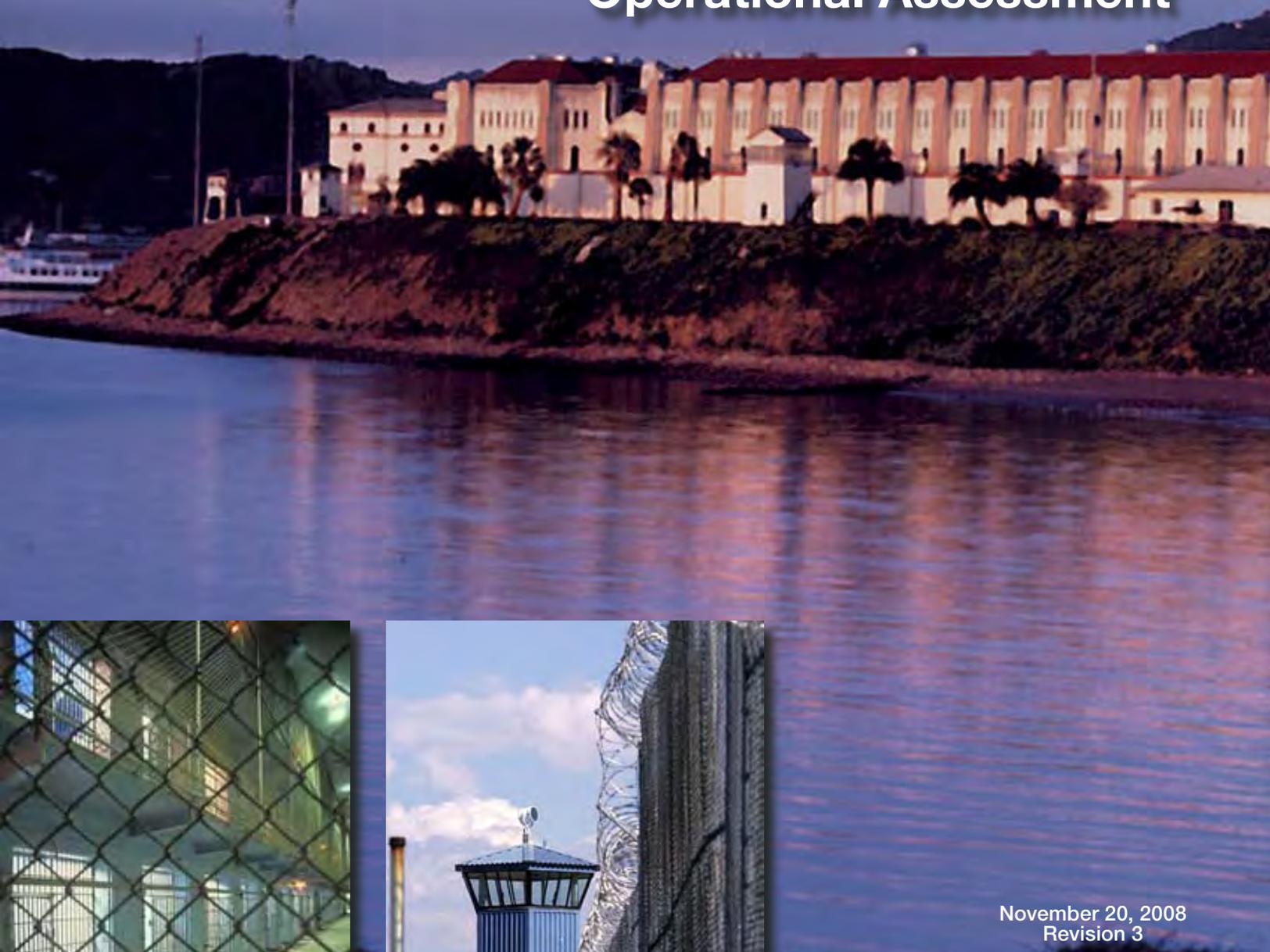




California Prison Health Care Receivership Corporation  
Office of the Receiver

# Health Information Management Operational Assessment



November 20, 2008  
Revision 3



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## EXECUTIVE SUMMARY

This report segment of the Health Records Management Services project incorporates the assessment of the Health Record Services/Health Information Management (HIM) functions taken from within a sample of institutions suggested by the HIM Steering Committee. The institutions are listed in the Table of Contents and covered in detail in their own section entitled Site Visits.

### FINDINGS

The picture at the right shows the conditions found throughout the institutions we assessed. Many of the problems discovered and documented, however, do not lend themselves to pictures.

Rather, there are severe conditions that endanger patient-inmates' health and waste resources through countless inefficient processes.

The Severity Level Dashboard on the next page presents summary assessment findings that are global in nature. These abhorrent conditions are present to a greater or lesser degree in every institution we assessed. Each of the assessment findings was analyzed against three impact criteria to establish the severity level. These criteria were:

1. Patient-inmate healthcare
2. Compliance with internal and external policies or standards
3. Efficiency in the use of resources

The assessment findings were then rated by risk and priority.



*"While the problems identified by the courts and the Receiver reach into almost every element of the medical care system, it is without question that the health information management (HIM) system is inadequate to meet the needs of the confined adult population. The Plata Court has found that "[t]he medical records in most CDCR prisons are either in shambles or non-existent." FFCL, at p. 20.*

## SEVERITY LEVEL DASHBOARD

Finding	Severity Level	Risk	Priority	Areas Impacted
Deficiency in leadership		H	H	<ul style="list-style-type: none"> <li>• Compliance</li> <li>• Patient-inmate care</li> <li>• Efficiency</li> </ul>
Inadequate staffing		H	H	<ul style="list-style-type: none"> <li>• Compliance</li> <li>• Patient-inmate care</li> <li>• Efficiency</li> </ul>
Poor record availability		H	H	<ul style="list-style-type: none"> <li>• Compliance</li> <li>• Patient-inmate care</li> <li>• Efficiency</li> </ul>
Poor quality of health record content		H	H	<ul style="list-style-type: none"> <li>• Compliance</li> <li>• Patient-inmate care</li> <li>• Efficiency</li> </ul>
Lack of current policies and procedures		H	H	<ul style="list-style-type: none"> <li>• Compliance</li> <li>• Patient-inmate care</li> <li>• Efficiency</li> </ul>
Loose filing backlogs significantly exceed standard		H	H	<ul style="list-style-type: none"> <li>• Compliance</li> <li>• Patient-inmate care</li> <li>• Efficiency</li> </ul>
Lack of chart tracking		H	H	<ul style="list-style-type: none"> <li>• Compliance</li> <li>• Patient-inmate care</li> <li>• Efficiency</li> </ul>
Lack of release of information (ROI) automation		M	H	<ul style="list-style-type: none"> <li>• Compliance</li> <li>• Efficiency</li> </ul>
Lack of encoding and abstracting software		M	L	<ul style="list-style-type: none"> <li>• Compliance</li> <li>• Efficiency</li> </ul>
Suboptimal use of existing space		M	M	<ul style="list-style-type: none"> <li>• Efficiency</li> </ul>
Inefficient and unsecured record transportation		M	M	<ul style="list-style-type: none"> <li>• Compliance</li> <li>• Efficiency</li> </ul>

	Major issue - immediate remediation
	Remediation in the near term
	No action required
Key = Severity Level	

Levels	H – High
	M – Medium
	L - Low

## IMPACT STATEMENT

The majority of the Severity Level ratings on the dash board on the previous page relate to reasons the current CPHCS patient-inmate health records are in such poor shape. The problems of the current health record, in the words of the “Analysis of Year 2007 Death Reviews” by Kent Imai, MD (Appendix 5) include:

1. “The typical patient health record is not easily navigated and not well organized” (page 7)
2. “The health record is often incomplete, missing critical recommendations from consultants or records of off-campus procedures, emergency room visits and hospitalizations” (page 7)

In the report’s analysis of patient-inmate deaths, several deaths were attributed to inadequacies of the health records, as follows:

Health Record Inadequacy	Non-preventable deaths (p.10)	Possible preventable deaths (p.12)	Preventable deaths (p.13)
Unavailable record	5	2	0
Failure of provider-to-provider communications in the record	4	5	1
Failure to adequately pursue abnormal test results	13	5	1
Totals	22	12	2

These unnecessary deaths could have been prevented if an adequate Health Information Management system existed to ensure accountability and ownership of the patient health record.

Based on these findings, the Health Information Management remediation plan will eliminate preventable patient-inmate deaths related to unavailable or inaccurate health records, by:

- Delivering a plan to initiate specific steps to alleviate the current issues related to the availability and quality of the health record
- Facilitating effective provider-to-provider communication, by ensuring timely updates are made to the health record
- Establishing best practice loose-filing standards to ensure clinical data is available in the right place at the right time
- Ensuring enterprise wide health record content/quality standards are enforced
- Establishing a professional Health Information Management organization whose mission will be to establish a program that will ensure timely implementation of consistent, repeatable and sustainable processes.

## ASSESSMENT METHODOLOGY

### Definition

**Health Information Management (HIM)** is an administrative service responsible for medical/health records. A medical/health record must be maintained for every individual evaluated or treated in a medical facility, as well as include every encounter for that individual. The organization of the HIM functions must be appropriate to the scope and complexity of the services provided. The enterprise must employ adequate personnel to ensure timely documentation, coding, completion, filing, and retrieval of records.

HIM improves the quality of healthcare by insuring that the most accurate, timely and complete information is available to make healthcare decisions. Health information management professionals manage healthcare data and information resources. The profession encompasses services in planning, collecting, aggregating, analyzing, and disseminating individual patient and aggregate clinical data. The American Health Information Management Association (AHIMA) issues two health information, three coding and privacy and security credentials.

*Id., at p. 21 (internal citations omitted). Simply put, “the CDCR medical records system is ‘broken’ and results in dangerous mistakes, delay in patient care, and severe harm.” Id.*

### Areas Assessed

The Health Information Management (HIM) functions that were assessed at the sites include:

1. Health Information Management staffing and management
2. Health Record Availability
3. The Unit Health Record (UHR) Workflow
4. The UHR Order/Assembly
5. The UHR Audit (Deficiency Analysis)
6. Coding/Abstracting/Indexing/Data Collection
7. Health Record Content/Documentation/Charting Guidelines
8. Transfers/Discharges/Deaths
9. Confidentiality/Release of Information (ROI)
10. Forms Control/Loose Reports
11. Plata Scheduling/Statistics
12. Dictation/Transcription
13. Use of Technology and Tools
14. Physical Infrastructure and Layout
15. Transportation of the UHR

## Assessment Process

The comprehensive site assessments were conducted by a team of two seasoned HIM professionals and an experienced paper record storage specialist.

- The team members used a variety of methods to gather data and evaluate the Health Record functions including: interviews, observation, counting, and measurement.
- A lengthy assessment survey form was the tool used to consistently and completely record the information at each site. This tool can be found in Appendix 4.
- The detailed work papers with the site specific assessment documents can be accessed via the California Prison Healthcare System (CPHCS) Clarity project management site.

Each of the three assessment team leaders reviewed the completed assessment survey forms from all sites. The resulting summaries were organized according to the five functional areas designated in the project statement of work as follows:

1. Human Resources
2. Procedural
3. Technology Approach
4. Physical Infrastructure
5. Transportation

The site specific findings can be found in the site visit section of this report under a heading with the name of each institution that was assessed.

## CHALLENGES

The need to provide the reader with a context in which our discovery process was conducted is the intent behind this section of the Executive Summary. What has become obvious to the assessors, and thus is implicitly understood, will not be obvious to the casual reader.

We will strive to provide the reader with a flavor of the environment in which the Health Information Management (HIM) functions are performed. HIM suffers from a second-class citizenship mentality, in a physically-challenged work environment. They struggle to provide services without the benefit of professional supervision and training or adequate technology tools and other resources to accomplish their mission.

***The HIM mission is: To provide an up-to-date, accurate, and usable health record for each patient-inmate at each healthcare encounter to aid in providing quality and constitutional patient care.***

## Background

To understand the current position of Health Information Management (HIM) within the California Department of Corrections and Rehabilitation (CDCR) environment, it is instructive to reflect on the development of the role of management of health information in the correctional environment versus its role in community healthcare environments.

An unbiased view of healthcare within any corrections organization would conclude that healthcare, and therefore health information management, is generally a secondary concern.

1. The long legal history of healthcare within CDCR bears witness to this.
2. The main focus of HIM has been custody of the health record.
3. Few resources have been allocated to the HIM function.
4. Little effort has been made to foster professionalism within the HIM workforce.

The reader should contrast the above situation to the role of HIM in a typical community hospital.

1. Custody of the health record is still a key responsibility.
2. However, the evolving role of HIM in the reimbursement system since the 1960s has increased the importance of HIM.
3. Key performance indicators of the revenue cycle process are directly the responsibility of HIM. These have daily visibility to the CEO.
4. The Joint Commission, a national accreditation body for hospitals and healthcare organizations, has established compliance criteria that are the responsibility of HIM.
5. Likewise, the Center for Medicare and Medicaid (CMS) and its enforcement arm, the Department of Justice (DOJ), are authorized to examine the output of HIM, specifically the accuracy of coding.

In response to these growing responsibilities, HIM has exponentially evolved in professionalism within the healthcare community. Prestigious colleges offer degrees at varying levels in HIM. There are nationally-recognized and required certification exams. In fact, California's Title 22 requires hospitals to have a credentialed HIM professional managing health information functions.

Meanwhile, HIM has been allowed to languish as a largely clerical function in each institution. The challenges presented in this section are the direct result of this history.

## Difficulty of Gathering Information

Rare was the situation at the institutions we visited where the HIM supervisor or manager could:

- Explain why many activities were being performed the way they were
- Provide any reliable metrics on functional performance
- Speak to the department's authorized staffing levels or financial budget

***This is a very poor management foundation upon which to build a remediation program.***

## HIM Culture

We found excuses were given for most everything. The defeatism this breeds allows the following to exist:

- Disregard for policies and procedures was evident.
- No apparent concern for the fact health records are frequently not produced for the providers of patient care. ("We just don't have the staff.")
- At one institution, HIM staff have ceased documenting inpatient episodes in the UHR. The result is that a provider, at a subsequent clinic appointment, would have no idea that the patient-inmate had recently been hospitalized or maybe what the medical condition was that caused the hospitalization. ("The person who used to do this retired and has not been replaced.")
- A small storage room, lit by a single light bulb which burned out, has been dark for two months. ("It takes forever to order things around here.")

***A culture like this is very negative and the hopelessness it breeds will need to be addressed during remediation.***

## Technology Infrastructure

HIM functions are performed in an environment where almost all computers are stand alone computers without networking capability. This means:

1. Few HIM staff have e-mail to communicate
2. Few HIM staff have Internet connectivity to access training or other knowledge resources
3. There is limited access to applications to use in processing transactions
4. There is heavy reliance on Access databases and intra-facility trading of information with flash drives
5. There is no mechanism to communicate throughout the Corrections environment, even the telephone systems are primitive

The good news is that this technology shortfall is being addressed by an enterprise wide technology rollout that will provide local area network (LAN), wide area network (WAN), connectivity, and enhanced telecommunications capability.

***This environment is not conducive to standardization or collaboration to foster effective work and is a major reason for low productivity and lack of initiative.***

## **Physical Facilities**

HIM suffers the same handicap as other functions in most of the institutions; namely that overcrowding, in often aging facilities, has put a huge premium on both the amount and location of space for allocation to HIM. Add to this factor the move toward spread out campus designs stretch the capability of resources for the paper record intensive processes currently used to bring patient-inmate health records to treatment areas.

***In the short run this is a fact of life. There are initiatives in place for retrofit construction to relieve the worst space problems. In addition, imaging technology is planned to help bridge the issue of distance and dispersion within two years.***

## **Institutional Independence**

Notwithstanding representations to the contrary, it is clear that the HIM functions within institutions have been allowed to evolve in their own directions. This is exemplified by:

1. There is little consistency in the HIM procedures between institutions
2. There is no culture of sharing and inter-institution meetings are extremely rare
3. The regional HIM structure was rarely mentioned by sites and seems invisible
4. Institution-specific health record forms continue to spring up everywhere
5. The CDCR Policy and Procedure Manual, Department Operations Manual (DOM), is out-of-date and is frequently ignored as being a valid resource authority by HIM staff in the field

***This chaotic situation does not allow for implementation of standards or accountability and needs to be reversed during remediation.***

## **Are there any bright spots?**

In spite of the handicaps placed on the HIM function within CDCR, there are rays of hope, namely:

- There are HIM individuals at institutions within CDCR for whom all is not hopeless. They exhibit a “can do” attitude and high spirits
- Without exception the institution-level healthcare providers are very supportive of the need for a properly functioning HIM area
- The many healthcare related projects initiated by CPHCS are beginning to have a positive impact at the institution level, which gives all staff more confidence that major positive change will occur

***Leveraging the positive will be important in managing change.***

## **ASSESSMENT FINDINGS**

### **Use of Global Assessment Findings**

The global findings documented in this report define the current status of Health Records in the California Department of Corrections and Rehabilitation (CDCR). The gap between these global findings and the desired state for Health Information Management, described in the previous Compliance, Regulatory and Best Practices report, will form the basis of the remediation plan.

### **Site Specific Assessment versus Global Assessment**

Each assessment team documented the comprehensive findings for each site visited. The synthesis of commonality of findings across the sites visited and assessed resulted in the global summary assessment findings documented in this report. Site specific remediation areas at the end of each assessment are considered unique to that institution.

## Receivership's Mission

*Reduce unnecessary morbidity and mortality and protect public health by providing patient-inmates timely access to safe, effective and efficient medical care, and coordinate the delivery of medical care with mental health, dental and disability programs.*

## GLOBAL SUMMARY ASSESSMENT

This portion of our report focuses on each of the functional elements of Health Records that, if consistently standardized, would promote more effective and efficient health information management thereby promoting a constitutional level of care. The following findings have universal applicability across the California Department of Corrections and Rehabilitation (CDCR) institutions. As such, they represent the current environment of Health Information Management (HIM) upon which remediation will be based. While we acknowledge there may be institution-specific variations to our global assessment findings, we are confident these global findings will form a basis for remediation planning. The detailed remediation plan will adjust for site specific differences.

### Summary of Assessment Findings

AREA	FINDING
<b>Human Resources</b>	Deficiency in leadership
	Inadequate staffing
<b>Procedural</b>	Poor health record availability
	Poor quality of health record content
	Lack of current policies and procedures
	Loose filing significantly exceeds goal
<b>Technology Approach</b>	Lack of chart tracking
	Lack of release of information automation (ROI)
	Lack of encoding and abstracting software
<b>Physical Infrastructure</b>	Suboptimal use of existing space
<b>Transportation</b>	Inefficient and unsecured record transportation

## HUMAN RESOURCES

### Deficiency in Leadership

---

#### Background

Prior to becoming familiar with California Department of Corrections and Rehabilitation (CDCR), we would have anticipated there to be sufficient professional subject matter expertise and leadership in a headquarters/regional organization related to a function as important as Health Information Management (HIM). This is the model found in private sector healthcare organizations that are as massive and geographically dispersed as the CDCR institutions.

#### Approach

Identifying the lack of a Health Information Management (HIM) leadership structure was obvious during site visits. Spending time to understand the evolution and current culture of healthcare and health records within CDCR was important to appreciate why the current state exists.

#### Findings

There is an absence of an adequate central management structure (headquarters and regions) composed of HIM professionals focused on the typical “corporate” objectives:

1. Uniformity of practice
2. Inter-facility staffing augmentation
3. Quality improvement and assurance
4. Development and participation in strategic initiatives

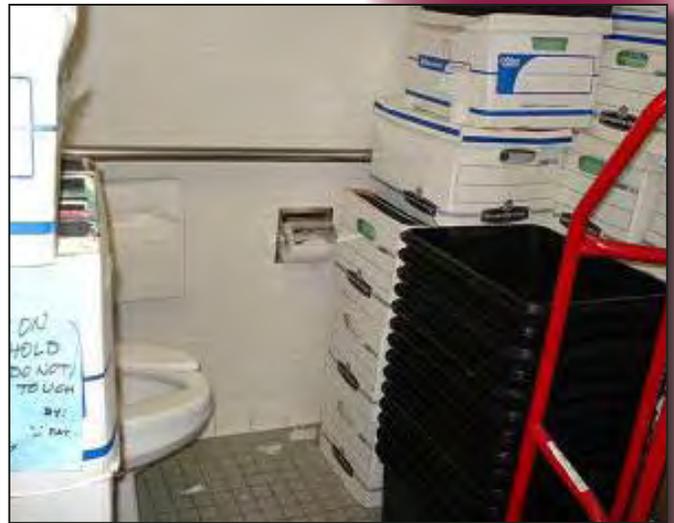
The HIM units were often seen to be drifting along without direction. The staff appeared to be working hard, but with a limited long-term view.

During interviews, there was frustration expressed about the Human Resource process being an obstacle to defining adequate management positions for HIM within CDCR. We would expect that could be addressed during remediation.

#### Implication

Health record processing has no corporate voice equivalent to the importance of the health record in the broader function of providing constitutionally adequate healthcare to patient-inmates within CDCR. The science of health records is far more than a glorified clerical function ... a status to which it seems to have been relegated. Having an adequate HIM management structure in both headquarters and in a regional structure would increase the likelihood that:

1. The HIM functions in each institution would be supported
2. Quality assurance of existing functions would be performed and corrective action taken
3. System wide improvements would be initiated and maintained
4. HIM would be represented in other Enterprise initiatives



*You have to ask yourself what kind of HIM leadership would allow these conditions to occur, let alone persist.*

## Inadequate Staffing

---

### Background

An important aspect of assessing similar functions across many institutions is to utilize a staffing model to determine if the workforce is adequate to accomplish the assigned responsibilities. Staffing adequacy has three dimensions:

1. Adequacy of skill levels (documented competencies)
2. Availability of staff coverage (in relationship to facility needs)
3. Sufficiency of staff head count
  - Effectiveness of staff (productivity)
  - Validated volumes for each functional task

### Approach

Staffing adequacy was assessed at each site by:

1. Determining head count and position levels from department sources
2. Interviewing staff
3. Observing staff at work
4. Evaluating unique duties (if any) within the HIM departments as well as needs of the institution

### Findings

We found:

1. Lack of qualified management and supervision
2. Insufficient numbers of staff for the work
3. Insufficient skill mix of staff
4. Coverage not conducive to supporting the healthcare function. (There was no maximization of staff through use of evening and weekend hours to perform non-time sensitive activities.)
5. Volume measurements for workload factors is not captured or could not be validated

In addition, there is a major missing factor that makes it difficult to both manage and staff Health Information Management (HIM) units. Specifically, there is a lack of productivity standards to use a goal and to monitor. Universally accepted and adopted standards are available throughout the healthcare industry.

Additional findings that relate to staffing and thereby affect the effective and efficient management of health information include:

1. Job descriptions which do not specifically call out the unique skill set related to HR functions and responsibilities
2. Significant turn-over with staff due to absence of career ladders within the Health Information Management area. (Time and money is invested to train newly hired staff who subsequently transfer out of HIM to obtain more senior positions within CDCR.)

3. No evidence of continuing education to develop the skills of current staff and to stay current with trends and best practices within the industry
4. Lack of tools and resources that would help staff be more productive

## Implication

Having at least one credentialed HIM professional in each HIM unit would raise the professionalism within the department and institution, as well as increase the likelihood that decisions rooted in HIM's body of knowledge and best practices would be appropriately made and priorities set and achieved.

There will be continuing backlogs and substandard performance in important HIM functions until staffing is improved. Proper levels of staffing are key to improving HIM performance. This includes:

- Increased staffing with personnel possessing the applicable competencies will help assure the required work is performed at the necessary level of proficiency
- Expansion of days and hours of coverage (with appropriate supervision) would enable a more orderly approach to accomplishing the work, access to equipment, and process improvements.

There were issues identified with Plata schedulers - some departments with all schedulers reporting to them, others with no schedulers reporting to HIM and some with a split of schedulers between HIM and another department. Remediation staffing models will require clear delineation of where this process should be managed.

*Lack of formal training and HIM knowledge in the institutions leads to poor decisions. In one institution turnover in one position lead to the decision to stop summarizing inpatient visits into the Uniform Health Record (UHR).*

*The result:*

- *No record of inpatient treatment recorded in the UHR*
- *Providers will have no way of knowing that the patient-inmate was treated as an inpatient, for what condition and on what meds*
- *One provider found out about a patient-inmate having a heart transplant only by observing the huge, fresh chest scar*

## PROCEDURAL

### Poor Health Record Availability

---

#### Background

We were guided in our targeting of health record availability by wording present in the original legal cases that eventually led to the establishment of the Receivership. The importance of having health records present when treatment is provided cannot be emphasized too heavily. While there have been attempts at improving health record availability within the current system, these attempts come up short.

#### Approach

Our assessment of record availability was accomplished in several ways:

- The measurements provided in monthly Plata reporting (when available)
- The input of various clinical providers
- Counting or accepting findings from various listings when available

#### Findings

We found that health record availability was significantly below Best Practice standards. Actual measurement ranged from 50% to 93%. Adhering to the old adage “that perception is reality”, providers universally listed health record availability as a key obstacle to providing adequate healthcare.

This finding is not surprising given the heavy reliance on manual tracking and limited intra-institution bar coding tracking. Availability failures occur for the following reasons:

1. Lack of health record tracking discipline and tools within most institutions
2. Lack of tracking capability involving intake and outtake
3. Inability to track and resolve non-compliance
4. Existing chart tracking systems (3 different products) are not integrated or networked
5. Providers will retain records with the knowledge that HIM is unaware of records kept out of file overnight
6. Patient-inmates with multiple appointments within the same day greatly decreased the percentage of chart availability

#### Implication

Poor health record availability is the single most important finding in our assessment. Remediation is key to improving patient-inmate healthcare. The ability to implement chart tracking systems will depend on the availability of other technology improvements.

Even when records are available, misfiling and loose materials in the the charts make it difficult for clinicians to find information needed for medical treatment. Duplicate copies of documentation, preliminary results and inconsistent placement of documents adds to the unwieldy nature of the UHR.

*Using the definition of an “available record” to be a complete record with the latest results located in the correct order in the record and at the place of treatment of a patient-inmate ... providers routinely cited 50-60% record availability for their clinic appointments during our interviews.*

*The implications:*

- *Providers struggling or unable to determine health status*
- *An epidemic of appointments rescheduled due to lack of test result availability*

## Poor Quality of Health Record Content

---

### Background

The primary health record in CDCR institutions is the Unit Health Record (UHR) which is contained in one or more multi-sectioned green file folders (see picture). The UHR should contain documentation from medical, dental, and mental health outpatient visits and a summary of inpatient visits.

### Approach

Our assessment of record content was accomplished in several ways:

- At each institution the assessment team analyzed 10 UHRs
- A medical documentation specialist reviewed 40 total records at CMF and CMC
- The assessment teams interviewed providers at each institution

### Findings

Physicians universally complained about the following aspects of record content:

1. Order of the UHR ... as it varies both within and between institutions
2. Actual documentation in the charts ... uniformity of forms has become a casualty as institution-designed forms proliferate
3. Lack of current clinical information ... caused by loose sheet backlogs
4. Unruly UHRs which are overstuffed and falling apart
5. Poor forms design with redundancy and questionable clinical relevance



Our detailed analysis found: unsigned physician orders, unprocessed requests for services, incomplete problem lists, forms with copies still attached (such as orders and preliminary and final results) as well as outdated forms. Departmental policies and procedures intended to prevent many of these issues are not being followed.

Finally, there are no quality control procedures in place to ensure completeness and integrity of the UHR.

### Implication

The UHR is difficult to use at best, and frequently so incomplete as to necessitate cancellation or rescheduling of clinic appointments. Thus, patient-inmate treatment is not supported and inefficiencies abound. This situation seriously compromises care and frustrates providers.

## Lack of Current Policies and Procedures

---

### Background

The more geographically disperse the enterprise, the more important standard policies and procedures are to establish, encourage, and enforce uniformity of process, and therefore outcome. Credibility of such standard policies and procedures erodes when they are not updated for years at a time.

The Department Operations Manual (DOM) was referenced minimally by Health Record Supervisors/Directors – seemingly not utilized to guide practice.

### Approach

We sought to review policies and procedures everywhere we assessed. When we interviewed supervisors and staff, we sought to understand how the policies and procedures were used and followed in the field.

*“We made up our own policies and procedures to cover those situations.”*

*Anonymous HIM staff*

### Findings

The existing policies and procedures are not current. The field has different versions, indicating the policies and procedures don't apply to their institution or have modified the policies/procedures to match their own practice.

The above finding sounds rather benign. However, enforcing current, comprehensive policies and procedures is the foundation to eliminate the following serious problems that are endemic throughout HIM.

If we just focus on issues with the Unit Health Record (UHR), enforcement of proper policies and procedures would address the following problems

1. Many UHR s are so stuffed with historical documentation, much of which is duplicative, that:
  - Bindings burst and volumes become so heavy that they are cumbersome for providers to use while providing healthcare
  - Filing more documentation for current encounters is difficult
  - Lifting and filing UHR volumes is actually dangerous

*Enforcement of proper policy would call for routinely thinning duplicate reports out of each record and volumizing more frequently to hold the size to a much thinner standard.*

2. The organization of the UHR is supposed to be uniform across the enterprise, but it is not:
  - There were differences in the sequence of documents across a sample of UHRs
  - There are non-standard forms included at many institutions

*Enforcement of proper policy would result in standard UHR content and sequence which would facilitate patient-inmate care by making the record much more user-friendly to the providers.*

3. The filing sequence and purging practices vary from institution to institution:
  - Some institutions have inefficient, non-standard ways of filing UHRs that cause departmental inefficiencies
  - Purging rules vary

*Enforcement of proper policy would result in standard UHR filing and purging processes.*

Once there are effective policies and procedures, then:

- Management becomes easier
- Compliance auditing becomes feasible
- Enforcement of error correction becomes practical

## **Implication**

Without current policies and procedures, it is difficult to:

1. Manage the HIM function
2. Train staff
3. Define and maintain a useable health record
4. Obtain uniform results across the enterprise, particularly in the UHR
5. Leverage experience to improve process
6. Ensure facilities are compliant with regulatory practices
7. Implement continuous process improvement

## Loose Filing Backlogs Significantly Exceed Standard

### Background

In paper-based health records loose reports are inescapable. Getting them filed in the respective UHR is always a challenge. Loose filing must be current because:

1. Unfiled loose reports are often lab and other diagnostic results, reports from external providers and progress notes from visits in which the UHR was not available
2. A health record with missing, unfiled loose reports may be dangerously incomplete
3. Unfortunately, loose reports tend to be the most current information and therefore most relevant to patient care
4. This incompleteness exposes the provider to making medical decisions without the latest results or not making decisions due to lack of information

### Approach

The amount of unfiled loose reports at each site was determined by requesting status from the supervisor in charge and directly observing/measuring piles of filing waiting to be inserted.

### Findings

There are unfiled loose reports at all institutions. Best Practice dictates that unfiled loose reports should be limited to one day after receipt. We found loose reports from as far back as 60-90 days.

The establishment of the Health Record Center (HRC) at Depot Park (aka Army Depot) in 2007 gave rise to a massive relocation of health records from institutions and regional record storage areas throughout the state to the HRC.

- Included in the health records shipped to the HRC were over 3,500 boxes of partial records and loose reports
- There are varying opinions as to the usefulness and criticality of this material to completing the health records to which they belong\*

Clerical discipline is the key to minimizing the amount of unfiled loose reports. Backlogs of unfiled loose reports occur for the following reasons:



*The amount of unfiled, disorganized and literally unusable medical records paperwork at some prisons is staggering. At California Institution for Men (CIM), the records were kept in a 30 foot long trailer with no light except for a small hole cut into the roof and were arranged into piles without any apparent order. Conditions are similar at other prisons as well. At some prisons, medical records are completely lost or are unavailable in emergency situations.*

1. Misunderstanding how important loose reports may be to the provision of adequate healthcare
2. Lack of management focus on this issue
3. Inadequate identification of patient-inmate information on loose reports
4. Care areas do not take the time to incorporate a report when they have the UHR present – seeing it as “not their job” to file
5. The UHR is continually moving making it difficult for timely incorporation of material

## Implication

Not filing loose reports in the correct UHR is dangerous to patient care.

- Correcting it in the institutions is a matter of setting priorities as the worst offender was no more than a month’s worth of work behind
- Correcting the situation at the HRC, on the other hand, is a massive undertaking which will be fully explored during remediation planning

Note: A sample analysis is being conducted of the 3,500 + boxes to determine the exact nature of the health record material in them. Final results are not yet available, but preliminary results indicate that there is a considerable amount of current, original health record documentation contained in the boxes.

Additional challenges:

- Loose documents are often received weeks or months after creation
- Records are decentralized at many of the facilities however location information is not recorded on the loose documents
- Printed forms are not hole-punched which discourages filing of the document at the time of creation
- The number of pages in a Medication Administration Record (MAR) has multiplied (approximately times ten) since implementation of computerized pharmacy systems
- Filing backlogs at institutions with reception centers significantly impacts care throughout all of the institutions

## **TECHNOLOGY APPROACH**

### **Lack of Chart Tracking**

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#### **Background**

Large, complex paper-based health records are usually managed with an automated chart tracking system. The more dispersed the health records are and the more inter-site transfers that occur, the more important the system is.

#### **Approach**

We reviewed how records are tracked at every site we assessed.

#### **Findings**

There are a variety of chart tracking solutions used throughout the organization. None have capability beyond the boundaries of an individual institution. The existing systems have some merit, but even within the institution the value is minimal.

At the Health Record Center (HRC), which has the most extensive amount of records, record inventory and control is established through a combination of Access data bases and periodic manual audits.

#### **Implication**

Accurate, timely chart tracking is the key to improving record availability. CDCR will have a need to manage paper records for the foreseeable future. Applying the lessons of other conversions to the CDCR environment suggests:

- Transitions to electronic records are lengthy, during which paper records exist
- The history that exists will be maintained for at least 10 years following implementation of electronic health records
- The UHR for inmates remaining in the system will likely exist in paper form for some lengthy time period unless destruction policies change

Computerized chart tracking systems (such as CRIS, MedCats, and MJTS) are in use at some institutions however each system is stand-alone and does not provide required access. At least one of the computerized chart tracking systems in use is not networkable.

Many of the institutions rely on manual chart tracking systems and chart locations are usually not updated as changes occur. The end result is that charts cannot be retrieved in a timely fashion and sometimes can't be found at all.

The various current paper and/or electronic chart tracking systems are antiquated, inadequate, and broken.

An enterprise-wide system is needed to facilitate tracking of medical charts within each institution as well as between the various institutions including HRC. Various industry standard chart tracking systems are available and should be considered for implementation. These systems include SoftMed, and Quadramed as well as other applications incorporated into health information management software suites.

Remediation planning will include evaluation of various software solutions to address all HIM applications: Chart Tracking, Release of Information, Encoding and Abstracting, and Chart Deficiency.

There is recognition of the need to interface these technology solutions with other projects such as Enterprise Master Index, Dictation and Transcription, Scheduling and Electronic Document Management. A single system for scheduling will be required to improve chart availability. SOURCECORP is and will participate in these other projects as required.

## Lack of Release of Information (ROI) Automation

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### Background

There is a large volume of requests from both outside entities and from inmates for copies of health record information contained within the UHRs and the inpatient records. Olson reviews have had a major impact on the workload of HIM departments. Due to inmates requesting multiple copies on a daily basis, inefficiencies are created for both custody and healthcare. HIM clerical staff have some concerns about security while meeting with inmates, often unaccompanied by custody.

### Approach

How requests for information are tracked and fulfilled at each institution was assessed through observation and interview.

### Findings

All work is performed on a manual basis. Tracking, utilizing manual logs, is confined to requests that have been processed. Pending requests are not tracked, therefore backlogs are not recognized and not managed. Hundreds of requests at the Health Record Center is particularly remarkable. Many of these requests are the result of inaccurate or missing patient-inmate moves.

### Implication

Measuring request volume and turnaround time is difficult at best. This equates to an inability to apply a staffing model to effectively manage this function.

Ensuring legally mandated, timely responses to requestors is dependent on each staff person performing ROI functions being accountable. There is no efficient automated look-up available when following up on or tracking requests.

In summary, we cannot detect how far out of compliance CPHCS is with the requirements to provide patient-inmate health information to valid requesters.

*Requests for release of patient information are only logged in when the clerk picks up the request or subpoena and goes to pull the file, make the copies, and mail it out.*

- This means there is no way to know the true backlog*
- Assessors reported seeing requests over 3 months old remaining unfilled*

## **Lack of Encoding and Abstracting Software**

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### **Background**

Large healthcare organizations generally utilize standard software to guide the coding and abstracting of clinical information. Coded clinical data is used for a variety of internal and external activities – credentialing, budgeting, quality care review, risk management and performance improvement. Coding activities within CDCR have no automated support. Minimal abstracting is performed and entered into CADDIS; however, there are no quality measures that ensure the integrity of this data.

### **Approach**

Presence and use of encoding and abstracting software was assessed at each institution visited through observation and interviewing key staff. When staff members were interviewed, we sought to understand what technology was utilized, as well as what the data source was for the information being submitted.

### **Findings**

1. No coding and abstracting automation was observed, and there was no knowledge of its existence anywhere in the enterprise.
2. The Census and Discharge Data Information System (CADDIS), into which codes are entered, has not been updated to accept entry of the currently utilized ICD-9-CM diagnosis codes
3. Some facilities only enter admitting diagnosis while others code all procedures and diagnoses available at discharge
4. Some facilities enter all UB04 data from external provider billing and some only enter the principal diagnosis and procedure (as provided by the HCCUP)
5. Coding was performed by staff with no professional training and corresponding credentials. When asked, staff expressed little to no understanding of anatomy and physiology, medical terminology, or pharmacology; all of which are necessary for accurate classification of diseases and procedures.
6. Additionally, tools such as coding books and current national coding guidelines were either outdated or completely absent. Unfortunately, due to no formal training, staff and leadership were not even aware that this was problematic.
7. Many staff with coding responsibility utilize “cheat sheets” which do not have updated codes available
8. Coding is performed only for inpatients

## Implication

Without coding and abstracting software, it is difficult to:

1. Abstract and capture the range or specialization and acuity of care being rendered
2. Aggregate data to evaluate the need for patient-inmate programs
3. Evaluate provider performance and track provider volume
4. Perform Quality Assurance or Risk Management related to care provided
5. Develop tools, such as Clinical Pathways that standardize care provided
6. Obtain uniform results across the healthcare continuum

In summary, the initial gap between data and useful information appears to be quite large.

## PHYSICAL INFRASTRUCTURE

### Suboptimal Use of Existing Space

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#### Background

There is almost universally a shortage of space for HIM operations and health record storage. This has three causes:

- Aging buildings built without much thought of health record processing
- Prison overcrowding
- The expansion of healthcare services in recent years

#### Approach

We observed HIM office space on each assessment. Measurements, layout CAD drawings, and pictures document the record storage space and need to plan for growth, as well as optimizing existing space.

#### Findings

Many sites have limited office space and filing capacity. The files for storage of the UHRs and inpatient records do not always make optimal use of space:

1. Fixed shelving is often used, rather than more space-saving designs
2. Frequently the shelving is not designed specifically for medical records
3. Files are sometimes arrayed throughout the entire horizontal sections of shelving versus vertically within sections making access by more than one person difficult and making work much more inefficient
4. Desks are generally large, non-ergonomic wooden Prison Industry Authority (PIA) products placed without consideration of work flow
5. There are almost no spaces for storing records that have been pulled, as well as area for sorting of records and loose material
6. Connex trailers generally do not have shelving for storage and are not climate controlled
7. Storage spaces are frequently shared space where sometimes other departments deposit unwanted equipment
8. Many of the sites have multiple locations for Health Information Management without the tools to support decentralized services
9. Some of the departments have little security for the entrance to the department and sometimes no designated space for physicians to complete their records
- 10 SOURCECORP is engaged to provide consulting services to the retrofitting team for several of the facilities. Recommendations can be found in the section for One Day Visits



## Implication

The inadequate HIM space layout has several consequences:

1. The overcrowding of areas causes staff to be inefficient
2. File layout impacts access and ability of staff to be in the files at the same time
3. Decentralized HIM space generally makes staff less efficient moving records, loose reports, etc between locations
4. Difficult to be organized without the space and tools
5. Providers and other reviewers are reluctant to come to the department
6. Layouts of some departments encourage traffic throughout the work areas
7. Transcriptionists and others whose work demands quiet are not able to concentrate



## TRANSPORTATION

### Inefficient and Unsecured Record Transportation

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#### Background

There is intra-institution transportation generally provided by HIM staff. Depending on the physical design of the institutions, physical transport of health records varies considerably. The general issue is to move records from the HIM work areas to the appropriate clinical settings to support appointments (scheduled or non-scheduled).

- Transportation may be inside a single building
- It also may involve transporting outdoors to another building
- Distances range from a hundred yards to a mile or more

Inter-institutional transport occurs as the record accompanies the transfer of inmates.

#### Approach

Transportation was observed on each assessment. Generally consultants accompanied staff on delivery or pick-ups. HIM staff members were interviewed about issues regarding transporting of records.

#### Findings

Inadequate vehicles, sometimes commandeered by others, require manual loading and are not always weather protected. Some transport methods do not protect the confidentiality of the records and abuse the physical nature of the folders. All processes require lifting of boxes or crates or records by staff that may not see this as part of office routine. Carts and other transportation tools are not sized to support the UHRs and cannot be pushed across some of the terrain. Carts to support refiling of records in the aisles and loose filing have not been purchased for most sites.

#### Implication

1. There is a universal issue of too much heavy lifting which can lead to workers' compensation claims. It also may lead to staff turnover
2. Records are not sufficiently secure from a privacy perspective; not all vehicles are covered for protection from the elements
3. There are productivity issues, as frequently several staff members are delivering or picking-up multiple times during the day
4. Lack of tools will impact efficiency and effectiveness of processes

This type of environment does not enhance respect for the health record

*Boxes of health records transported around the institutions routinely weigh 30-40 lbs.*

- *No uniform containers*
- *Boxes have to be hoisted around by a largely female work force leading to unsafe working conditions and high turnover*
- *Depending on the physical layout of the institution, inclement weather is an ongoing threat to record integrity*