease. Although providers prescribed these inhalers to be KOP, the MAR routinely noted them to be NA. This is also discussed below, and in the *Specialized Medical Housing* indicator.

Pharmacy Errors

In six cases, rescue inhalers were changed from KOP to NA upon the patient's admission to the CTC due to some inappropriate pharmacy process. This issue was discussed with the medical leadership during the OIG clinicians' onsite visit and is further discussed in the *Specialized Medical Housing* indicator.

Medication Continuity

Multiple problems related to medication continuity were found. In four cases, nursing staff did not administer or dispense medications to patients transferring to RJD from other CCHCS facilities. Issues with medication continuity were especially prevalent for patients returning from local hospitals. In large part due to inadequate reviews of hospital discharge records, providers oftentimes prescribed recommended medications inaccurately, late, or not at all upon the patients' return to RJD. This was seen in nine cases. This is further discussed in the *Inter- and Intra-System Transfers* indicator.

Anticoagulation Medication

Pharmacy staff performed much of the anticoagulation management. Pharmacists reviewed laboratory anticoagulation values and made appropriate recommendations for adjustments in dosages, subsequent laboratory tests, and follow-ups; providers then ordered the medication adjustments based on the pharmacist recommendations.

Conclusion

Due to the patterns and high number of deficiencies, the OIG rated the case review portion of the *Pharmacy and Medication Management* indicator *inadequate*.

Compliance Testing Results

The institution received an *inadequate* compliance score of 70.4 percent in the *Pharmacy and Medication Management* indicator. For discussion purposes below, this indicator is divided into three sub-indicators: medication administration, observed medication practices and storage controls, and pharmacy protocols.

Medication Administration

In this sub-indicator, the institution received an average score of 69.5 percent, which fell into the *inadequate* range. The institution scored poorly in the following areas:

- Three of the ten sampled patients who were in transit to another institution and were temporarily laid over at RJD received their medications without interruption (30 percent). Seven patients each missed at least one dose of their required medications (MIT 7.006).

- The institution timely and correctly administered all required chronic care medications or followed proper protocols for only 21 of 35 patients sampled when they refused or did not show up to receive their medications (60 percent). Many notable instances led to the low score in this sub-indicator, and for some patients sampled there was more than one identified problem area, as follows (MIT 7.001):

    - Four patients' DOT MARs indicated they did not show for their medication.

    - One patient was taking his critical HIV medication by directly observed therapy (DOT), but it is unknown whether the patient actually took them because there was no MAR scanned into the eUHR.

    - Two patients never received their monthly supply of KOP chronic care medications.

    - Nine patients missed or refused doses of critical medications and never received medication counseling.

    - One patient was taking chronic care medications by KOP, then the provider switched the medication to DOT, but the patient did not receive the medications as DOT for seven days.

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

- RJD timely provided hospital discharge medications to 19 of 25 patients sampled who had returned from a community hospital (76 percent). For five patients, discharge medications were one to six days late, and one patient did not receive his discharge medication at all (MIT 7.003).

RJD scored in the *proficient* range on the following tests:

- The institution timely administered or delivered new medication orders to 38 of the 40 patients sampled (95 percent). Two patients received their medications one day late (MIT 7.002).

- Among 30 sampled patients at RJD who had transferred from one housing unit to another, 26 (87 percent) received their prescribed medications without interruption. Four patients did

not receive their medications by the next dosing interval after the transfer occurred (MIT 7.005).

Observed Medication Practices and Storage Controls

For this sub-indicator, the institution received an average score of 48.2 percent, scoring in the *inadequate* range on the following tests:

- The OIG interviewed nursing staff and inspected narcotics storage areas at ten applicable locations to assess narcotics security controls, and only two clinic locations (20 percent) were in compliance. At eight other sampled locations, nursing staff did not always complete required control log entries. More specifically, during the OIG's 30-day review period, log books at seven locations were missing from one to 11 required signature entries, generally relating to shift change narcotics count reconciliations, and nursing staff at one other location did not update the narcotics log after administering the narcotic medication, which resulted a narcotics discrepancy during the physical count (MIT 7.101).

- Non-narcotic medications that required refrigeration were properly stored in only 5 of 17 inspected clinics and medication line storage locations (29 percent). Some inspected locations had more than one identified problem area. Deficiencies consisted of the following: eight sampled locations did not have a designated area for return-to-pharmacy medications; four locations had recorded temperatures above or below CCHCS guideline levels; three locations had refrigerators with temperature logs missing entries; another two locations had stored medications beyond the recommended time frame; two locations had refrigeration units that were unsanitary; and one location had an unlocked refrigerator (MIT 7.103).

- Nursing staff at only three of eight sampled medication preparation and administration locations followed proper hand hygiene contamination control protocols during the medication preparation and administration processes (38 percent). Nursing staff at three locations did not always sanitize their hands prior to initially putting on protective gloves or between subsequent glove changes, and staff at two other locations did not have an accessible sink to wash their hands (MIT 7.104).

- Only three of eight observed medication areas demonstrated appropriate administrative controls and protocols when staff administered medications to patients (38 percent). Nursing staff at two locations did not verify the identification of two patients prior to administering medication, and the nurse at one location did not crush and float medications per the provider's orders. A nurse at another location administered medication to a patient who did not have an order for it. At one location, neither clinical staff nor custody staff verified that patients taking medications by DOT had swallowed their medication. Lastly, two clinic locations did not have an adequate overhang at the medication line to protect patients from extreme heat and inclement weather (MIT 7.106).

- Non-narcotic medications that did not require refrigeration were properly stored at only 13 of 20 applicable clinics and medication line storage locations (65 percent). Inspected locations had one or more of the following deficiencies: five locations had opened bottles of medications that were not labeled with the date opened; one location had expired medication on hand; two locations did not have a designated area for return-to-pharmacy medications; and one location stored internal and external medications together (MIT 7.102).

RJD scored in the *proficient* range on the following test:

- Nursing staff at all eight of the inspected medication and preparation administration locations followed appropriate administrative controls and protocols during medication preparation (MIT 7.105).

Pharmacy Protocols

For this sub-indicator, the institution received an average score of 98.0 percent, scoring in the *proficient* range in the following test areas:

- RJD's main pharmacy followed general security, organization, and cleanliness management protocols; properly stored non-refrigerated and refrigerated or frozen medications; and maintained adequate controls and properly accounted for narcotic medications (MIT 7.107, 7.108, 7.109, 7.110).

- RJD's pharmacist in charge timely processed 27 out of 30 sampled medication error reports and related monthly statistical reports (90 percent). One medication error report was completed one day late, and the related monthly statistical report for the same month did not properly report the number of level 4 errors for the month. The monthly statistical report for another month was not shared with the applicable quality improvement committees (MIT 7.111).

Non-Scored Tests

- In addition to the OIG's testing of reported medication errors, inspectors follow up with institution management about any significant medication errors that were 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 RJD, the OIG did not find any applicable medication errors (MIT 7.998).

- The OIG tested patients in isolation units to determine if they had immediate access to their prescribed KOP rescue asthma inhalers or nitroglycerin medications, and identified 18 patients whom this test applied. Inspectors found that 17 of the patients had possession of their prescribed inhalers or nitroglycerin medications. One patient stated he did not have his prescribed nitroglycerin, and inspectors immediately notified the institution's CEO. The

CEO took immediate action and made contact with the patient, who then admitted to the CEO that he actually had his rescue medication in his possession (MIT 7.999).

Recommendation

The OIG recommends that RJD ensure rescue medications such as rescue inhalers and sublingual nitroglycerin are dispensed to patients as KOP and not nurse administered.

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
(60.4%)

Overall Rating:
Inadequate

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

Compliance Testing Results

The institution performed in the *inadequate* range in the *Preventive Services* indicator, with a compliance score of 60.4 percent. The institution scored in the *inadequate* range on the following tests:

- The institution scored 17 percent in conducting annual tuberculosis screenings. Although RJD screened all 30 patients sampled for tuberculosis within the prior year, zero of the 15 patients identified as Code 22 (requiring a tuberculosis skin test in addition to screening of signs and symptoms) were properly tested. For all 15 of these patients, inspectors identified one or more of the following errors: the 48-to-72-hour window to read test results was not clear because nursing staff did not document either the administered (start) or read (end) date and time; an LVN read the test results rather than a registered nurse, public health nurse, or provider; or nursing staff did not complete all required sections of the Tuberculin Testing/Evaluation Report (CDCR Form 7331). In addition, 10 of the 15 patients identified as Code 34 (requiring only a signs and symptoms screening) did not receive a proper evaluation because nursing staff did not properly complete the history section of the TB form. For one of the ten patients, the history section of the TB form was completely blank (MIT 9.003).

- RJD scored 33 percent in regard to the timely administration of TB medications. Of six patients sampled, two received all required doses of their medications in the most recent 3-month or 12-week period. Four patients did not receive all of their TB medications and did not receive provider counseling regarding missed doses (MIT 9.001). Of the six patients tested that were taking TB medications, only two of them (33 percent) received timely monthly or weekly monitoring while taking TB medications. One patient did not receive monthly monitoring for two months. Three other patients received all the required monitoring, but the monitoring forms were not scanned into the eUHR after each monitoring visit (MIT 9.002).

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

- The OIG tested whether RJD offered required influenza, pneumonia, and hepatitis vaccinations to patients who suffered from chronic conditions; 19 of the 24 patients sampled (79 percent) received or were offered the vaccinations. The institution did not offer five patients one or more of the vaccinations (MIT 9.008).

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

- All 30 patients sampled timely received or were offered influenza vaccinations during the most recent influenza season (MIT 9.004).
- All 30 patients sampled timely received or were offered colorectal cancer screenings subject to the annual screening requirement, or had a normal colonoscopy within the last 10 years (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 requests, 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 health care services 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 correctional treatment center (CTC) 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 evaluated 766 nursing encounters during case review, of which 491 were outpatient nursing encounters. In general, nursing performed well. In all, 144 deficiencies were found in outpatient nursing services, the majority of which were unlikely to contribute to patient harm. Nevertheless, these deficient areas are clearly established in CCHCS policy as requirements for nursing care and, therefore, require quality improvement strategies. Three cases (7, 8, and 16) did display deficiencies with the potential for adverse outcomes or unnecessary delays in needed health care services, as identified below.

Outpatient Nursing Encounters

The majority of outpatient nursing encounters appropriately assessed complaints and symptoms, and provided necessary interventions for patients presenting with medical issues. The quality of nursing performance was affected by patterns of deficiencies that included poor assessment, improper interventions based on assessment, and inadequate nursing documentation, as identified in the cases below:

- In case 7, the patient, who had a history of respiratory failure, tracheal stenosis (narrowing of the windpipe), asthma, and chronic obstructive pulmonary disease (COPD), was seen for

throat pain, nasal congestion, and cough. He complained his tracheal stent (tube to keep his airway open) was moving. The nurse failed to assess the patient's rescue inhaler use and did not contact a provider or initiate a provider referral. On a separate occasion, the patient's blood pressure was elevated at 138/109, but the LVN failed to contact a provider or nurse and to recheck the patient's blood pressure.

- In case 8, the patient complained of abdominal pain and diarrhea. The triage nurse failed to perform a same-day face-to-face evaluation. The next day, the patient reported having had abdominal pain and diarrhea for three days, his pulse was 112 beats a minute, and his blood pressure was low at 98/62. He had decreased lung sounds and localized edema (swelling). Fortunately, RJD staff transferred the patient to the TTA, and ultimately transported by ambulance to the hospital.

- In case 9, the patient's abdomen was distended and the nurse noted dizziness related to liver issues with possible hepatic encephalopathy (loss of brain function due to a damaged liver) and provided hepatic encephalopathy educational information, but the patient did not have a history of liver disease. The nurse did not further assess the patient's abdominal distention and dizziness.

- In case 43, the diabetic patient had throat pain and hoarseness. He attributed his symptoms to heartburn. The nurse failed to assess the patient for initial onset and frequency of symptoms; did not assess for associated symptoms such as nausea, vomiting, and epigastric pain; and failed to assess non-steroidal anti-inflammatory medication use and whether prescribed antacids improved symptoms. The nurse inappropriately advised the patient to gargle with warm water and did not initiate a follow-up appointment.

Wound Care

On several occasions, nurses failed to document thorough wound care and assessment and failed to provide appropriate interventions, including notifying providers. Often, nurses did not document wound size, but even when they did, the documentation was often inconsistent. Nursing staff also did not document the condition of surrounding skin or characteristics of drainage.

- In case 16, a diabetic patient was receiving wound care. When an additional toe wound was noted, the nurse did not document the size and appearance of the wound, and a provider was not contacted. Instead, nursing staff started wound care without provider orders.

- In case 19, the diabetic patient had a knee wound following an incision and drainage procedure. Wound assessments and documentation were often inconsistent. An initial wound description was not completed, and some wound assessments noted more than one wound while others noted just one wound. On several occasions, the nurse did not document the wound size and drainage characteristics.

- In case 20, the diabetic patient was receiving wound care. Initially, nursing staff noted the wound was healing. However, soon thereafter, the nurse noted the wound to be red and swollen and to have drainage and decreased sensation. The nurse failed to notify a provider of this change.

Medication Administration

On several occasions, nursing staff did not administer new outpatient medication orders within required time frames. There were instances when provider orders indicated medication line nurses were notified of the orders, but nursing follow-up did not occur when medications or medication records were not received. This is also discussed in the *Pharmacy and Medication Management* indicator. These types of errors occurred in cases 7, 9, 16, 18, 20, 25, and the following:

- In case 8, an order to discontinue warfarin and begin aspirin was sent to the medication line. The nurse discontinued warfarin, but aspirin was not started. On a separate occasion, an RJD provider ordered filgrastim (bone marrow stimulant prescribed after chemotherapy), but not administered.

Clinician Onsite Visit

The nursing staff expressed satisfaction with their leadership and worked well with providers. The outpatient nurses were active participants in the primary care team morning huddles, where the discussion topics included the current hospital census, intra-system transfers, and newly discharged TTA patients. Staff also brought forward and addressed specific patient concerns. The medication line nurses verbalized having good communication with the medical clinic providers and nurses. They reported receiving new medications orders electronically, which were reconciled with incoming medications and MARs.

Recommendation

The OIG recommends that RJD educate on and monitor nurses' wound care assessments and documentation.

QUALITY OF PROVIDER PERFORMANCE

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

Case Review Rating:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

Case Review Results

The OIG clinicians reviewed 428 medical provider encounters and identified 169 deficiencies related to provider performance. Of these 169 deficiencies, 38 increased the risk of harm to patients. The providers generally performed well managing complex medical patients. Providers usually made sound and accurate diagnoses, and treatment plans were appropriate. While review of medical records was not always thorough, provider performance as it related to emergency care, chronic care, and specialty services was generally adequate. The main issue found with health information management by providers was the use of legacy notes. Pharmacy and medication management by providers was adequate. Despite the relatively high number of deficiencies noted, taking into account the complexity of patients and the fact that the majority of deficiencies were due to inadequate review of records and use of legacy notes, the OIG clinicians rated this indicator *adequate*.

Assessment and Decision-Making

The assessment and decision-making by RJD providers was generally appropriate. The majority of deficiencies in this subcategory were inappropriately lengthy follow-up intervals, found in cases 7, 8, 10, 21, 31, and 32. Examples of other isolated deficiencies are as follows:

- In case 12, the provider noted the patient's high blood pressure was "under control" when, in fact, it was significantly elevated at 188/85.
- In case 31, the provider noted the patient's diabetes was "very well controlled," when, in fact, a recent blood test showed it was not.
- In case 32, the provider did not document a testicular exam for a patient complaining of testicular pain.

Review of Records

Approximately one-third of the provider deficiencies were related to inadequate review of records. Multiple deficiencies involved inadequate reviews of diagnostic reports, provider and nursing

progress notes, medication reconciliation and administration records, hospital records, and specialty reports.

- In case 7, the provider did not correctly order hospital discharge recommendations for various medications. Providers incorrectly noted medications the patient was taking and failed to note that the patient had repeatedly requested inhalers that the provider had prescribed but the patient had not received.

- In case 8, aspirin was restarted despite a positive stool test for blood and a hospital discharge report recommending that aspirin not be restarted. A separate hospital discharge report recommended two medications for adrenal insufficiency; these were not prescribed. This case is also discussed in the *Inter- and Intra-System Transfers* indicator.

- In case 9, medication orders changed from NA to KOP and back several times. Had providers reviewed the chart, they would have noted that a provider ordered the medications NA because the patient reported that he forgot to take his medication when the medication was prescribed as KOP.

Emergency Care

Provider performance related to emergency care was generally adequate. There were eight deficiencies out of the 56 TTA encounters reviewed. In general, TTA and on-call providers made accurate assessments and triage decisions and appropriately transferred patients requiring higher levels of care. There were a few exceptions. In two cases, providers failed to consider cardiac causes for chest pain in patients with cardiac risk factors. In three cases, orders for transfer should have been for ACLS instead of for BLS.

Chronic Care

Provider performance related to chronic care was also generally adequate. While providers demonstrated adequate skills and knowledge in caring for patients with complicated chronic medical issues, there were some exceptions. In two cases, blood sugar logs to monitor diabetes were not reviewed. In two other cases, insulin management was subpar for uncontrolled diabetes.

Specialty Services

Provider performance related to specialty services was generally adequate, though at times suboptimal. The majority of deficiencies noted were inadequate reviews of specialty reports (discussed above). Other issues included intended referrals noted on progress notes not ordered by providers on order forms, and specialty referrals not always ordered appropriately. More notable examples (also discussed in the *Specialty Services* indicator) included the following:

- In case 12, two referrals for cancer screening tests were inappropriately submitted and approved for this patient, whose life expectancy was less than six months.

- In case 15, the patient with newly diagnosed cancer required specialty diagnostic imaging to determine the next course of care. The provider should have submitted the referral for this diagnostic imaging as urgent rather than routine.

- In case 17, the provider submitted a routine referral for a patient with possible periorbital shingles. The provider should have submitted the referral as urgent because timely diagnosis and management are critical. Fortunately, the patient was seen by optometry right away.

- In case 20, the provider should have submitted referrals for cardiology and cardiac diagnostic tests as urgent rather than routine for this patient with cardiac symptoms.

Health Information Management

While the majority of progress notes were adequate, a pattern of legacy notes was found in a few cases. These notes were cloned copies of prior notes with few changes made. In some of these cases, portions of the notes were misleading or confusing, and often resulted in inconsistencies in the progress notes. The use of legacy notes can cause confusion for subsequent providers and creates a risk of harm to patients.

- In case 6, after the patient's recent altercation and hospitalization, the provider's review of systems noted no labored breathing on exertion, no chest pain, and no recent bruising. The subjective portion of the same note noted bruised ribs and pain with deep inspiration.

- In case 7, the provider's review of systems noted the patient denied cough, shortness of breath, and wheezing. However, the patient was being seen for difficulty breathing, and the nurse noted the patient complained of a productive cough.

- In case 13, the provider indicated effective communication had been reached with the patient having asked questions and summarized information despite having elsewhere noted the patient was not responding.

- In case 25, the progress note indicated the wound had healed, but then the provider ordered daily dressing changes "until healed."

- In two cases, the provider noted stable vital signs after elsewhere noting the patient had refused vital signs.

In other cases, while providers noted plans in the progress notes for various orders, they failed to do so by writing them on the order forms. In cases 8 and 33, providers did not order intended laboratory tests; in cases 24 and 28, providers did not order intended referrals to specialists, and in case 42, the provider did not order an intended ultrasound.

Pharmacy and Medication Management

Pharmacy and medication management by the RJD providers was generally adequate. In the CTC, a pattern was found in which rescue inhalers were NA even though providers had prescribed them as KOP. This appeared to be a pharmacy error, and not a provider error (this is further discussed in the *Pharmacy and Medication Management* indicator). There were, however, a few instances when patients discharged from the CTC had their rescue inhalers renewed by providers as NA rather than KOP, likely due to an inadequate review of records, noted in cases 2, 7, 24, and the following:

- In case 9, the patient's daily low-dose aspirin taken for prevention of heart attack and stroke was inappropriately stopped when ibuprofen was started.
- In case 33, the provider failed to realize the drug interaction between doxycycline and warfarin. This resulted in an increased risk of bleeding.

Clinician Onsite Visit

During the onsite visit, the OIG clinicians found that the providers were generally content with their work, and felt they were given adequate time and tools necessary to provide appropriate medical care. Providers reported good working relationships with clinic staff and custody. Ancillary services, including laboratory, pharmacy, radiology, and specialty services, generally functioned well.

The providers felt well supported by their leadership, and many mentioned that one of the strengths at RJD was the medical leadership. Another strength was the collegiality and camaraderie among the providers.

New providers were given a comprehensive orientation over a period of weeks before providing medical care on their own. In addition to shadowing experienced providers in different yards at RJD, new providers rotated through various departments relevant to patient care and were educated on the various processes involved, such as diagnostics, pharmacy, and specialty services.

Many providers voiced concern with the volume of phone calls when on call after business hours and on weekends. This was due to the complexity of RJD's patients, and included the multiple offsite hospital and specialty appointment returns after hours. There was additional concern with the soon-to-open E yard, which was to house approximately 800 inmates, and a dialysis center under construction.

Provider meetings occurred at the start of each weekday. During these meetings, providers discussed various issues, including patients addressed by the on-call provider overnight or over the weekend, patients seen in the TTA, and patients transported in and out of the institution. Providers also discussed challenging cases and specialty referrals.

The OIG clinicians also observed the morning huddle meetings for two different yards. The issues discussed were comprehensive and pertinent to each yard, following the outline provided by CCHCS to all institutions.

Recommendations

The OIG recommends that RJD management conduct training for providers in the importance of thorough review of all medical records, including interim nursing notes, medication administration records, and laboratory reports, with special attention to hospital records and specialty reports. The OIG further recommends that leadership audit this process to ensure thorough reviews are completed.

The OIG recommends that RJD management conduct training for providers on the dangers of legacy notes and on thorough review of notes to ensure they are consistent and up to date.

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. RJD's only specialized medical housing unit is the Correctional Treatment Center (CTC).

Case Review Rating:
Adequate
Compliance Score:
Proficient
(92.0%)

Overall Rating:
Adequate

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

Case Review Results

The CTC at RJD had 28 beds, 14 of which were dedicated to medical care, and the other 14 to mental health care. The OIG reviewed 410 CTC-related events for 11 patients admitted to the CTC for a higher level of supervised medical treatment and monitoring. Of the 189 deficiencies found, 7 were significant (twice each in cases 7 and 33, and once in cases 2, 13, and 32). There were 41 provider deficiencies, 3 of which were significant and increased the risk of harm to patients. There were 120 minor nursing deficiencies identified.

Provider Performance

The quality of provider performance in the CTC was consistent with the quality of provider performance in general. The majority of the deficiencies in this area involved legacy charting (cloned progress notes) and inadequate review of records. These issues are discussed further in the *Health Information Management* and *Quality of Provider Performance* indicators.

Nursing Performance

The CTC nursing performance was also generally adequate, with some care issues identified at times. The majority of deficiencies found were due to inadequate assessment, intervention, and documentation. On a few occasions specialist recommendations were not acknowledged by nursing staff. While most nursing deficiencies related to the CTC were unlikely to cause patient harm, the number and pattern of these deficiencies is of concern. A few examples are listed below.

- In case 7, the patient was admitted to the CTC on several occasions due to respiratory issues. When he had expiratory wheezing, the CTC nurse failed to initiate a breathing treatment and

did not reassess lung sounds. Failure to examine the chest for lung sounds was seen throughout this review.

- In case 8, the patient with diarrhea had a heart rate of 122 beats per minute (bpm). Reassessment did not occur for six hours, at which time he had a fever of 101.4 ˚F and a heart rate of 120 bpm. He was subsequently transferred to a higher level of care. After seven days in the hospital for infectious diarrhea, he returned to RJD. The following day, his heart rate was 113 bpm; the nurse failed to reassess the rate and assess for further diarrhea. Two days later, the patient reported diarrhea and his rate was 112 bpm. The nurse failed to assess the frequency of diarrhea, assess oral intake, and assess for dehydration signs.

- Case 12 had nearly half of the nursing deficiencies related to the CTC. While the patients' mental capacity and multiple refusals complicated the care of this complex patient, inadequate documentation suggested assessments and interventions were not attempted (e.g. nurses continued to administer stool softeners for five days while the patient had diarrhea). When staff documented assessments, they were often incomplete. On a different occasion, after a wound care specialist saw the patient, the nurse failed to assess the new wound, and failed to review the specialist's recommendations.

Medication Management

Rescue inhalers in the CTC were routinely changed from KOP to NA despite provider orders. This inappropriate practice is discussed in the *Pharmacy and Medication Management* indicator.

Clinician Onsite Visit

The OIG clinicians learned RJD had one provider assigned to the CTC beds for continuity of care. In addition to providing medical care to patients residing in the medical beds, the provider also performed consultations for patients residing in the mental health beds. The OIG also learned CTC patients returning from offsite specialty services returned directly to the CTC rather than via the TTA as most other patients did. Therefore, the CTC nurse completed an assessment and review of records rather than the TTA nurse. The CTC nursing supervisor reported the CTC nurse performed nursing care audits monthly. Nursing care plans, changes in level of care and condition, patient education, discharge education, and unusual occurrences were audited for ten patients monthly (five mental health and five medical patients).

Clinician Summary

RJD provided generally *adequate* care to patients housed in the CTC. While most deficiencies did not place patients at increased risk of harm, there were a high number of nursing deficiencies (inadequate nursing assessments, interventions, and documentation).

Compliance Testing Results

The institution received a *proficient* compliance score of 92.0 percent in the *Specialized Medical Housing* indicator, which focused on the institution's CTC. The institution scored in the *proficient* range on the following tests:

- RJD utilized a working call-button system in the CTC, and CTC staff properly documented call-button tests in a daily log. Knowledgeable staff who regularly worked in the CTC collectively indicated that during an emergent event, responding staff could generally access a patient's room in under one minute, which management determined to be a reasonable response time. As a result, the institution scored 100 percent on this test (MIT 13.101).

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

- Providers evaluated all 10 patients within 24 hours of each patient's admission to the CTC. In addition, providers completed a history and physical within 72 hours of admission to the CTC for all 10 patients sampled (MIT 13.002, 13.003).

RJD scored in the *inadequate* range on the following test:

- Providers completed their Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes at the required three-day intervals for six of ten sampled patients (60 percent). For four patients, providers' SOAPE notes were completed one to two days late (MIT 13.004).

Recommendations

The OIG recommends that RJD leadership audit and enforce complete, accurate, organized, and timely documentation of up-to-date progress notes by both providers and nursing staff.

The OIG recommends that RJD leadership review its current CTC nursing audit process to ensure accuracy of the nurse reviewer, and provide additional training and education when deficiencies are noted.

SPECIALTY SERVICES

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

Overall Rating:
Adequate

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

Case Review Results

The OIG clinicians reviewed 442 events related to *Specialty Services*, the majority of which were specialty consultations and procedures. Other events related to provider and nursing follow-up visits and orders after specialty consultations and procedures. There were 93 deficiencies found in this category, with 11 significant deficiencies (once each in cases 2, 15, 17, 21, and 36; twice in case 28; and four times in case 20).

Access to Specialty Services

While specialty services were generally provided within adequate time frames for both routine and urgent services, delays in specialty follow-ups occurred in multiple cases. Fortunately, the delays, ranging from days to months, did not significantly affect patient care. In one case, follow-up did not occur:

- In case 20, an orthopedic follow-up was ordered due to a leg fracture. At the time of this review, the follow-up had yet to occur, indicating a delay of at least three months. OIG clinicians discussed this issue with the medical leadership at RJD, and a follow-up was scheduled.

Nursing Performance

Nursing care after an offsite specialty appointment was most often adequate. However, when CTC patients returned directly to the CTC rather than via the TTA, nursing staff did not always thoroughly review the recommendations**.** On several occasions, the telemedicine nurses failed to provide diagnostic results to the specialist**.**

- In case 2, the patient was admitted to the CTC after a cardiac bypass procedure. A few weeks later, he was seen for an offsite vascular surgery follow-up and then returned directly to the CTC. The CTC nurse failed to perform a return assessment and did not note the specialist appointment at all. The specialist's concern regarding the cardiac graft function

and the specialist's recommendation for a lower extremity ultrasound were not addressed or ordered. Specialty CTC nursing deficiencies are also discussed in the *Specialized Medical Housing* indicator.

- In case 8, the telemedicine nurse failed to ensure recent laboratory results were available during an oncology appointment. The nurse did not provide a urinalysis result to the urologist.

- In case 41, the nurse failed to contact a supervisor or provider when the patient did not receive an urgent CT scan after a custody lockdown.

Provider Performance

Provider performance as it related to specialty services was generally adequate, though at times suboptimal. Some of the issues noted included providers that did not follow-up on specialty recommendations, providers not documenting why specialty recommendations were not followed, referrals for services noted on progress notes that were never ordered by a provider, and referrals not always being ordered appropriately. Some of these issues were likely due to an inadequate review of records. These issues are also noted in the *Health Information Management* and *Quality of Provider Performance* indicators. The more notable examples are again noted here:

- In case 12, two referrals for cancer screening tests were inappropriately submitted and approved for this patient with a life expectancy of less than six months.

- In case 15, the patient with newly diagnosed cancer required specialty diagnostic imaging to determine the next course of care. The provider should have submitted the referral for diagnostic imaging as urgent rather than routine.

- In case 17, the provider submitted a routine referral for a patient with possible periorbital shingles. The referral should have been submitted as urgent because timely diagnosis and management are critical. Fortunately, optometry saw the patient right away.

- In case 20, this patient had known heart disease and was experiencing cardiac symptoms. The referrals for cardiology and cardiac diagnostic tests should have been submitted as urgent rather than routine.

- In case 28, a provider failed to order an ophthalmology follow-up, although the intent was noted in the progress note. At the time of this review, follow-up still had not occurred for this patient with diabetic retinopathy, glaucoma, and cataracts.

Health Information Management

Health information management deficiencies related to specialty services included specialty reports that were not found in the eUHR; delays in specialty reports being retrieved, reviewed, and signed by providers; and patient health records and diagnostic reports not being available to specialists. The more serious deficiencies were as follows:

- In case 21, the handwritten consult note included recommendations but also that final recommendations and follow-up would be specified in the dictated report. This dictated report was retrieved three months later, which delayed patient care.

- In case 36, a patient was to begin chemotherapy following surgery for colon cancer. Possibly due to a consult report being retrieved late, chemotherapy did not begin, and the oncology follow-up did not occur.

Compliance Testing Results

The institution received an *adequate* score of 80.7 percent in the *Specialty Services* indicator. RJD scored in the *proficient* range on the following tests:

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

- Providers timely received and reviewed the specialist's reports within the required time frame for 14 of 15 sampled patients who received a high-priority specialty service as well as for 14 of 15 sampled patients who received a routine specialty service. Both tests resulted in proficient scores of 93 percent. For the high-priority test, one specialist's report was received three days late; for the routine priority test, the specialists' report was received 12 days late (MIT 14.002, 14.004).

- High-priority specialty service appointments occurred within 14 calendar days of the provider's order for 13 of the 15 patients sampled (87 percent). Two patients received their specialty services one and two days late (MIT 14.001).

- Routine specialty service appointments occurred within the required time frame for 13 of the 15 patients tested (87 percent). One patient received his specialty service 21 days late. Another patient had two specialties services; one was four days late, and the other never occurred (MIT 14.003).

The institution scored in the *inadequate* range in the following areas:

- Among 18 patients sampled who had a specialty service denied by the institution's health care management, only 9 (50 percent) received timely notification of the denied service that included the provider meeting with the patient within 30 days to discuss alternate treatment strategies. For eight patients, the provider's follow-up visit occurred from 8 to 62 days late,

and another patient never received communication regarding his denied service (MIT 14.007).

- When patients at one institution have an approved, pending, or scheduled specialty service appointments, and then transfer to a different institution, policy requires that the receiving institution reschedule or provide the patient's appointment within the required time frame. Of 20 sampled patients who transferred in to RJD with an approved specialty services, only 11 timely received their specialty service appointments (55 percent). Six patients received their specialty appointments from one to 131 days late, and three patients never received their appointment (MIT 14.005).

Recommendations

The OIG recommends RJD review current processes to ensure access to specialty services occurs timely.

The OIG recommends RJD conduct training for providers regarding the appropriateness of routine versus urgent referrals.

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 RJD.

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 RJD in June 2016. They also reviewed documents obtained from the institution and from CCHCS prior to the start of the inspection. Of these 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
(58.3%)

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 the *Internal Monitoring, Quality Improvement, and Administrative Operations* indicator, with a compliance score of 58.3 percent. RJD received an *inadequate* score in the following test areas:

- RJD's 2015 Performance Improvement Work Plan did not include adequate evidence demonstrating the institution's improvement in achieving targeted performance objectives for any of its five quality improvement initiatives. In general, the work plan included insufficient progress information to demonstrate that, in each of its performance objectives, the institution either improved or reached the targeted level (MIT 15.005).

- None of the 12 sampled incident packages reviewed by the EMRRC included the required Emergency Medical Response Review Event Checklist Form (MIT 15.007).

- Inspectors reviewed drill packages for three medical emergency response drills conducted in the prior quarter, and all of the packages lacked the completion of required forms. However, the drills did include participation by both health care and custody staff (MIT 15.101).

- Inspectors reviewed RJD's local governing body (LGB) meeting minutes to determine if the LGB met quarterly to exercise its responsibility for the quality management of patient health care. However, the LGB only met during two of the four most recent quarters; there was no LGB meeting during the July 2015 to September 2015 quarter or the October 2015 to December 2015 quarter. The January 2016 meeting did not discuss general management and planning, and the next meeting did not timely approve the minutes. RJD scored 25 percent on this test (MIT 15.006).

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

- RJD processed inmate medical appeals timely for all 12 of the most recent months. In addition, inspectors sampled ten second level inmate medical appeals and found that all of the appeal responses addressed the inmate's initial complaint (MIT 15.001, 15.102).

- Inspectors reviewed six recent months of QMC meeting minutes and confirmed that RJD's QMC did meet monthly. During those meetings, the QMC evaluated program performance and took action when it identified improvement opportunities. Consequently, RJD received a score of 100 percent on this test (MIT 15.003). Additionally, RJD scored 100 percent regarding taking adequate steps to ensure the accuracy of its Dashboard data reporting (MIT 15.004).

- Medical staff promptly submitted the Initial Inmate Death Report (CDCR Form 7229A) to the CCHCS Death Review Unit for the ten applicable deaths that occurred at RJD in the prior 12-month period (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 (DRC) did not timely complete its death review summary for any of the ten deaths that occurred during the testing period. The DRC is required to complete a death review summary within 30 business days for deaths that occurred prior to November 2015, and within either 30 or 60 calendar days for deaths that occurred after November 1, 2015 (depending on whether the death was expected or unexpected). The DRC then notifies the institution's CEO of the review results so that any needed corrective action can be promptly pursued. For five of the ten inmate deaths tested, the committee completed its summary from 25 to 46 days late (55 to 76 days after the death) and then notified the institution's CEO of the review results from 2 to 13 days after that. For one inmate, the death review was completed timely, but the CEO was notified 35 days late. However, for four patients' deaths, there was no final report issued; therefore, the CEO had yet to be notified of the review results. As of the time of this report, all four death reports were late (MIT 15.996).

- Inspectors met with the institution's CEO to inquire about RJD's protocols for tracking appeals. The institutions management team received from CCHCS a weekly report as well as a monthly report, in which appeals were broken down by category. RJD management reviewed the reports and responded accordingly. The CEO reported that RJD received the greatest number of appeals related to pain management, specifically patients requesting an increase in narcotic medication for pain. In response to this, RJD developed a pain management consultation meeting, which included medical personnel and the patient to discuss the patient's concerns (MIT 15.997).

- Non-scored data gathered regarding RJD's practices for implementing local operating procedures (LOPs) indicated that the institution had an effective process in place for developing LOPs. The Chief Support Executive stated the institution had an LOP workgroup that met with the appropriate stakeholders to review each LOP annually. After the LOP was signed, it was sent to the QMC committee. Once the QMC approved of the revised LOP, an email was then sent out to staff informing them of the change. The LOP was also placed in the institution's shared drive, to allow RJD staff access to the revised LOP. At the time of the OIG's inspection, RJD had implemented all 49 applicable LOPs relating to the core topical areas recommended by the clinical experts who helped develop the OIG's medical inspection compliance program (MIT 15.998).
- The OIG discusses the institution's health care staffing resources in the *About the Institution* section on page *2* 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
(67.5%)

Overall Rating:
Inadequate

Compliance Testing Results

The institution received an *inadequate* compliance score of 67.5 percent in the *Job Performance Training, Licensing, and Certifications* indicator, scoring in the *inadequate* range on the following four tests:

- When the institution hires new nursing staff, it is required to provide new employee orientation within 30 days of their being hired. However, RJD did not timely provide new employee orientation for 18 new nurses hired in the most recent 12 months. As a result, the institution scored zero in this test area (MIT 16.107).

- Inspectors examined records to determine if nursing supervisors completed the required number of monthly performance reviews for subordinate nurses and discussed the results of those reviews. The OIG sampled reviews completed for five subordinate nurses. Four of the five nurses had the required number of reviews completed by their supervisors, but only two were complete. In two instances, the nursing supervisor failed to address the positive, well-performed aspects of the employee's performance. Finally, for one nurse, there was no signature proof that the findings or review itself was discussed with the nurse (40 percent) (MIT 16.101).

- Four of the ten nurses sampled (40 percent) were current on their clinical competency validations. Six nurses did not receive a clinical competency validation within the required time frame (MIT 16.102).

- OIG inspectors examined provider, nursing, and custody staff records to determine if the institution ensured that those staff members had current emergency response certifications. RJD's provider and nursing staff were all compliant, but custody staff did not always have current certifications. Specifically, managerial custody officers above the rank of captain did not have current certifications. Although the California Penal Code exempts those 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).

While RJD scored low in the areas above, it received *proficient* scores in the following test areas:

- OIG inspectors found that 14 of 15 providers (93 percent) received timely clinical performance evaluations. However, one provider (the chief physician and surgeon), who periodically performed patient evaluations, did not receive a performance evaluation (MIT 16.103).
- All providers were current with their professional licenses, and nursing staff and the pharmacist in charge were current with their professional licenses and certification requirements (MIT 16.001, 16.105).
- The pharmacy and providers who prescribed controlled substances had current Drug Enforcement Agency registrations (MIT 16.106).

Recommendations

No specific recommendations.

POPULATION-BASED METRICS

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

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

Methodology

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

Comparison of Population-Based Metrics

For the Richard J. Donovan Correctional Facility, nine HEDIS measures were selected and are listed in the following *RJD 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. RJD performed very well with its management of diabetes.

When compared statewide, RJD outperformed Medi-Cal in all five measures, and outperformed Kaiser in four of five diabetic measures selected. Kaiser South performed 4 percentage points higher than RJD for eye exams. When compared nationally, RJD outperformed Medicaid, Medicare, and commercial health plans in all five diabetic measures. RJD outscored the United States Department of Veterans Affairs (VA) in three of the applicable measures, but scored 13 percentage points lower than the VA in diabetic eye exams.

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 vaccinations to younger adults, RJD outperformed all Statewide and national plans. For administering influenza vaccinations to older adults, the institution scored lower than Medicare by 1 percentage point, and the VA by 5 percentage points. However, the institution's score was negatively affected by the 29 percent refusal rate. With regard to administering pneumococcal vaccines to older adults, RJD scored higher than Medicare, but 9 percentage points lower than the VA.

Cancer Screening

With respect to colorectal cancer screening, RJD scored higher than all health care plans, statewide and nationally, by more than 4 percentage points.

Summary

RJD's population-based metrics performance reflected an adequate chronic care program, corroborated by the institutions *adequate* ratings in *Quality of Provider Performance*, *Access to Care*, and *Quality of Nursing Performance* indicators. The institution may improve its scores for immunizations by reducing patient refusals through patient education.

RJD Results Compared to State and National HEDIS Scores

Clinical Measures	California					National		
	RJD Cycle 4 Results[1]	HEDIS Medi-Cal 2015[2]	HEDIS Kaiser (No. CA) 2015[3]	HEDIS Kaiser (So.CA) 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]	**15%**	39%	18%	24%	44%	31%	25%	19%
HbA1c Control (<8.0%)[6]	**75%**	49%	70%	62%	47%	58%	65%	-
Blood Pressure Control (<140/90)[6]	**90%**	63%	84%	85%	62%	65%	65%	78%
Eye Exams	**77%**	53%	69%	81%	54%	56%	69%	90%
Immunizations								
Influenza Shots - Adults (18–64)	**65%**	-	54%	55%	-	50%	-	58%
Influenza Shots - Adults (65+)	**71%**	-	-	-	-	-	72%	76%
Immunizations: Pneumococcal	**84%**	-	-	-	-	-	70%	93%
Cancer Screening								
Colorectal Cancer Screening	**86%**	-	80%	82%	-	64%	67%	82%

1. Unless otherwise stated, data was collected in June 2016 by reviewing medical records from a sample of RJD'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 RJD 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

Richard J. Donovan Correctional Facility Range of Summary Scores: 58.33% - 92.00%	
Indicator	**Compliance Score (Yes %)**
Access to Care	89.54%
Diagnostic Services	88.40%
Emergency Services	Not Applicable
Health Information Management (Medical Records)	58.57%
Health Care Environment	82.58%
Inter- and Intra-System Transfers	81.41%
Pharmacy and Medication Management	70.44%
Prenatal and Post-Delivery Services	Not Applicable
Preventive Services	60.42%
Quality of Nursing Performance	Not Applicable
Quality of Provider Performance	Not Applicable
Reception Center Arrivals	Not Applicable
Specialized Medical Housing (OHU, CTC, SNF, Hospice)	92.00%
Specialty Services	80.71%
Internal Monitoring, Quality Improvement, and Administrative Operations	58.33%
Job Performance, Training, Licensing, and Certifications	67.50%

Reference Number	*Access to Care*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
1.001	**Chronic care follow-up appointments:** Was the inmate-patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter?	33	7	40	82.50%	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?	15	14	29	51.72%	1
1.003	**Clinical appointments:** Did a registered nurse review the inmate-patient's request for service the same day it was received?	30	0	30	100.00%	0
1.004	**Clinical appointments:** Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed?	29	1	30	96.67%	0
1.005	**Clinical appointments:** If the registered nurse determined a referral to a primary care provider was necessary, was the inmate-patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter?	11	1	12	91.67%	18
1.006	**Sick call follow-up appointments:** If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified?	5	0	5	100.00%	25
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?	28	2	30	93.33%	0
1.008	**Specialty service follow-up appointments:** Do specialty service primary care physician follow-up visits occur within required time frames?	27	3	30	90.00%	0
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:					**89.54%**	

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?	9	1	10	90.00%	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?	9	1	10	90.00%	0
2.007	**Pathology:** Did the institution receive the final diagnostic report within the required time frames?	9	1	10	90.00%	0
2.008	**Pathology:** Did the primary care provider review and initial the diagnostic report within specified time frames?	8	1	9	88.89%	1
2.009	**Pathology:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	6	3	9	66.67%	1
Overall percentage:					**88.40%**	

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

Reference Number	*Health Information Management (Medical Records)*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated progress notes, initial health screening forms, and health care services request forms scanned into the eUHR within three calendar days of the inmate-patient encounter date?	9	1	10	90.00%	0
4.002	Are dictated / transcribed documents scanned into the eUHR within five calendar days of the inmate-patient encounter date?	6	14	20	30.00%	0
4.003	Are specialty documents scanned into the eUHR within the required time frame?	19	1	20	95.00%	0
4.004	Are community hospital discharge documents scanned into the eUHR within three calendar days of the inmate-patient date of hospital discharge?	11	9	20	55.00%	0
4.005	Are medication administration records (MARs) scanned into the eUHR within the required time frames?	12	8	20	60.00%	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?	23	9	32	71.88%	0
4.008	**For inmate-patients discharged from a community hospital:** Did the preliminary hospital discharge report include key elements and did a PCP review the report within three calendar days of discharge?	20	10	30	66.67%	0
Overall percentage:					**58.57%**	

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?	12	0	12	100.00%	0
5.102	**Infection control:** Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	11	1	12	91.67%	0
5.103	**Infection Control:** Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	10	2	12	83.33%	0
5.104	**Infection control:** Does clinical health care staff adhere to universal hand hygiene precautions?	5	4	9	55.56%	3
5.105	**Infection control:** Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	12	0	12	100.00%	0
5.106	**Warehouse, Conex and other non-clinic storage areas:** Does the medical supply management process adequately support the needs of the medical health care program?	1	0	1	100.00%	0
5.107	**Clinical areas:** Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	10	2	12	83.33%	0
5.108	**Clinical areas:** Do clinic common areas and exam rooms have essential core medical equipment and supplies?	8	4	12	66.67%	0
5.109	**Clinical areas:** Do clinic common areas have an adequate environment conducive to providing medical services?	9	3	12	75.00%	0
5.110	**Clinical areas:** Do clinic exam rooms have an adequate environment conducive to providing medical services?	9	3	12	75.00%	0
5.111	**Emergency response bags:** Are TTA and clinic emergency medical response bags inspected daily and inventoried monthly, and do they contain essential items?	7	2	9	77.78%	3
5.999	**For Information Purposes Only:** Does the institution's health care management believe that all clinical areas have physical plant infrastructures sufficient to provide adequate health care services?	Information Only				
Overall percentage:					**82.58%**	

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?	26	4	30	86.67%	0
6.002	**For endorsed inmate-patients received from another CDCR institution or COCF:** When required, did the RN complete the assessment and disposition section of the health screening form; refer the inmate-patient to the TTA, if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening?	30	0	30	100.00%	0
6.003	**For endorsed inmate-patients received from another CDCR institution or COCF:** If the inmate-patient had an existing medication order upon arrival, were medications administered or delivered without interruption?	15	4	19	78.95%	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?	14	6	20	70.00%	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?	5	2	7	71.43%	3
Overall percentage:					**81.41%**	

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?	21	14	35	60.00%	5
7.002	Did health care staff administer or deliver new order prescription medications to the inmate-patient within the required time frames?	38	2	40	95.00%	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?	19	6	25	76.00%	5
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?	26	4	30	86.67%	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?	3	7	10	30.00%	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?	2	8	10	20.00%	10
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?	13	7	20	65.00%	0
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?	5	12	17	29.41%	3
7.104	**Medication preparation and administration areas:** Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes?	3	5	8	37.50%	12
7.105	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when preparing medications for inmate-patients?	8	0	8	100.00%	12
7.106	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when distributing medications to inmate-patients?	3	5	8	37.50%	12
7.107	**Pharmacy:** Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and satellite pharmacies?	1	0	1	100.00%	0

Reference Number	*Pharmacy and Medication Management*	Scored Answers				
		Yes	No	Yes + No	Yes %	N/A
7.108	**Pharmacy: Does the institution's pharmacy properly store non-refrigerated medications?**	1	0	1	100.00%	0
7.109	**Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications?**	1	0	1	100.00%	0
7.110	**Pharmacy: Does the institution's pharmacy properly account for narcotic medications?**	1	0	1	100.00%	0
7.111	**Pharmacy: Does the institution follow key medication error reporting protocols?**	27	3	30	90.00%	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:					**70.44%**	

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?	2	4	6	33.33%	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?	2	4	6	33.33%	0
9.003	**Annual TB Screening:** Was the inmate-patient screened for TB within the last year?	5	25	30	16.67%	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 50 through the age of 75:** Was the inmate-patient offered colorectal cancer screening?	30	0	30	100.00%	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?	19	5	24	79.17%	6
9.009	Are inmate-patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	Not Applicable				
Overall Percentage:					**60.42%**	

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

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

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

Reference Number	*Specialized Medical Housing (OHU, CTC, SNF, Hospice)*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	**For all higher-level care facilities:** Did the registered nurse complete an initial assessment of the inmate-patient on the day of admission, or within eight hours of admission to CMF's Hospice?	10	0	10	100.00%	0
13.002	**For OHU, CTC, & SNF only:** Did the primary care provider for OHU or attending physician for a CTC & SNF evaluate the inmate-patient within 24 hours of admission?	10	0	10	100.00%	0
13.003	**For OHU, CTC, & SNF only:** Was a written history and physical examination completed within 72 hours of admission?	10	0	10	100.00%	0
13.004	**For all higher-level care facilities:** Did the primary care provider complete the Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes on the inmate-patient at the minimum intervals required for the type of facility where the inmate-patient was treated?	6	4	10	60.00%	0
13.101	**For OHU and CTC Only:** Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter inmate-patient's cells?	1	0	1	100.00%	0
Overall Percentage:					**92.00%**	

Reference Number	*Specialty Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	Did the inmate-patient receive the high priority specialty service within 14 calendar days of the PCP order?	13	2	15	86.67%	0
14.002	Did the PCP review the high priority specialty service consultant report within three business days after the service was provided?	14	1	15	93.33%	0
14.003	Did the inmate-patient receive the routine specialty service within 90 calendar days of the PCP order?	13	2	15	86.67%	0
14.004	Did the PCP review the routine specialty service consultant report within three business days after the service was provided?	14	1	15	93.33%	0
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?	20	0	20	100.00%	0
14.007	Following the denial of a request for specialty services, was the inmate-patient informed of the denial within the required time frame?	9	9	18	50.00%	2
Overall Percentage:					**80.71%**	

Reference Number	*Internal Monitoring, Quality Improvement, and Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.001	Did the institution promptly process inmate medical appeals during the most recent 12 months?	12	0	12	100.00%	0
15.002	Does the institution follow adverse/sentinel event reporting requirements?	Not Applicable				
15.003	Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified?	6	0	6	100.00%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	1	0	1	100.00%	0
15.005	For each initiative in the Performance Improvement Work Plan (PIWP), has the institution performance improved or reached the targeted performance objective(s)?	0	5	5	0.00%	1
15.006	**For institutions with licensed care facilities:** Does the local governing body (LGB), or its equivalent, meet quarterly and exercise its overall responsibilities for the quality management of patient health care?	1	3	4	25.00%	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?	10	0	10	100.00%	0
15.996	**For Information Only:** Did the CCHCS Death Review Committee submit its inmate death review summary to the institution timely?	Information Only				
15.997	**For Information Only:** Identify the institution's protocols for tracking medical appeals.	Information Only				
15.998	**For Information Only:** Identify the institution's protocols for implementing health care local operating procedures.	Information Only				

Reference Number	*Internal Monitoring, Quality Improvement, and Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.999	**For Information Only:** Identify the institution's health care staffing resources.	Information Only				
Overall Percentage:					**58.33%**	

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?	17	0	17	100.00%	0
16.101	Does the institution's supervising registered nurse conduct periodic reviews of nursing staff?	2	3	5	40.00%	0
16.102	Are nursing staff who administer medications current on their clinical competency validation?	4	6	10	40.00%	0
16.103	Are structured clinical performance appraisals completed timely?	14	1	15	93.33%	0
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?	5	0	5	100.00%	1
16.106	Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	1	0	1	100.00%	0
16.107	Are nursing staff current with required new employee orientation?	0	1	1	0.00%	0
Overall Percentage:					**67.50%**	

APPENDIX B — CLINICAL DATA

Table B-1: RJD Sample Sets	
Sample Set	**Total**
Anticoagulation	3
Death Review/Sentinel Events	5
Diabetes	3
Emergency Services – CPR	5
Emergency Services – Non-CPR	5
High Risk	5
Hospitalization	4
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	25
Specialty Services	5
	66

Table B-2: RJD Chronic Care Diagnoses	
Diagnosis	**Total**
Anemia	11
Anticoagulation	5
Arthritis/Degenerative Joint Disease	3
Asthma	13
COPD	17
Cancer	10
Cardiovascular Disease	17
Chronic Kidney Disease	9
Chronic Pain	15
Cirrhosis/End-Stage Liver Disease	3
Coccidioidomycosis	5
Deep Venous Thrombosis/Pulmonary Embolism	3
Diabetes	29
Gastroesophageal Reflux Disease	25
Gastrointestinal Bleed	1
HIV	2
Hepatitis C	16
Hyperlipidemia	28
Hypertension	49
Mental Health	20
Migraine Headaches	1
Seizure Disorder	5
Sleep Apnea	7
Thyroid Disease	5
	299

Table B-3: RJD Event — Program	
Program	**Total**
Diagnostic Services	338
Emergency Care	112
Hospitalization	161
Intra-System Transfers in	20
Intra-System Transfers out	16
Not Specified	1
Outpatient Care	873
Specialized Medical Housing	343
Specialty Services	253
	2,117

Table B-4: RJD Case Review Sample Summary	
	Total
MD Reviews, Detailed	30
MD Reviews, Focused	0
RN Reviews, Detailed	19
RN Reviews, Focused	36
Total Reviews	85
Total Unique Cases	66
Overlapping Reviews (MD & RN)	19

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

Richard J. Donovan Correctional Facility			
Quality Indicator	**Sample Category (number of samples)**	**Data Source**	**Filters**
Access to Care			
MIT 1.001	Chronic Care Patients (40)	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) (30)	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 (10)	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	(20)	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 (12)	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 (10)	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 (40)	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 (40)	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 (8)	OIG inspector onsite review	• Identify and inspect onsite clinical areas that prepare and administer medications
MITs 7.107-110	Pharmacy (1)	OIG inspector onsite review	• Identify & inspect all onsite pharmacies
MIT 7.111	Medication Error Reporting (30)	Monthly medication error reports	• All monthly statistic reports with Level 4 or higher • Select a total of 5 months
MIT 7.999	Isolation Unit KOP Medications (18)	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 (6)	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • **Randomize**
MIT 9.003	TB Code 22, Annual TST (15)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (22) • **Randomize**
	TB Code 34, Annual Screening (15)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (34) • **Randomize**
MIT 9.004	Influenza Vaccinations (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • **Randomize** • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • **Randomize**
MIT 9.006	Mammogram *N/A at this institution*	SOMS	• Arrival date (at least 2 yrs prior to inspection) • Date of birth (age 52–74) • **Randomize**
MIT 9.007	Pap Smear *N/A at this institution*	SOMS	• Arrival date (at least three yrs prior to inspection) • Date of birth (age 24–53) • **Randomize**
MIT 9.008	Chronic Care Vaccinations (30)	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • **Randomize** • Condition must require vaccination(s)
MIT 9.009	Valley Fever (number will vary) *N/A at this institution*	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • **All**

Quality Indicator	Sample Category (number of 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)	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 (all)	OIG inspector onsite review	• Review by location
Specialty Services Access			
MITs 14.001–002	High-Priority (15)	MedSATS	• Approval date (3–9 months) • **Randomize**
MITs 14.003–004	Routine (15)	MedSATS	• Approval date (3–9 months) • Remove optometry, physical therapy or podiatry • **Randomize**
MIT 14.005	Specialty Services Arrivals (20)	MedSATS	• Arrived from (other CDCR institution) • Date of transfer (3–9 months) • **Randomize**
MIT 14.006-007	Denials (10)	InterQual	• Review date (3–9 months) • **Randomize**
	(10)	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • **Randomize**

Quality Indicator	Sample Category (number of 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) (6)	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 (10)	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.996	Death Review Committee (10)	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 (17)	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 (15)	OIG Q:16.001	• All required performance evaluation documents

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

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

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

January 17, 2017

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

Dear Mr. Barton:

The purpose of this letter is to inform you that the Office of the Receiver has reviewed the draft report of the Office of the Inspector General (OIG) Medical Inspection Results for R.J. Donovan Correctional Facility (RJD) conducted from June 2016 to August 2016. California Correctional Health Care Services (CCHCS) acknowledges all OIG findings.

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

Sincerely,

Janet Lewis

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

cc: Clark Kelso, Receiver
Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Richard Kirkland, Chief Deputy Receiver
Roy Wesley, Chief Deputy Inspector General, OIG
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