# EXHIBIT

# A

# California Institution for Men (CIM)

# Health Care Evaluation

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Prepared by the Plata Medical Experts

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## Introduction

In September 2012, the Federal Court, in Order Re: Receivership Transition Plan and Expert Evaluations, requested that the Court medical experts conduct evaluations at each CDCR prison to determine whether an institution is in substantial compliance. The Order contemplates that an institution "shall be deemed to be in substantial compliance, and therefore constitutionally adequate, if it receives an overall OIG score of at least 75% and an evaluation from at least two of the three court experts that the institution is providing adequate care."

To prepare for the prison health evaluations, in December 2012, the medical experts participated in a series of meetings with Clark Kelso, Receiver, and California Correctional Health Care Services (CCHCS) and CDCR leadership to familiarize us with structural changes that have occurred in the health care system since the beginning of the Receivership. Information gained from these meetings was invaluable to us in planning and performing the evaluations, and we express our appreciation to Mr. Kelso, CCHCS and CDCR.

In conducting the reviews, the medical experts evaluated essential components to an adequate health care system. These include organizational structure, health care infrastructure (e.g., clinical space, equipment, etc.), health care processes and the quality of care.

Methods of assessment included:

- Interviews with health care leadership and staff and custody staff
- Tours and inspection of medical clinics, medical bed space (e.g. Outpatient Housing Units, Correctional Treatment Centers, etc.) and administrative segregation units
- Review of the functionality of business processes essential to administer a health care system (e.g., budget, purchasing, human resources, etc.)
- Reviews of tracking logs and health records
- Observation of health care processes (e.g. medication administration)
- Review of policies and procedures and disease treatment guidelines
- Review of staffing patterns and professional licensure, and
- Interviews with inmates.

With respect to the assessment of compliance, the medical experts seek to determine whether any pattern or practice exists at an institution or system wide that presents a serious risk of harm to inmates that is not being adequately addressed.[1]

To evaluate whether there is any pattern or practice that presents a serious risk of harm to CDCR patients, our methodology includes review of health records of patients with serious medical conditions using a "tracer" methodology. Tracer methodology is a systems approach to

[1] Order re: Receivership Transition Plan and Expert Evaluations No. C01-1351 TEH, 9/5/12.

evaluation that is used by the Joint Commission for Accreditation of Health Care Organizations. The reviewer traces the patient through the organization's entire health care process to identify whether there are performance issues in one or more steps of the process, or in the interfaces between processes.

The experts reviewed records using this methodology to assess whether patients were receiving timely and appropriate care, and if not, what factors contributed to deficiencies in care. Review of any given record may show performance issues with several health care processes (e.g., medical reception, chronic disease program, medication issues, etc.). Conversely, review of a particular record may demonstrate a well-coordinated and functioning health care system; as more records are reviewed, patterns of care emerge.

We selected records of patients with chronic diseases and other serious medical conditions because these are the patients at risk of harm and who use the health care system most regularly. The care documented in these records will demonstrate whether there is an adequate health care system.

The tracer methodology may also reflect whether any system wide issues exist. Our methodology includes a reassessment of the systemic issues that were described in the medical experts report to Judge Henderson in April 2006 at the time the system was found to be unconstitutional and whether those systemic issues have been adequately addressed.[2]

We are available to discuss any questions regarding our audit methodology.

[2] The Status of Health Care Delivery Services in CDCR Facilities. Court-Appointed Medical Experts Report. April 15, 2006.

## Overall Finding

We find that the California Institution for Men (CIM) is not providing adequate medical care to patients, and that there are systemic issues that present an on-going serious risk of harm to patients and result in preventable morbidity and mortality.

## Executive Summary

On August 5-9, 2013, the Plata Court Medical Experts visited the California Institution for Men (CIM) to evaluate health care services. Our visit was in response to the OIG Medical Inspection Results Cycle 3 report showing that CIM scored 89.6% in February 2013. This report describes our findings and recommendations. We thank Warden Brenda Cash, Chief Executive Officer (CEO) Robert Herrick and staff for their assistance and cooperation in conducting the review.

With respect to its medical mission, CIM has undergone a major change in the past year. Once a reception center, it has been designated as an Intermediate Facility and has accumulated increased numbers of inmates with serious medical conditions. Health care leadership advised us that approximately 70% of the population has one or more chronic illnesses and 30% of the population is medically high risk. With the increased medical acuity of the population there has been a corresponding increase in the demand for health care services; however, the Acuity Based Staffing Realignment (ABSR) has reduced health care staffing. Since ABSR was implemented in March 2013, use of overtime and registry staff has increased 50%. In addition, although the population has declined in recent years, the current population is 162.8% of design capacity.

Our review suggests that CIM is approaching, if it has not already reached, its capacity to manage inmates with high medical acuity. For example, in Facility A, which is designated to house inmates of higher medical acuity, the number of inmates requiring bottom bunks has exceeded the number of available lower bunks. Officers we interviewed make a decision as to who gets the lower bunk based upon their perception of who needs it more. This reflects deficiencies in the CIM classification system and results in some inmates not receiving prescribed accommodations for their medical impairments (e.g., low bunk).

We also found significant problems related to the management of patients with chronic diseases, both in terms of the timeliness and the quality of care, in 19 of the 25 cases we reviewed. Primary care providers do not adequately address each of the patient's chronic diseases or abnormal laboratory findings in a timely or appropriate manner.

With respect to medical reception/intrasystem transfer, nurses do not perform medical screening in a clinical setting, but instead in a "confessional booth," as was done when we made our last site visit in 2006. Review of records showed problems with medical reception and the intrasystem transfer process that include transfer of seriously ill inmate/patients without

direct provider-to-provider communication; transfer of inmate/patients pending specialty services scheduled on or around the day of transfer; untimely medical reception history and physical examinations; and lack of timely follow-up of abnormal laboratory tests at the previous facility. Issues related to intrasystem/medical reception processes contributed to preventable deaths and delayed diagnosis and treatment of serious medical conditions.

With respect to access to care, CIM health care staff collects and triages health request forms (7362) in a timely manner following submission of health service requests. However, nurses did not consistently see patients in a timely manner and/or effectively address their health concerns, including urgent dental and mental health complaints.[3] Nursing evaluations were inadequate, often due to deficiencies in nursing protocols that do not provide adequate guidance to the nurse. When primary care provider (PCP) referrals were made, the provider referrals did not occur timely and providers did not consistently address the reason for the referral. Our findings were consistent with CIM internal audit reports that showed that nurses saw patients submitting health requests containing symptoms timely in 74% of cases; routine provider referrals took place timely in 58% of cases; and urgent provider referrals took place within policy time frames in 63% cases.[4] These delays in access occurred after the implementation of ABSR staffing reductions.

A related concern is that the CDCR Health Care Access Team in headquarters reduced correctional officers' posts assigned to health care operations. For example, staff reported that in Facility C, an evening shift correctional officer post was eliminated, so that there is no officer in the clinic with the nurse when inmates are sent to the clinic. This is an access issue as well as a safety issue for health care personnel.

Review of specialty services showed problems related to timeliness in seven (35%) of the 20 records, including two cases which involved delayed evaluation and treatment for malignancies.

Mortality review showed serious systemic issues and lapses in care. We reviewed deaths that we believe were preventable and that are described in this report. These cases involved the following issues:

- Deficiencies in the intrasystem transfer and medical reception process
- Failure in two deaths to identify serious illness and take action to treat
- Failure to examine a critically ill patient on the OHU for five days
- Failure of providers to examine patients when clinically indicated (e.g. following trauma, altered mental status, etc.)

[3] In these cases, dental and mental health staff did not see the patient timely.
[4] CIM access to care data from 5/1/2013 to 7/15/2013.

- Failure of a mental health provider to report a patient reporting sexual abuse and failure of custody to protect the inmate following known assault
- Failure to have an adequate policy regarding amitriptyline

Review of internal monitoring reports show lack of substantive discussion of issues that includes data and root cause analysis, corrective action plans or follow-up studies to demonstrate whether problems have been resolved. Although some communicable disease reporting takes place, there is not a functional infection control program to monitor surveillance of tuberculosis screening and other infections, which is a serious patient safety issue, particularly at an intake facility.

We found that health care leadership has not written local operating procedures that provide operational detail to implement the CCHCS statewide policies and procedures. As noted in previous reports, issues related to the budget process, discipline of health care professionals and inadequate clinic space, sanitation and privacy are found at CIM as well.

In summary, we found significant problems with the reception/intrasystem transfer process, chronic care program, access to care, timeliness of specialty services, mortality review, and the adequacy of clinic space that could cause or contribute to harm to patients with serious medical problems. The change in CIM's medical mission with the resultant increase of medically vulnerable patients with concurrent staffing reductions has significantly contributed to the problems in clinical care. We recommend that CCHCS/CDCR evaluate CIM's capacity from a classification perspective to ensure that the facility has sufficient resources to provider timely and appropriate medical care.

# Findings

## Facility Description

CIM opened in 1941 on 2,500 acres of land. It is a large complex consisting of four separate facilities under the administration of one Warden. The design capacity of the facility is 2,976. The current population is 4,845[5] or 162.8% of design capacity.

Facility A has a population of approximately 960 medium security Sensitive Needs Yard (SNY) inmates. The facility consists of eight dormitory housing units, and each unit has a capacity of approximately 140 inmates. One housing unit, Mariposa Hall, is currently vacant and being used for inmate programming.

Facility B has an inmate population of approximately 946 medium/maximum security inmates and serves as a male reception center, receiving and processing newly committed inmates. In addition to a reception center, Facility B includes Palm and Cypress Halls, which are designated as administrative segregation (Ad-Seg) units. These units receive inmates from CIM, CRC, local CDCR/Cal Fire Camps, and inmates serving a SHU term en route to other CDCR Institutions.

Facility C was converted in December 2011 from a Reception Center and currently houses an inmate population of approximately 760 medium/maximum Sensitive Needs Yard (SNY) inmates, many of whom are serving life sentences. The facility is located approximately two miles east of CIM's main complex.

Facility D, a secure level I facility, has a population of approximately 2500 inmates housed in open dormitories. Minimum level inmates can be housed and work outside the secure perimeter. Inmates with medium custody are housed and work inside the secure perimeter, but can live in a dormitory environment.

## Organizational Structure and Health Care Leadership

**Methodology:** We interviewed facility health care leadership and reviewed tables of organization, health care and custody meeting reports, and quality improvement reports.

**Findings:** The current executive team at CIM has been in place for three years and provides excellent leadership. The CIM administrative table of organization is organized along functional lines of authority. Robert Herrick has been the CEO at CIM for three years. Prior to that, he was involved in private sector hospital administration for over 30 years. Part of that time had been as a hospital CEO. This is his first prison system job.

[5] CDCR Weekly Report of Population. CIM. July 31, 2013.

Dr. Muhammad Farooq, the Chief Medical Executive (CME), has been in the system for approximately seven years and in his current position for three years. Dr. Tom Le is the Chief Physician and Surgeon (CPS). He has been at CIM in his current position approximately seven years. The Pharmacist in Charge (PIC) is Kerim Bangou. He has been at CIM approximately seven years. The Chief Nurse Executive (CNE) is Jorge Gomez and he has been at CIM for approximately eight years. This leadership team appears to work together well.

The Warden at the time of our visit was Brenda Cash. Since our visit, she has retired and Tim Perez is the acting Warden. There have been five Wardens over the past 19 months. The Assistant Warden (AW) position for health care has been vacant since 7/3/13. The health care Captain is Jesse Tolvert. Mr. Herrick attends the daily Warden briefing and meets with the Warden as needed. The AW and Captain attend the bimonthly Quality Management Committee (QMC) meetings. The AW and Captain also attend medical services meetings, medication management meetings, Emergency Response and Death Review Program Subcommittee meetings, and the medical chief's meeting every Tuesday.

Mr. Herrick reports to Dr. Tharratt. He also reports to Dr. Mort Rosenberg for dental issues and to Tim Belavich for mental health issues. There are group CEO meetings three times a year. In addition to these meetings, Mr. Herrick communicates with Dr. Tharratt as needed.

## Human Resources, Staffing and Budget

**Methodology:** We interviewed facility health care leadership and human resources staff. We reviewed current and planned acuity-based staffing plans, vacancy and fill rates. We reviewed budget allocations. We also reviewed the process for credentialing, peer review and annual performance evaluations.

**Findings:** As with other facilities, CCHCS posts all positions and performs initial screening of employee candidates. CCHCS then provides a list of candidates to the facility and CIM leadership re-screens candidates, interviews and completes the hiring process. It takes about two months to hire a candidate. The CEO feels that the hiring process works well.

CIM had 375.4 staff positions and lost 30.2 positions in the March 2013 Acuity Based Staffing Realignment (ABSR). CIM currently has 345.2 positions, of which 27.1 (7.8%) are vacant. The major changes as a result of ABSR were a loss of 13.4 office staff, 14.9 Registered Nurses and 4 Supervising Nurse II positions. There were deletions and additions of one or two positions in other areas.

Leadership at CIM believes that the loss of office technicians and nurses will be problematic. The population went from 6,104[6] to 4,845[7] under ABSR. This is a 25% reduction in population.

[6] CDCR Weekly Report of Population. January 2, 2008.

However, under ABSR, CIM became an Intermediate Facility. This has resulted in a significant increase of high-risk patients assigned to CIM. As of the day of our visit, the high-risk population at CIM had increased from approximately 900 individuals to 1,355. The high-risk population is expected to increase to 1,400, a 55% increase from baseline. CIM also has housing for the disabled and those who are developmentally delayed, as well as an Outpatient Housing Unit (OHU).[8] In addition, CIM continues to be a reception center, taking in approximately 120 new inmates each week.

Beginning in March with the reductions in staffing, overtime and registry use increased approximately 50%. The total of registry and overtime expenditures is equivalent to 50 full time equivalent (FTE) staff. The use of 50 FTE staff in overtime and registry exceeds the 30.2 positions deleted in the ABSR. Registry and overtime costs for the four months since the inception of ABSR was $178,096 per month as opposed to $99,655 for the four months before ABSR started. This is a 78% increase in overtime and registry cost. Given the changes in medical acuity of the population, CCHCS needs to re-evaluate staffing at this facility.

Credentialing and Peer Review

CCHCS performs all credentialing for CIM. CCHCS sends letters to CIM announcing initial credentialing and biennial renewal. The CIM leadership keeps these letters on a hard drive accessible to the CME and CPS. CIM maintains no other credentialing information on-site. The CME maintains a list of every credential decision on a log with the date of credentialing and the expiration date of the credentials.

With respect to peer review, CIM keeps an electronic file for each provider. The CME and CPS have an electronic file of all eUHR Clinical Appraisals (UCAs). Each provider receives a UCA annual performance evaluation from the CPS. Of the 17 providers who have been on staff over the past year, all 17 had a UCA on file. All but one of these UCA reviews has been done within the past year. No significant problems have been identified. However, the CPS documented a discussion of the review with the provider in only five of 17 cases. This needs to be done for every review. In addition to the UCA reviews, Dr. Le and Dr. Farooq perform random record reviews of patients whose chronic illness is not in control as identified from patients in the chronic illness registry. They do not document the results of these record reviews.

We asked leadership at this facility how they would address discipline for a physician who committed a serious clinical error. The response was that they would refer the doctor to the Office of Investigative Affairs (OIA) for investigation. They were not familiar with the 2008

[7] CDCR Weekly Report of Population. July 31, 2013.
[8] The OHU consists of 44 medical and 36 mental health beds. While classified as an OHU, it is used similarly to a CTC.)

policies[9] on physician clinical competency. CCHCS needs to ensure that all leadership staff are aware of these Court ordered policies.

The CME and CPS meet every morning with all providers to discuss patients who had returned from the hospital, on-call problems and problem patients. This is an excellent vehicle to communicate problems and to discuss management issues as a group. After this morning report, providers return to their yard clinics and attend a morning "huddle" with the other clinic staff during which similar issues are discussed.

Training for providers consists of webinars and didactic discussions conducted in the morning report. These are discussions of patient cases. There are 16 providers and all are Board Certified. Eight are Board Certified in Family Practice and eight are Board Certified in Internal Medicine. Most providers have been at the facility for more than four years.

**Disciplinary Process**

Ten disciplinary actions are pending as of 7/15/13. These have been pending, on average, for 6.6 months each. The range is 1 month to 11 months. One new employee was found allegedly diverting narcotics and has been reassigned to housekeeping duties outside of the perimeter of the prison pending investigation. No other employees are reassigned. We continue to recommend that CCHCS assign the investigators for the initial disciplinary investigation of CCHCS employees.

**Health Care Budget**

In FY 2010/2011, the initial budget allocation was approximately $27.86 million, the final allocation was approximately $53.68 million and final expenditures were approximately $62.96 million. Final expenditures exceeded the initial allocation by $35.1 million (126%). In this fiscal year, the Department of Finance reduced the correctional health care budget to be in line with an estimate of per inmate cost in other states.

In FY 2011/2012, the initial allocation was approximately $46.75 million, the final allocation was approximately $55.55 million and final expenditures were approximately $68.20 million. Final expenditures exceeded the initial allocation by $21.45 million (46%). Changes in this fiscal year included moving nursing mental health positions into the medical program.

In FY 2012/2013, the initial allocation was approximately $58.93 million. This was only 86% of the prior year's expenditures.

The Department of Finance continues to significantly underfund CCHCS medical programs.

[9] Plata Physician Professional Clinical Practice Review, Hearing and Privileging Procedures; Pursuant to Order Approving, With Modifications, Proposed Policies Regarding Physician Clinical Competency, July 9, 2008.

Health care expenditures exceeded initial allocations for two consecutive years. And in fiscal year 2012 to 2013, the initial allocation is below the prior year's expenditures. The Receiver provides additional funding so that the programs can operate; however, this process does not assure an adequate and sustainable health care budget once the Receivership ends.

## Health Care Operations, Clinic Space and Sanitation

**Methodology:** We toured central and housing medical clinics, the Outpatient Housing Unit (OHU) and administrative and ancillary support areas. In addition, we interviewed staff involved in health care operations.

**Findings:** While CIM does not currently have a Periodic Automatic Replacement (PAR) system, they are in the process of developing one. CIM has a warehouse for medical supplies which is 2000-3000 square feet. They have no prime vendor. Mr. Maldonado, who maintains the supplies and equipment, provided The Medical Equipment Quarterly Preventive Maintenance Inspection Service Report. All the equipment had been documented as calibrated and maintained within the past quarter. However, as noted below, we found numerous oto-ophthalmoscopes that did not have working bulbs, were not properly mounted or were not operating. The inspection report listed only one oto-ophthalmoscope as not working. This discrepancy needs to be reviewed by leadership.

CIM has not been able to use the CDCR Business Inventory System (BIS) for all supply items, so they have to maintain two inventories; one inventory is of items that are in BIS and one inventory is of items that are not in BIS. The two inventories are not reconciled. As a result, a complete current inventory was not available.

The clinic space at CIM is inadequate. Many clinics are not adequately sized or designed. For example, Facility A nurse triage and assessment area is shared by three nurses and several office staff, and thus lacks privacy. We were told that privacy is assured by talking softly. Facility C nurse triage and assessment is also shared by both nursing and office staff and lacks privacy.

Clutter is everywhere in all clinics. For example, in Facility C, one of the provider examination rooms had wheelchairs and a box of opened floor buffing pads stored at the end of the examination table so that the foot extender could not extend. Clearly, a patient would not be able to lie down for a proper examination. Examination tables in several areas are used as storage shelves. In the C clinic, the provider stores her supplies on the foot extension of the examination table. Because there are no break rooms, staff eats in clinical areas, which violates OHSA regulations. Microwaves, coffee pots and toasters are kept in clinical areas.

Many clinical examination spaces are makeshift. For example, Facility A recently had a large influx of high-risk patients and another provider was added. That provider works in an old office

previously used by the supervising nurse. He performs patient examinations with the patient in a chair. No sink is available. Also in Facility A, another provider examination room was formerly a storage room. When the door opens, it butts up against the examination table. It is not possible for a patient to lie flat on the table or to extend the foot support of the table.

Some rooms did not have oto-ophthalmoscopes. One room had an oto-ophthalmoscope unit that was built to be mounted on a wall. It was not mounted on a wall but was lying on a shelf so far from the examination table that it could not be used. We note that several other oto-ophthalmoscopes were not mounted in correct locations. We were told that CCHCS no longer provides maintenance of fixed medical equipment. This is now provided by CDCR plant operations. There have been delays in getting work orders completed. Additionally, because the walls may have lead paint or asbestos, drilling holes requires a study to determine if the drilling will result in hazardous exposure. We were told that this is a barrier to timely installation of equipment. Multiple rooms had oto-ophthalmoscopes that had nonfunctioning light bulbs. Some rooms did not have sinks.

CIM is an intake facility. The nurse reception screening area consists of two rooms. Each is a 5-foot by 4-foot booth sealed with Plexiglas with a small opening to ask the patient questions. The patient stands outside the room. The nurse performs vital signs, a tuberculin skin test and completes a questionnaire through the small porthole. The lower wall is solid material. It is difficult to hear and see the patient. This room is unacceptable for its intended purpose and needs to be changed as soon as possible. Some of the problems described with medical reception screening may be a direct result of this inadequate arrangement.

In Facility A, inmates wait for clinic visits outside on bleachers. In Facility C, there is a small bench inside the clinic that seats approximately three people and another bench outside that also seats about three people. Patients must be able to wait indoors for their clinic appointments.

The OHU is an 80-bed unit separated into four wings. There are two nursing stations, each of which serves two wings. The nursing stations are small and do not have sufficient counter space for every staff member to have a workspace to type a note into the eUHR. All keyboards and terminals for the eUHR are located on the counter edge making them extremely difficult to use. The providers have no workspace, so they see patients and walk back to an office in another area of the building to write their notes. As noted in the OHU section of this report, this resulted in patient safety issues.

The Health Care Facility Improvement Plan (HCFIP) includes a schedule to start construction at CIM on 9/10/14. Construction will be completed by 9/16/16. The HCFIP will correct almost all of the deficiencies we noted. One exception is the OHU. Renovation plans for the OHU include repair of vinyl tile in several inmate rooms with an epoxy material for purposes of improved

sanitation. The HCFIP does not include renovation of the two nursing stations. These nursing stations are inadequate. They lack sufficient workspace; they do not have appropriate space for terminals for the eUHR, and are poorly designed for nursing workflow.

Sanitation of clinic space is not consistent. Some clinics and the OHU were clean. Others were not clean. All clinics were cluttered. Four civil servant janitors (one supervisor and three janitors) clean Facility D and supervise inmate porters who also clean Facility D. Inmate porters supervised by a custody sergeant clean Facilities A, B and C. The civil service staff and inmate porters clean the pharmacy under the supervision of pharmacy staff. There is a cleaning schedule; all clinics are cleaned five days a week and the OHU seven days a week.

## Policies and Procedures

**Methodology:** We interviewed health care leadership and staff, and reviewed selected statewide and local policies and procedures to determine whether they were periodically reviewed and whether local policy was consistent with statewide policies.

**Findings:** CIM has used the CCHCS Inmate Medical Services Policies & Procedures (IMSPP) as a template for their local operating procedures (LOPs).[10] This saves time and ensures standardization of procedure and generally is a good idea. However, the CIM LOPs are almost all verbatim copies of the equivalent IMSPP. The local procedures have insufficient CIM specific information to guide staff. Verbatim substitutions used at CIM often do not make sense or are unclear. LOPs need to clearly identify implementation steps as they are to occur at CIM.

For example, item 9 in the LOP on Healthcare Transfer Process (Volume 4, Chapter 3) contains the statement, "The CIM Supervising Registered Nurse shall ensure the health care staff includes copies from the eUHR of all active CDCR Form 7221s in the transfer envelope." There are 3 SRN III positions and 12 SRN II positions on staff. The local operating procedure does not make clear which of these supervising nurses is assigned to this duty.

Item 11 of the LOP on Access to Primary Care (Volume 4, Chapter 4) states:

> The facility is responsible for developing a system to ensure that the CDCR Form 7362 and associated Nurse Encounter information is available to the PCP at the time of scheduled appointment with the inmate-patient.

This is taken verbatim from the IMSPP, but does not clarify who at CIM is responsible for making these forms available to the provider. In other sections of the same policy, there are references to a "designated RN" without being more specific. These are confusing instructions.

[10] Inmate Medical Services Policies & Procedures found at the website www.cphcs.ca.gov/imspp.aspx.

The LOP on Overview of Health Care Services (Volume 1, Chapter 3) is a verbatim replication of the IMSPP, stating that the facility is to deliver medically necessary services. However, it does not specifically address the arrangements at CIM to accomplish this. For example, what local hospitals, specialists and radiology services are used?

While it is time saving to mimic the IMSPP, procedural instructions need to be specific enough so that it is clear who is to perform the procedure, what they are to do, where they are to do it, when the procedure is to be done and how the procedure is to be done.

At times, the verbatim replication of IMSPP results in having a procedure that is unnecessary. For example, the LOP on Credentialing (Volume 1, Chapter 9) provides policy on credentials, including the manner of credentialing in General Acute Care Hospitals, Correctional Treatment Centers, and Skilled Nursing Facility, none of which are present at CIM.

Furthermore, verbatim replication of IMSPP can result in LOPs that are confusing. For example, the LOP on Professional Clinical Staff (Volume 1, Chapter 5) states:

> Where there is an organized Clinical Staff, the following is the officer of the Clinical Staff
>
> - Chief of Staff
>
> The Chief of Staff is appointed by Executive Clinical Staff for a two-year term. Where there is no organized Clinical Staff, the Chief Medical Executive (CME) shall provide official leadership for the Medical Staff as long as they retain their respective positions.

There is no organized medical staff at CIM. This LOP is confusing. Instead, CIM needs to have a procedure that clarifies how the CME and CPS supervise and direct providers and how they perform their annual peer review evaluations. This section needs to include a statement about how peer review is managed and must reference the 2008 Court order[11] regarding provider clinical competency and its associated policy.[12] Another example is the LOP on Reception Health Care Procedure (Chapter 4, Volume 4.2.2). It is identical to the IMSPP to the extent that it contains directions for forms to use to screen female patients. There are no female inmates at CIM.

While using IMSPP as a template is useful, CIM must revise the IMSPP so that it accurately reflects expected procedures at CIM.

One LOP is missing. There is no procedure for the Outpatient Housing Unit. There is a LOP entitled Correctional Treatment Center (Volume 4, Chapter 15) which consists of one

[11] Order Approving, with Modifications, Proposed Policies Regarding Provider Clinical Competency; NO. C01-1351 TEH Document 1302 filed 07/09/2008.

[12] Plata Provider Professional Clinical Practice Review, Hearing and Privileging Procedures Pursuant to Order Approving with Modifications, Proposed Policies Regarding Provider Clinical Competency, July 9, 2008.

paragraph, stating that CIM is not licensed to operate a CTC and instead operates an Outpatient Housing Unit (OHU). However, there is no policy or procedure for the OHU. This needs to be developed.

With the exception of the OHU, all major areas of service are covered by LOPs.

## Medical Reception/Intrasystem Transfer

**Methodology:** We toured the receiving and release (R&R) area in Facility B, interviewed facility health care leadership and staff involved in intrasystem transfer and reviewed tracking logs, staffing and 22 health records.

Intrasystem Transfers

**Findings:** As noted above, CIM's medical mission has changed from primarily a medical reception facility to an Intermediate Facility that includes a medical reception component. Staff reported that prior to the change in mission the facility used to receive approximately 100 inmates per day, but this has decreased to approximately 20-25 per day. Counties transfer inmates on Tuesdays and Thursdays. The facility also receives transfers from other CDCR facilities. There is no regular schedule for these transfers.

While health care staff screens newly arriving inmates in a timely manner, the screening is not performed in an appropriate clinical setting that permits the nurse to perform an adequate assessment. In fact, the conditions of health care screening are unchanged from those described in our 2006 report. Nurses conduct screening in what amounts to a "confessional booth" where the nurse sits on one side of the booth separated from the inmate by Plexiglas and a metal grate that has a small 4" x 6" opening for the nurse to speak to the inmate. The inmate must stand throughout the process because there is no seating on that side of the booth. We stepped into the booth and had a staff member step into the other side to evaluate the ability to see and hear the inmate. We found that lighting was poor and negatively impacted the nurse's ability to observe the person's expression and color. The arrangement did not permit the nurse to observe the patient below the waist.[13] The Plexiglas and metal grate combined with the small opening made it difficult to hear the other person. Ironically, the medical clinic for Facility B is directly across the hall and could easily be utilized for medical screening of new arrivals.

Review of records showed several problems with medical reception and the intrasystem transfer process. These include transfer of seriously ill inmates without direct provider-to-provider communication; transfer of inmates pending specialty services scheduled on the day of transfer; untimely medical reception history and physical examinations; and lack of timely follow-up of abnormal laboratory and diagnostic tests at the previous facility. Two cases

[13] This does not permit the nurse to observe patient's lower extremities.

involved delays in diagnosis and treatment for malignancies and are described in the Specialty Services section of this report.[14] Our review also revealed cases in which medical providers did not perform and document clinical evaluations of patients when medically indicated. Examples are described below.

- This 29-year-old patient with a medical history that included newly diagnosed AIDS, disseminated MAC[15] and renal disease transferred from Avenal State Prison (ASP) to CIM on 10/5/12.[16] At ASP, in August 2012, the patient complained of weight loss, diarrhea and painful feet. He also had severe anemia.[17] On 9/9/12, the patient was sent to the TTA urgently with high fever (Temp=102.6°F), tachycardia (pulse=132/bpm), 25 lbs. weight loss and leg pain. The ASP provider ordered intravenous (IV) fluids, Tylenol, antibiotics, laboratory tests and a chest x-ray to be obtained the following day, and sent the patient back to his housing in Ad-Seg. Three days later, the patient was admitted to a local hospital with newly diagnosed AIDS (CD4[18] count=5, normal >500 cells) and esophageal candidiasis.[19] On 9/20/12, he was discharged and housed in the ASP OHU and arrangements were made to transfer him from the cocci hyperendemic area. On 9/28/12, his blood count showed an elevated white blood cell count (WBC=17, normal=4-10) suggesting systemic infection, but the lab did not report this result for a week (10/4/12) and a provider did not review it until 10/6/12. On 10/5/12, an ASP OHU nurse completed a transfer form that did not adequately describe the severity of the patient's illness (e.g., 50 lbs. weight loss since his arrival in CDCR in April 2011). Upon arrival at CIM, a nurse notified a provider of the patient's condition but a provider did not see the patient. The following morning a provider did not document a clinical evaluation but completed a Request for Services (RFS) to transport the patient to the local hospital where he was admitted for fever, cough and tachycardia. He was subsequently diagnosed with MAC. Over the following months, he was treated by two infectious disease (ID) physicians and a primary care provider and the patient's care became fragmented. For example, in February 2013, the ID physician treating the patient for MAC advised the primary care provider that his treatment regimen did not meet the standard of care and that his antiretroviral regimen was not appropriate for the patient due to his renal disease. The primary care provider doubted the patient had MAC and did not address the consultant's recommendations, which created a risk of harm to the patient. In March and May, the ID consultant again raised concerns regarding the patient's treatment plan and it was not until late May 2013 that the recommendations were adequately addressed.

[14] Specialty Services Patient #8 and #15.
[15] Mycobacterium Avium Complex, an infection found in patients with compromised immune systems.
[16] Intrasystem Transfer/Sick Call Patient #3.
[17] This 9/6/12 abnormal lab report was not reviewed by a provider until 9/20/12.
[18] A type of white blood cell that is decreased in HIV-infected patients.
[19] A fungal infection that is typically found in patients with compromised immune systems.

Assessment

There were both system and quality of care issues at ASP related to timely receipt and review of abnormal labs and sending an acutely ill patient to administrative segregation instead of admitting him to a medical bed. Intrasystem transfer issues include lack of provider-to-provider communication between ASP and CIM and lack of provider evaluation on the day of transfer. Following transfer, the CIM provider did not follow ID consultant recommendations in a timely manner, resulting in delayed provision of the standard of care.

- This 31-year-old patient arrived at Wasco State Prison (WSP) on 4/23/13 and transferred to CIM on 7/25/13.[20] His medical history included HIV infection/AIDS, syphilis, MAC, peripheral neuropathy, a bowel obstruction for which he had surgery in 2011, chronic coccidioidomycosis, deep vein thrombosis and depression. The patient had been treated for syphilis in the past and his last known titer was 1:2 in 2011. At Wasco, the patient's syphilis test was positive with an increased titer of 1:16, suggesting treatment failure or new infection. Wasco providers did not obtain a sexual history or review of systems related to syphilis, but planned to obtain previous medical records; this did not occur. A repeat RPR titer was 1:8 and the provider planned to follow the patient, but did not order repeat titers. Also, on 5/31/13, while still at WSP the patient presented to a nurse with bilateral lower leg edema and leg discoloration for five weeks. The nurse notified the provider, who did not see the patient but ordered a diuretic and potassium, and follow-up in 14 days. On 6/6/13, the patient submitted a 7362 stating that his legs were still painful and swollen. A provider did not document an examination but completed a RFS and sent the patient to San Joaquin General Hospital (SJGH) for a lower extremity ultrasound. We did not find the report in the record. On 7/24/13, the patient transferred to CIM. Since his arrival at CIM, the patient's ultrasound report is still not in the record. Apparently, the patient is being anticoagulated for deep vein thrombosis. We also found no documentation of the patient's onset of his symptoms or planned duration of therapy. In August and September his INRs have been either subtherapeutic or supratherapeutic.

  Assessment

  There was a delay in evaluation and treatment of the patient's elevated syphilis titer and inadequate documentation related to the patient's history and treatment plan for his DVT. We discussed this case with the CME prior to leaving the facility and thereafter the patient was evaluated for neurosyphilis and treated for latent syphilis.

- This 62-year-old patient transferred from Mule Creek State Prison (MCSP) to CIM on 12/29/11 and died on 1/24/12.[21] His medical history included gastric bypass surgery, benign prostatic hypertrophy, prostatitis, transurethral resection of the prostate (TURP) in 2008,

[20] Medical Reception/Intrasystem Transfer Patient #1.
[21] Medical Reception/Intrasystem Transfer Patient #11.

low back pain, glaucoma and gastroesophageal reflux disease (GERD). At MCSP, on 11/14/11, the patient had urinary hesitancy and was sent out to the hospital, where he was diagnosed with bladder outlet obstruction due to benign prostatic hypertrophy (BPH). The urologist inserted a Foley catheter and requested follow-up in his office for cystoscopy with transrectal ultrasound to evaluate the patient's prostate. The urologist also requested a renal ultrasound to evaluate the status of the patient's kidneys, a chemistry panel and PSA. Upon his return to MCSP, a nurse saw the patient and scheduled him to follow-up in 14 days. On 11/23/11, the MCSP provider requested the renal ultrasound and cystoscopy. The patient's PSA was mildly elevated (PSA=7.6, normal=<4.0). Approximately two weeks later on 12/8/11, the request for renal ultrasound was approved and scheduled for 12/29/11. On 12/16/11, the request for cystoscopy was approved but there is no date documented as to when it was scheduled. On 12/27/11, a MCSP nurse completed a 7371 noting that the patient had a pending chronic disease appointment for BPH, but did not note that the patient had a Foley catheter or pending procedures. The patient was scheduled for a renal ultrasound on 12/29/11, but this was not completed due to his transfer to CIM and on 12/29/11, a nurse documented that per provider a medical hold was not necessary. On 12/29/11, CIM staff completed a 7277, noting that the patient had a Foley catheter. The nurse did not document a complete set of vital signs (no temperature or respirations). The nurse made a routine referral to a provider. On 1/10/12, at 8:30 p.m., the patient was at pill line and told the nurse that his Foley catheter was leaking all over his underpants and asked if he could get a new one, stating it was last changed 2-3 months ago. The nurse changed the patient's catheter. His vital signs, except blood pressure (that was not measured), were normal. The following day, the patient was admitted to Chino Valley Medical Center, apparently with complaints of dizziness, weakness and altered mental status. (We did not find nursing or provider documentation of his condition prior to being sent to the hospital). Upon arrival at the hospital, he was hypotensive requiring vasopressors.[22] He subsequently went into respiratory distress and was intubated. His condition progressively worsened and he died on 1/24/12 of complications from urosepsis.[23]

Assessment

System issues related to this case include lack of coordination of care between the MCSP primary care provider and urologist, delayed request, approval, and scheduling of his cystoscopy and renal ultrasound. The patient was transferred on the day of a scheduled medical procedure, which was not appropriate. We reviewed the Combined Death Review Summary for this patient and noted that the patient's death was determined to be "Natural and Expected" and "Definitely Preventable." Based on the patient's baseline medical condition, we do not agree that the patient's death was natural and expected because his underlying condition was benign prostatic hypertrophy with urinary retention and is not a

[22] Medications used to increase blood pressure.

[23] A severe illness that occurs when an infection starts in the urinary tract and spreads into the bloodstream.