

# Folsom State Prison Medical Inspection Results Cycle 4



April 2015

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Service ♦ Transparency**

# Office of the Inspector General FOLSOM STATE PRISON Medical Inspection Results Cycle 4



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## EXECUTIVE SUMMARY

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As a result of the April 2001 *Plata v. Brown* federal court class action lawsuit, and under the authority of California Penal Code Section 6126, which assigns the Office of the Inspector General (OIG) responsibility for oversight of the California Department of Corrections and Rehabilitation (CDCR), the OIG developed a comprehensive inspection program to evaluate the delivery of medical care at each of CDCR's 35 adult prisons.

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

From January to March 2015, the OIG performed its first Cycle 4 medical inspection at FSP. The inspection included evaluation of 76 inmate-patient files conducted by clinicians as well as reviews of documents from 426 inmate-patient files conducted by deputy inspectors general, covering 88 objectively scored tests of compliance with policies and procedures applicable to the delivery of medical care. OIG inspectors assessed the case review and compliance results at FSP using 13 health care quality indicators applicable to the institution, which included 11 primary clinical indicators and 2 secondary administrative indicators. See *Health Care Quality Indicators* table on page ii.

## Health Care Quality Indicators

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

## Overall Assessment: *Adequate*

Based on the clinical case reviews, compliance testing, and population-based metrics, the OIG's overall assessment rating for FSP was *adequate*. For the 11 primary (clinical) quality indicators applicable to FSP, the OIG found three *proficient*, five *adequate*, and three *inadequate*. For the two secondary (administrative) quality indicators, the OIG found one *proficient* and one *inadequate*. At the time of this inspection, FSP was providing adequate health care services.

**Overall Assessment  
Rating:  
*Adequate***

### ***Clinical Case Review and OIG Clinician Inspection Results***

The OIG's clinical case reviews of a sample of patients with high medical needs found the health care services provided at FSP to be *adequate*. Clinicians reviewed 861 patient care events. For the 11 primary indicators applicable to FSP, nine were evaluated by clinician case review; one was *proficient*, six were *adequate*, and two were *inadequate*. When determining the overall adequacy of care, extra emphasis was placed on the clinical nursing and provider quality indicators, as adequate health care staff can sometimes overcome suboptimal processes and programs. However, the opposite is not true. Inadequate health care staff cannot provide adequate care, even though the established processes and programs onsite may be adequate.

#### Program Strengths

- Folsom State Prison was led by medical management with a strong commitment to excellence and continuous quality improvement.
- The institution employed providers and nurses of high quality. Their diligence and work ethic allowed for successful mitigation of many of the deficiencies identified in this report, especially with regard to *Diagnostic Services* and *Health Information Management (HIM)*.
- The FSP Specialty Services Department was committed to providing timely and appropriate specialty services to patients. Specialty access was found to be excellent.
- During the period of review, FSP provided excellent access to primary care services, including both the nursing sick call and chronic care programs.
- Health information scan times were found to be current without backlogs throughout health care areas during the review period.

- While not all specialty reports and hospital records were retrieved from outside health care facilities, the vast majority were obtained. The institution demonstrated a systematic process for ensuring the retrieval, provider review, and scanning of these critically important documents.
- Folsom State Prison provided timely access to high quality emergency services. Physical plant infrastructure limitations prevented the OIG from rating this indicator as *proficient*.

### Program Weaknesses

1. Physical plant limitations posed everyday challenges to the delivery of medical care. For example, several examination rooms were so small it was difficult for providers to perform full physical examinations; and the layout of the triage and treatment area (TTA) prevented health care staff from keeping a direct line of sight on a patient while performing other duties, such as contacting the on-call physician. This layout may have contributed to a slight delay in care in case 1.
2. Onsite radiology results were left in a separate computer system (RIS-PACS). The reports were not linked to the electronic unit health record (eUHR), the current medical record. Providers had no method of documenting review of the reports, as they were not printed at FSP. This was a severe deficiency that markedly increased the risk of a lapse in care, especially when care was transferred to another provider.
3. Providers considered same-day x-ray services to be unreliable.
4. There was a low overall error rate in the completion of provider orders throughout the institution, but the OIG identified significant missing orders and incomplete lab, x-ray, and medication orders. The OIG recommended that the institution identify areas where errors in transmission are most likely to occur and rectify them with further safeguards. The future implementation of electronic health records can potentially eliminate errors in provider order transmission.
5. While FSP's overall provider performance was considered adequate for the time frame reviewed, the reduction in provider staffing in December 2014 and personnel changes at the Chief Medical Executive position place FSP at risk for being unable to maintain the adequacy rating in this category. This indicator will require careful reassessment during subsequent OIG medical inspections.

## ***Compliance Testing Results***

The OIG’s compliance testing also resulted in an overall rating of *adequate*. There were 88 individual compliance questions addressing the 10 applicable indicators of health care that were tested for compliance with California Correctional Health Care Services (CCHCS) policies and procedures.<sup>1</sup> Those 88 questions are detailed in *Appendix A—Compliance Test Results*. The institution’s inspection scores for the 10 applicable indicators ranged from 50.8 percent to 91.4 percent, with the secondary (administrative) indicator *Internal Monitoring, Quality Improvement, and Administrative Operations* receiving the lowest score, and the primary (clinical) indicator *Specialty Services* receiving the highest. For the eight primary indicators, the OIG rated five *proficient*. The remaining three were rated *inadequate*. For the two secondary indicators, which involve administrative health care functions, one was rated *proficient* and the other *inadequate*.

As the *Executive Summary Table* on page ix indicates, the institution’s primary indicator compliance scores were in the *proficient* range for the following five indicators: *Access to Care* (87.8 percent); *Inter- and Intra-System Transfers* (87.3 percent); *Pharmacy and Medication Management* (89.3 percent); *Preventive Services* (91.0 percent); and *Specialty Services* (91.4 percent). In the secondary indicator *Job Performance, Training, Licensing, and Certifications*, FSP also scored in the *proficient* range (86.5 percent).

Below are some of the strengths identified based on FSP’s compliance scores for individual questions within the primary health care indicators:

- Nursing staff reviewed patients’ service requests timely and completed face-to-face visits with patients within one business day.
- Providers conducted timely patient appointments upon referral, timely follow-up appointments with patients who were released from a community hospital and returned to the institution, and timely specialty service follow-up appointments.
- Nursing staff completed timely assessments for inmate-patients who transferred into FSP from other CDCR institutions, and medications were continued without interruption for those with existing prescriptions.
- Nursing staff timely administered newly-ordered prescriptions to inmate-patients and ensured that patients who transferred from one housing unit to another received their prescribed medications without interruption.

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<sup>1</sup> The OIG used its own clinicians to provide clinical expert guidance for testing compliance in certain areas where CCHCS policies and procedures did not specifically address an issue.

- Required protocols were followed, and strong administrative controls were employed in all of FSP's medication storage areas. Nursing staff also followed appropriate protocols during the preparation and administration of medications.
- The institution was prompt in offering required preventive services screenings, such as influenza vaccinations and screenings for tuberculosis and colorectal cancer. Also, female patients were offered timely mammogram and pap smear screenings.
- For high-priority specialty services, FSP provided the service within 14 calendar days of the order and timely reviewed the consultant's report and scanned it into the patient's eUHR. In addition, the institution timely processed denials of routine specialty service requests and timely communicated the denials to the patients.

Identified strengths within the secondary indicator *Job Performance, Training, Licensing, and Certifications* related to the following administrative areas:

- Supervising nurses conducted required reviews of nursing staff, and nursing staff were current on all training requirements, licenses, and certifications.
- Providers, the pharmacist-in-charge, and the pharmacy had current licenses and registrations.

The institution's three primary indicators that received ratings in the *inadequate* range were the following: *Diagnostic Services* (73.8 percent); *Health Information Management (Medical Records)* (62.6 percent); and *Health Care Environment* (70.6 percent). In the secondary indicator *Internal Monitoring, Quality Improvement, and Administrative Operations*, FSP also scored poorly (50.8 percent).

Examples of some weaknesses identified during the OIG's testing of specific compliance questions within the primary indicators included the following:

- Diagnostic radiology reports were maintained in a separate computer system and not filed in patients' eUHRs, making it impossible to ensure that providers who review a patient's file are aware of the report results. Also, final diagnostic pathology reports were not routinely filed in the patients' eUHRs; and providers did not timely communicate results of diagnostic studies to the patient or did not communicate results at all.
- Inspected health care documents were incorrectly labeled in patients' eUHRs.
- The institution did not receive final discharge reports for patients released from a community hospital and did not timely review reports upon receipt.

- Clinicians' signatures on health care records were not legible.
- Providers did not always follow universal hand hygiene precautions before or after examining patients.
- Clinics and exam rooms lacked essential core medical equipment and supplies to conduct comprehensive examinations, and equipment items were not calibrated.
- Some clinical areas lacked an environment conducive to providing adequate medical services, affecting the clinicians' ability to ensure patients' auditory privacy; and several clinical areas did not have adequate exam space or were not wheelchair accessible. Also, emergency response bags were not always inventoried monthly or did not have fully charged or operational oxygen tanks.

The lowest scoring questions within the secondary indicator *Internal Monitoring, Quality Improvement, and Administrative Operations* resulted from the following administrative deficiencies:

- Monthly meeting minutes from the Quality Management Committee (QMC) did not address whether the QMC used program data to evaluate and discuss each program's performance, did not identify where improvements were needed, and did not address improvement action plans.
- Required documentation was absent for both emergency medical response drills and emergency medical response reviews.
- The institution did not always follow requirements for timely reporting adverse/sentinel events or inmate-patient deaths.
- The institution did not identify the status of performance objectives for all quality improvement initiatives identified in its 2014 Performance Improvement Work Plan.

### ***Population-Based Metrics***

In general, FSP performed well for population-based metrics. Especially notable was the high percentage of diabetics considered to be under good control and the low percentage of diabetics considered to be under poor control. In addition, FSP scored 100 percent with diabetic monitoring. Blood pressure control and eye exam rates for diabetic patients were comparable to Kaiser Permanente, typically one of the highest scoring health organizations in California. For breast and cervical cancer screening rates, the institution outperformed State and national

organizations. Colorectal cancer screening rates were slightly lower than Kaiser Permanente and the Department of Veterans Affairs (VA), but higher than Commercial and Medicare rates. The institution's immunization performance was higher than the VA in all areas except pneumococcal immunizations and was higher than applicable Commercial and Kaiser Permanente immunization performance levels. Overall, FSP's performance demonstrated by the population-based metrics indicated that the chronic care program was well run and operating as intended.

The following summary table lists the quality indicators the OIG inspected and assessed during the clinical case reviews and objective compliance tests and provides the institution’s rating in each area. The overall indicator ratings were based on a consensus decision by the clinical and non-clinical inspectors. The inspection compliance results for each component are detailed in *Appendix A* of this report.

### Executive Summary Table

<u>Primary Indicators (Clinical)</u>	<u>Case Review Rating</u>	<u>Compliance Score</u>	<u>Overall Indicator Rating</u>
<i>Access to Care</i>	Proficient	87.8%	Proficient
<i>Diagnostic Services</i>	Inadequate	73.8%	Inadequate
<i>Emergency Services</i>	Adequate	Not Applicable	Adequate
<i>Health Information Management (Medical Records)</i>	Inadequate	62.6%	Inadequate
<i>Health Care Environment</i>	Not Applicable	70.6%	Inadequate
<i>Inter- and Intra-System Transfers</i>	Adequate	87.3%	Adequate
<i>Pharmacy and Medication Management</i>	Adequate	89.3%	Adequate
<i>Preventive Services</i>	Not Applicable	91.0%	Proficient
<i>Quality of Nursing Performance</i>	Adequate	Not Applicable	Adequate
<i>Quality of Provider Performance</i>	Adequate	Not Applicable	Adequate
<i>Specialty Services</i>	Adequate	91.4%	Proficient
<u>Secondary Indicators (Administrative)</u>	<u>Case Review Rating</u>	<u>Compliance Score</u>	<u>Overall Indicator Rating</u>
<i>Internal Monitoring, Quality Improvement, and Administrative Operations</i>	Not Applicable	50.8%	Inadequate
<i>Job Performance, Training, Licensing, and Certifications</i>	Not Applicable	86.5%	Proficient

Note: *Prenatal and Post-Delivery Services, Reception Center Arrivals, and Specialized Medical Housing* indicators did not apply to this institution.

## **INTRODUCTION**

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

From January to March 2015, the OIG inspected Folsom State Prison (FSP) as its first Cycle 4 medical inspection.

## **BACKGROUND**

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The *Plata v. Brown* federal court class action lawsuit resulted in the United States District Court for the Northern District of California appointing a federal Receiver to raise medical care standards, manage the delivery of medical care, and develop a sustainable system that provides constitutionally adequate medical care to inmates at California's adult correctional institutions. At the request of the federal court and the court-appointed Receiver, and authorized by California Penal Code Section 6126, in 2007 the OIG developed a comprehensive inspection program in cooperation with key stakeholders to periodically review delivery of medical care at each State prison and measure compliance with health care policies and procedures.

At the conclusion of the OIG's third cycle of inspections, OIG stakeholders determined that the health care provided at the institutions was not fully evaluated by OIG's policy compliance testing alone. As a result of this input, for this fourth cycle of inspections, the OIG added a clinical case review component and significantly enhanced the compliance portion of the program. During the clinical case reviews, OIG physicians and nurses reviewed selected cases in detail to assess the overall quality of health care provided to those inmate-patients. For the compliance component of the program, the OIG added detailed onsite inspections of all clinical environments, added many new clinical and administrative tests, and increased sample sizes for some of the compliance tests conducted in prior cycles. In addition, to augment the qualitative assessment of health care at each institution, the OIG analyzed selected population-based metrics using Healthcare Effectiveness Data and Information Set (HEDIS) measures for other State and national health care organizations and compared that data to similar results for the institution under inspection. After conducting seven pilot inspections, the OIG implemented its Cycle 4 round of inspections in January 2015.

During the current inspection process, the OIG assesses the delivery of medical care to inmate-patients for 14 primary clinical health care indicators and 2 secondary administrative health care indicators, as applicable to the institution under inspection. It is important to note that while the

primary quality indicators represent the clinical care being provided by the institution at the time of the inspection, the secondary quality indicators are purely administrative and are not reflective of the actual clinical care provided.

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

## **ABOUT THE INSTITUTION**

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California's second oldest prison, Folsom State Prison (FSP), primarily houses medium security general population Level II male inmates. Additionally, FSP houses minimum security Level I male inmates within a minimum security facility located just outside of the main security perimeter. FSP offers rehabilitative programs in academic courses and career technical education, and many volunteer-run rehabilitative programs. Under the administration of FSP, Folsom Women's Facility (FWF) was activated in January 2013, which includes a 523-bed stand-alone facility providing housing, rehabilitative and reentry programming, substance abuse treatment, and job training to the medium and minimum security female population. FSP and FWF run eight medical clinics where staff handle non-urgent requests for medical services. FSP also treats inmates needing urgent or emergency care in its two triage and treatment areas. Lawrence Fong serves as the institution's Chief Executive Officer for Health Care Services, while Paramvir Sahota, M.D., had served until recently as the Chief Medical Executive (CME).

Based on staffing data OIG obtained from the institution in January 2015, FSP had a vacancy rate of zero percent for primary care providers. The institution lost a 1.0 full-time equivalent (FTE) physician and surgeon position in December 2014 due to the implementation of the CCHCS acuity-based staffing model. However, due to recent personnel changes and the lack of a budgeted Chief Physician and Surgeon (Chief P&S) position, total filled primary care provider (PCP) positions were at 113 percent of budgeted positions as of January 2015. This was offset by a vacancy in the CME position, which is designated as a management position. Regarding non-supervisory nursing levels, FSP had a 21 percent vacancy rate at the time of OIG's inspection. Various institutional health care meeting minutes indicated that the deviation was caused by recently established nursing positions for which management had not received immediate authority to fill. Currently, the institution is actively attempting to fill all nursing vacancies.

## FSP Health Care Staffing Resources—January 2015

Description	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff		Totals	
	Number	%	Number	%	Number	%	Number	%	Number	%
<i>Authorized Positions</i>	3	3%	8	8%	16	16%	73.1	73%	100.1	100%
<i>Filled Positions</i>	2	67%	9	113%*	14	88%	57.6	79%	82.6	83%
<i>Vacancies</i>	1	33%	0	0%	2	13%	15.5	21%	18.5	18%
<i>Recent Hires (within 12 months)</i>	0	0%	0	0%	5	36%	4	7%	9	11%
<i>Staff Utilized from Registry</i>	0	0%	0	0%	0	0%	2	3%	2	2%
<i>Redirected Staff (to Non-Patient Care Areas)</i>	0	0%	0	0%	0	0%	2	3%	2	2%
<i>Staff under Disciplinary Review</i>	0	0%	0	0%	0	0%	4	7%	4	5%
<i>Staff on Long-term Medical Leave</i>	0	0%	0	0%	1	7%	1	2%	2	2%

\*The one vacancy in the management category is offset by one too many practitioner positions in the PCP category.

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

As of April 15, 2015, the California Correctional Health Care System (CCHCS) reflected that FSP had a population of 2,927 inmates, of which 495 were females. Within that total population, 2.7 percent were designated as high-risk Level I, and 7.7 percent were designated as high-risk Level II. High-risk patients are at greater risk for poor health outcomes than average patients. The chart below illustrates the inmate-patient breakdown.

### CCHCS Master Registry as of April 15, 2015

Risk Level	# of Inmate-Patients	Percentage
High I	79	2.7%
High II	224	7.7%
Medium	1,295	44.2%
Low	1,329	45.4%
Total	2,927	100%

## OBJECTIVES, SCOPE, AND METHODOLOGY

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

To maintain a metric-oriented inspection program that evaluates medical care delivery consistently at each State prison, the OIG identified 14 primary (clinical) and 2 secondary (administrative) quality indicators of health care to measure. The primary quality indicators cover clinical categories directly relating to the health care provided to inmate-patients, whereas the secondary quality indicators address the administrative functions that support a health care delivery system. The 14 primary quality indicators are *Access to Care*, *Diagnostic Services*, *Emergency Services*, *Health Information Management (Medical Records)*, *Health Care Environment*, *Inter- and Intra-System Transfers*, *Pharmacy and Medication Management*, *Prenatal and Post-Delivery Services*, *Preventive Services*, *Quality of Nursing Performance*, *Quality of Provider Performance*, *Reception Center Arrivals*, *Specialized Medical Housing (OHU, CTC, SNF, Hospice)*, and *Specialty Services*. The two secondary quality indicators are *Internal Monitoring*, *Quality Improvement*, and *Administrative Operations*; and *Job Performance*, *Training*, *Licensing*, and *Certifications*.

The OIG rates each of the quality indicators applicable to the institution under inspection based on case reviews conducted by OIG clinicians and compliance tests conducted by OIG deputy inspectors general. The ratings may be derived from the case review results alone, the compliance test results alone, or a combination of both these information sources. For example, the ratings for the primary quality indicators *Quality of Nursing Performance* and *Quality of Provider Performance* are derived entirely from the case review results, while the ratings for both of the secondary quality indicators are derived entirely from compliance test results. As another example, primary quality indicators such as *Diagnostic Services* and *Specialty Services* receive ratings derived from both sources.

Consistent with the OIG's agreement with the Receiver, the report only addresses the conditions found related to medical care criteria. Further, the OIG does not review for efficiency and economy of operations. Moreover, if the OIG learns of an inmate-patient needing immediate care, the OIG notifies the Chief Executive Officer of Healthcare Services and requests a status report. Additionally, if the OIG learns of significant departures from community standards, it may report

such departures to the institution's Chief Executive Officer or to CCHCS. Because these matters involve confidential medical information protected by State and federal privacy laws, specific identifying details related to any such cases are not included in the OIG's public report.

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

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## **CASE REVIEWS**

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

### ***PATIENT SELECTION FOR RETROSPECTIVE CASE REVIEWS***

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

1. The goal of retrospective chart review is to evaluate all aspects of the health care system. Statewide, high-risk/high-utilization patients consume medical services at a disproportionate rate; 9 percent of the patient population who are considered high risk account for more than half of the institution's pharmaceutical, specialty, community hospital, and emergency costs.
2. Selecting this target group for chart review provides a significantly greater opportunity to evaluate all the various aspects of the health care delivery system at an institution.

Underlying the choice of high-risk patients for detailed case review are three assumptions:

1. If the institution is able to provide adequate clinical care to the most challenging patients with multiple complex and interdependent medical problems, it will be providing adequate care to patients with less complicated health care issues. Such an analysis requires clinical expertise and is, therefore, provided by experienced correctional physicians and registered nurses.
2. The health of less complex patients is more likely to be affected by processes such as timely appointment scheduling, medication management, routine health screening, immunizations, etc. For this reason the OIG simultaneously performs a broad compliance review.
3. Patient charts from death reviews, sentinel events (an unexpected occurrence involving death or serious injury, or risk thereof), and hospitalizations are mostly of high-risk patients.

### ***BENEFITS AND LIMITATIONS OF TARGETED SUBPOPULATION REVIEW***

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

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

Nonetheless, the health care system's response to this subpopulation can be accurately evaluated and yields valuable systems information. In the above example, if the health care system is providing appropriate diabetic monitoring, medication therapy, and specialty referrals for the high-risk patients reviewed, then it can be reasonably inferred that the health care system is also providing appropriate diabetic services to the entire diabetic subpopulation. However, if these same

high-risk patients needing monitoring, medications, and referrals are generally not getting those services, it is likely that the health care system is not providing appropriate diabetic services to the greater diabetic subpopulation.

### ***CASE REVIEWS SAMPLED***

For FSP case reviews, OIG clinicians evaluated medical charts for 76 unique inmate-patients. Nineteen of those patients were reviewed by both nurses and physicians, for a total of 95 reviews. Physicians performed detailed reviews of 30 charts, and nurses performed detailed reviews of 13 charts, totaling 43 detailed reviews. For detailed case reviews, physicians or nurses looked at all encounters occurring in approximately six months of medical care. Nurses also performed a limited or focused review of medical records for an additional 52 inmate-patients. Because of the high-risk, complex patients selected, most case reviews identified multiple chronic care diseases, and most involved review of many health care processes and programs.

The reporting format provides details on whether the encounter was adequate or had significant deficiencies. Further, the deficiencies are identified by programs and processes to help focus the institution on improvement areas. While the sample method (*Appendix B, Table B-1*) specifically pulled only six chronic care patient records (three diabetes patients and three anticoagulation patients), the final samples included patients with 225 chronic care diagnoses (*Appendix B, Table B-2*). Many chronic care programs were evaluated with the OIG's sample selection tool because the complex and high-risk patients selected from the different categories often had multiple medical problems. While not every chronic disease or health care staff member was evaluated, the overall operation of the institution's system and staff were assessed for adequacy. The OIG's case review methodology and sample size matched other qualitative research. The empirical findings, supported by expert statistical consultants, showed adequate conclusions after 10 to 15 charts had undergone full clinician review. In qualitative statistics, this phenomenon is known as "saturation". The OIG asserts that the sample size of over 30 detailed reviews certainly far exceeds the saturation point necessary for an adequate qualitative review. With regard to reviewing charts from different providers, the OIG's pilot inspections have shown that most providers have been adequately reviewed. The case review is not intended to be a focused search for poorly performing providers; rather, it is focused on how the system cares for those patients who need care the most. Providers would only escape OIG case review if institutional management successfully mitigated patient risk by having the more poorly performing PCPs care for the less complicated, low-utilizing, and lower-risk patients. The OIG concluded that the case review sample size was more than adequate to assess the quality of services provided.

Based on the collective results of clinicians' case reviews, the OIG rated each Quality Indicator as either *proficient* (excellent), *adequate* (passing), *inadequate* (failing), or *not applicable*. A separate *Confidential—Supplemental Case Review Summaries* report details the case reviews OIG clinicians conducted and is available to specific stakeholders. For further details regarding the sampling

methodologies and counts, see *Appendix B: Sample Sets, Table B-1; Chronic Care Diagnoses, Table B-2; and Event-Program, Table B-3.*

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## COMPLIANCE TESTING

### *SAMPLING METHODS FOR CONDUCTING COMPLIANCE TESTING*

For the compliance component testing, deputy inspectors general obtained answers to 88 objective test questions designed to assess the institution's compliance with critical policies and procedures applicable to the delivery of medical care. The inspectors conducted these tests by reviewing individual inmate-patients' electronic health records and conducting an onsite inspection of FSP during the week of January 26, 2015. In total, inspectors reviewed health records for 426 inmate-patients and inspected various transactions within their records for evidence that critical events occurred. During the onsite inspection, field inspectors conducted detailed inspections of the institution's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents.

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

### *SCORING OF COMPLIANCE TESTING RESULTS*

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

- Primary indicators: *Access to Care, Diagnostic Services, Health Information Management (HIM), Health Care Environment, Inter- and Intra-System Transfers, Pharmacy and Medication Management, Preventive Services, and Specialty Services.*
- Secondary indicators: *Internal Monitoring, Quality Improvement, and Administrative Operations; and Job Performance, Training, Licensing, and Certifications.*

After compiling the answers to the 88 questions, the OIG derived a score for each primary and secondary quality indicator identified above by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Then, based on those results, the OIG assigned a rating to each quality indicator of *proficient*, *adequate*, or *inadequate* using the following scale: *proficient* (greater than 85.0 percent), *adequate* (75.0 percent to 85.0 percent), or *inadequate* (below 75.0 percent).

## ***DASHBOARD COMPARISONS***

For some of the individual compliance questions, the OIG identified where similar metrics were available within the CCHCS Dashboard. The OIG compared OIG compliance test results with the Dashboard and reported on that comparative data under various applicable quality indicators within the *Medical Inspection Results* section of this report.

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## **OVERALL QUALITY INDICATOR RATING FOR CASE REVIEWS AND COMPLIANCE TESTING**

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

To derive an overall assessment rating for the institution's medical inspection, the OIG evaluated the various rating categories assigned to each of the quality indicators applicable to the institution, giving more weight to the rating results for the primary quality indicators, which directly relate to the health care provided to inmate-patients.

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## **POPULATION-BASED METRICS**

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

For ease of reference, the following is a table of common abbreviations that may be used in this report.

### Abbreviations Used in This Report

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

# MEDICAL INSPECTION RESULTS

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## PRIMARY (CLINICAL) QUALITY INDICATORS OF HEALTH CARE

### Case Reviews

The case review portion evaluated medical charts of 76 unique inmate-patients, some of whose charts were used for multiple reviews. This generated 861 clinical events for review (*Appendix B-3*). There was detailed physician review of 30 inmate-patients for approximately six months of care. There was detailed nursing review of 13 inmate-patients for approximately six months of care. Nurses performed 52 additional focused reviews of inmate-patients. Because of the high-risk, complex patients selected, most case reviews identified multiple chronic care diseases and many health care processes and programs. Even though the chart selection process selected only three patients with diabetes, the case reviews included a total of 17 patients with diabetes; 14 additional patients with diabetes were pulled from other sample requests since patients often have multiple medical problems (*Appendix B-2*). The OIG's 76 samples included 225 chronic care diagnoses. The OIG's clinicians concluded the sample size was adequate to assess the quality of services provided.

There were 30 case reviews rated on adequacy of care. Of these 30 cases, seven were *proficient*, 15 were *adequate*, and eight were *inadequate*. For 861 events reviewed, there were 232 deficiencies, of which 46 were considered likely to cause patient harm.

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

There were four significant adverse events for three patients identified in the case reviews. They were not reflective of the overall medical care provided at FSP. However, they were significant events that did impact the overall rating, and played a significant role in the institution's inability to attain a *proficient* rating.

- A patient with a working diagnosis of end-stage liver disease and severely low platelets was prescribed aspirin, which is known to decrease platelet function and clotting ability. The patient subsequently died from a severe intestinal bleed (case 41).

- A provider ordered laboratory studies for a patient with end-stage liver disease and kidney cancer. The laboratory department drew blood from the wrong patient and sent it for processing (case 30).
- A patient returned from the hospital after being treated for pulmonary emboli (blood clots in the lungs). His blood thinners (enoxaparin and warfarin) were not administered properly upon the patient's return to the institution (case 80).
- Three weeks later, in the same case, a provider ordered the blood thinner (warfarin) stopped in preparation for a medical procedure; however, the medication was continued despite the stop order (case 80).

## **Compliance Testing**

From January to March 2015, deputy inspectors general conducted detailed inspections of the institution's medical facilities and clinics, interviewed key institutional employees, and obtained answers to questions designed to assess the institution's compliance with critical policies and procedures. The OIG's inspectors also reviewed the electronic health records for selected inmate-patients and inspected various transactions within their records for evidence that critical events occurred.

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## ***ACCESS TO CARE***

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

<p><b><i>Case Review Rating:</i></b> <i>Proficient</i></p> <p><b><i>Compliance Score:</i></b> 87.8%</p> <p><b><i>Overall Rating:</i></b> <i>Proficient</i></p>
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## ***Case Review Results***

Office of the Inspector General clinicians reviewed over 558 provider and nursing encounters and found only six deficiencies related to access to care. The OIG found no significant problems with access to care, with only the rare deficiency. Appointments were timely in all aspects reviewed, including nursing sick call appointments, nurse-to-provider sick call referrals, triage and treatment

area and hospital follow-ups, intra-system transfers, specialty appointments, and outpatient provider follow-ups. Overall, FSP performed excellently with regard to access to care, and the indicator rating is thus *proficient*.<sup>2</sup>

### ***Compliance Testing Results***

The institution received an overall score of 87.8 percent in the *Access to Care* indicator, scoring well in most areas, as described below:

- OIG inspectors found that inmates had access to Health Care Services Request Forms (CDCR Form 7362) at all six housing units inspected, receiving a score of 100 percent for this test (MIT 1.101).
- Inspectors sampled 40 Health Care Services Request Forms submitted by inmate-patients across all facility clinics. As documented on the service request (CDCR Form 7362), nursing staff reviewed the request form on the same day it was received for 36 of the inmate-patients (90 percent). In three cases, the nursing staff reviewed the request form one or two days late and in the other case, the nurse failed to document the review date on the form at all (MIT 1.003). However, for all 40 of those samples (100 percent), nursing staff completed a face-to-face encounter with the inmate-patient within one business day of reviewing (or receiving) the request (MIT 1.004).
- For all 19 of the health care service requests sampled where the nursing staff referred the inmate-patient for a primary care provider (PCP) appointment (100 percent), the inmate-patient received a timely appointment (MIT 1.005). In addition, for seven inmate-patients for whom the PCP determined a follow-up appointment was necessary, all seven patients (100 percent) either received a timely appointment or refused the appointment (MIT 1.006).
- When inspectors sampled 28 inmate-patients who had been discharged from a community hospital, they found that 27 (96 percent) timely received a follow-up appointment with a PCP. While one patient was seen by a TTA physician one day after discharge, that patient did not see a PCP until the sixth calendar day after discharge, one day late (MIT 1.007).

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<sup>2</sup> The *proficient* rating for this indicator represents the time period prior to the reduction in physician staffing. In December 2014, FSP lost a 1.0 full-time equivalent (FTE) physician and surgeon position due to the implementation of the CCHCS acuity-based staffing model. The OIG has significant concerns regarding the reduction of physician staffing based on interviews with the medical leadership and provider line staff at FSP. CCHCS Dashboard data suggest a marked and sudden decline in scheduling and access performance at FSP shortly after the loss of the physician position (December 2014–February 2015).

- Inspectors also sampled 30 inmate-patients who had received a specialty service and found that 27 of them (90 percent) received a timely follow-up appointment with a PCP. One of the untimely appointments was only one day late, but for the other two inmate-patients, inspectors did not find evidence that the follow-up appointment occurred at all (MIT 1.008).

The institution needs to improve in the following areas:

- Inmate-patients who transfer into FSP from other institutions and are referred to a PCP for a routine appointment based on nursing staff’s initial health care screening of the patient are not being seen timely. Inspectors found that only 6 of the 21 patients sampled (29 percent) received timely PCP appointments. On average, untimely appointments were ten days late (MIT 1.002).
- Further, when the OIG reviewed recent appointments for 40 inmate-patients with chronic care conditions, it found that only 34 of the patients (85 percent) received timely appointments. For four patients, their appointments were either three or four days late; for two other patients, there was no evidence the appointments occurred at all (MIT 1.001).

### ***CCHCS Dashboard Comparative Data***

The Dashboard uses the average of eight medical access measure indicators to calculate the score for access to medical services. The OIG compared FSP compliance scores with all eight Dashboard indicators.

As indicated in the following table, the OIG’s comparative score for *Access to Care* was 96 percent and ranked 13 percentage points higher than CCHCS’s Dashboard score of 83 percent. This difference can be partially explained by differences in methodologies. For example, CCHCS Dashboard data includes access to care for inmate-patients returning from CDCR inpatient housing units and from emergency departments, whereas the OIG excluded those patients.

#### ***Access to Care—CCHCS Dashboard and OIG Compliance Results***

<b>CCHCS DASHBOARD RESULTS</b>	<b>OIG COMPLIANCE RESULTS</b>
Scheduling & Access to Care: Medical Services  February 2015	<i>Access to Care</i> (1.001, 1.004, 1.005, 1.007) <i>Diagnostic Services</i> (2.001, 2.004) <i>Specialty Services</i> (14.001, 14.003) February 2015
<b>83%</b>	<b>96%</b>

## ***Recommendations***

The institution must take steps to ensure that inmate-patients who suffer from chronic care illnesses receive their routine follow-up appointments within required time frames. In addition, for those inmate-patients who transfer into FSP and receive registered nurse referrals to see a provider, the institution must ensure that nurses document the time frame for provider referral appointments on the Initial Health Screening (CDCR Form 7277) and that inmate-patients are seen within required time frames.

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## ***DIAGNOSTIC SERVICES***

This indicator addresses several types of diagnostic services. Specifically, it addresses whether radiology and laboratory services were timely provided to inmate-patients; whether the primary care provider timely reviewed the results; and whether the results were communicated to the inmate-patient within the required time frames. In addition, for pathology services, the OIG determines whether the institution received a final pathology report and whether the primary care provider timely reviewed and communicated the pathology results. The case reviews also factor in the appropriateness, accuracy, and quality of the diagnostic test(s) ordered and the clinical response to the results.

***Case Review Rating:***  
*Inadequate*  
***Compliance Score:***  
*73.8%*  
***Overall Rating:***  
*Inadequate*

### ***Case Review Results***

Office of the Inspector General clinicians reviewed 139 diagnostic-related events and found 42 deficiencies. Of those 42 deficiencies, 26 related to health information management and 16 related to the delay or non-completion of diagnostic tests.

When diagnostic services were successfully completed, they were performed timely. When reports were available, they were reviewed timely by PCPs. Patients were notified of the test results quickly. Onsite inspection of the laboratory department revealed a working system that ensured that lab orders received were processed appropriately. Pathology reports were generally retrieved and reviewed timely, but there was one deficiency identified related to pathology reports:

- A pathology report from a surgical excision performed on November 14, 2014, was not found in the eUHR (case 27).

In multiple cases, laboratory tests and x-rays were not performed when ordered by a provider. Laboratory tests were more likely to be delayed or not completed than x-rays and urine tests. Case

review found 16 deficiencies across ten patients for whom diagnostic studies were ordered but not completed as ordered.<sup>3</sup>

- Diagnostic tests ordered but not performed were found in cases 1, 6, 15, 18, 19, 28, and 30.
- Diagnostic tests that experienced delays in processing were found in cases 3, 11, 13, and 19.
- In case 30, a blood sample was drawn from the wrong patient and submitted for processing. This was considered a “never event” by OIG clinicians (a medical mistake that should never happen).
- In case 6, x-rays ordered on three separate occasions by the provider between June 24, 2014, and July 24, 2014, were not obtained until the patient was seen in the TTA on August 4, 2014.
- Onsite interviews with provider staff indicated that same-day x-ray services were not consistently available. Notices of the unavailability of same-day x-ray services commonly occurred. During the provider meeting, the Chief Physician and Surgeon reminded providers that the lack of availability of x-ray services should not be allowed to hinder patient care, and that if clinically necessary, providers should not hesitate to send patients outside the facility to obtain those services.

In addition to the general unreliability of obtaining diagnostic tests, FSP also had significant problems with health information management related to those services. Radiology reports generally were not retrieved from the RIS-PACS system, signed-off by a PCP, or scanned into the eUHR.

- Radiology reports (x-rays and onsite CT/MRI scans) left in RIS-PACS and not properly processed (signed-off by a PCP, scanned into the eUHR) were widespread. This deficiency was found in cases 1, 5, 6, 10, 13, 15, 17, 19, 20, 28, 29, 30, 41, and 72.

Because of the relatively high number of improperly processed laboratory orders, and the intermittent unavailability of same-day x-ray services, overall diagnostic testing at FSP is considered unreliable by the OIG. The combination of the unreliable diagnostic testing and the lack of scanning of onsite radiological reports into the eUHR has increased the medical risk for FSP patients and was the major reason for the *inadequate* rating in this category.

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<sup>3</sup>These findings may seem contradictory to the compliance findings in MIT 2.001 and MIT 2.004 due to testing methodology. Compliance testing begins with the completed test and tests backward, whereas case review begins with the physician order and tests forward.

The following deficiencies did not affect FSP's case review rating for this indicator, but provided for quality improvement purposes related to FSP's contracted laboratory provider.

- On two occasions, the laboratory provider did not report STAT or critical labs timely. In case 11, STAT labs drawn on July 22, 2014, were not reported until August 4, 2014. In case 30, a critically low hemoglobin level was not reported to FSP for two days.
- In case 80, a laboratory order from August 25, 2014, ordered STAT was not processed STAT, being reported almost 14 hours later.

### ***Compliance Testing Results***

The institution received an overall score of 73.8 percent in the *Diagnostic Services* indicator, which encompasses radiology, laboratory, and pathology services. For clarity, each type of diagnostic service is discussed separately below:

#### **Radiology Services**

- OIG inspectors found that for all ten (100 percent) of the radiology services sampled, the service was timely performed and the test results were timely communicated to the inmate-patient (MIT 2.001, 2.003). However, there was no evidence that final radiology reports were reviewed by the ordering provider and scanned into the patients' eUHR files. Specifically, only two of the ten patients' eUHR files included the final radiology report. One of those final reports had no evidence of review, and the other indicated that the final report was reviewed several months late. As a result, FSP received a score of 0 percent for this test. This eUHR omission occurs because health care staff does not always print the final radiology report from the RIS-PACS electronic imaging database and submit it to the provider for review and eventual eUHR scanning (MIT 2.002).

#### **Laboratory Services**

- Nine of ten laboratory services ordered (90 percent) were performed timely. The one exception was an urgent service request that was performed six days late (MIT 2.004). Also, nine of those ten sampled inmate-patients' eUHR files (90 percent) included the laboratory diagnostic report with evidence that the provider had reviewed the diagnostic test results timely. The only exception was an instance where the provider failed to initial the report to document evidence of review (MIT 2.005). In addition, inspectors found that all ten of the diagnostic studies (100 percent) were communicated to the inmate-patient timely (MIT 2.006).

## Pathology Services

- The institution documented the final pathology report in the eUHR for only seven of ten inmate-patients sampled (70 percent), and the provider timely reviewed the pathology results for six of those seven patients (86 percent). One exception was attributable to a provider who failed to properly document evidence of review (MIT 2.007, 2.008). Further, inspectors found that providers communicated the final pathology results to only two of those seven inmate-patients (29 percent). For three patients, there was no evidence that the provider met with the patient after the pathology service was performed, and in two other cases, the provider met with the inmate-patient, but failed to discuss the pathology results (MIT 2.009).

### ***Recommendations***

As it relates to the overall institutional rating, FSP successfully mitigated inadequacies in *Diagnostic Services*. Providers reviewed diagnostic tests timely and used online services to review tests that were not yet available through the eUHR. Providers also compensated for unreliable diagnostic services by reordering tests not completed.

Folsom State Prison appears to have a small percentage of diagnostic orders not completed or completed outside of the requested period. The OIG suspects that sometimes orders are not sent to or received by the laboratory department in a reliable manner. This would be consistent with case review findings of other types of either missing or improperly processed physician orders. The root cause of this unreliability will likely be identified and corrected with the computerized physician order entry module of the coming electronic health record system. Until then, FSP could implement a crosschecking strategy to ensure all orders written are properly sent and received at their intended destinations. Radiology reports from RIS-PACS should be routed to a PCP for review and signature, and must be scanned into the eUHR. PCPs should be reminded to always print their names legibly, or use a name stamp in addition to their initials or signature. Also, FSP must ensure it receives a final pathology report, evidences a review of the report, and scans it into the eUHR. Then, within two business days of receiving the report, providers must communicate the results to the inmate-patient.

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### ***EMERGENCY SERVICES***

An emergency medical response system is essential to providing effective and timely emergency medical response, assessment, treatment, and transportation 24 hours per day. Provision of urgent/emergent care is based on a patient's emergency situation, clinical condition, and need for higher level of care. The OIG

***Case Review Rating:***

*Adequate*

***Compliance Score:***

*Not Applicable*

***Overall Rating:***

*Adequate*

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

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

### ***Case Review Results***

Office of the Inspector General clinicians reviewed 64 urgent/emergent events and found 24 deficiencies in a variety of areas. Most deficiencies were considered minor and did not significantly affect patient care. In general, FSP performed well with emergency response times, BLS care, and 9-1-1 call activation times. Overall, the case reviews showed that patients requiring urgent or emergent services received timely and adequate care in the majority of cases reviewed.

### **Provider Care**

The triage and treatment area (TTA) provider generally saw the patient timely and made adequate assessments. Triage decisions were sound, and patients were sent to the appropriate levels of care. The general TTA physician was also utilized on occasion as a wound care expert. While the OIG identified a few minor deficiencies, the quality of provider care in *emergency services* was good.

### **Nursing Care**

Emergency nursing care was also adequate with documented evidence of commendable performances by experienced nurses in some of the emergency medical response cases reviewed (cases 1, 5). However, several case examples demonstrated areas for improvement, primarily related to incomplete or inaccurate documentation. The following cases are examples of these case review findings:

- Case 1 involved a patient with the initial complaint of chest pain at level 10 out of 10, which remained at that level for approximately 22 minutes. Although the patient was alert and stable in the TTA, there was no documentation of current pain status assessments for about 45 minutes. The patient suddenly went into cardiac arrest, and underwent two cycles of CPR and was administered Narcan and epinephrine before regaining spontaneous heartbeat and respirations. Nursing interventions during this emergent situation were timely, appropriate, and exemplary.
- In case 2, the patient was found unresponsive in his cell on March 21, 2014, and CPR was subsequently initiated. CPR was discontinued after the patient regained spontaneous pulse

and respirations. The RN documented that Narcan was given by intravenous route (“push”), when, in fact, an intravenous line had not been inserted.

- In case 19, the LVN medical responder assessed the patient on scene with sudden onset 9 out of 10 chest pain radiating to left arm on July 24, 2014. Although the patient had a 99 percent oxygen saturation, the documentation was unclear if the patient was receiving supplemental oxygen, and where initiated. The documentation is also unclear as to whether medical staff remained with the patient en route to the TTA.
- Documentation of numerous time discrepancies for the same occurrences entered by different medical staff or by one person on various documents was found in several cases (cases 2, 5, 13, 19).

### **Patient Care Environment**

- In case 1, the patient developed cardiovascular collapse while the RN was communicating with the on-call physician. The case review suggested that the RN was not able to maintain visual contact with the patient while discussing the case on the phone. This was verified during the onsite inspection.

### **Onsite Clinician Inspection**

During the onsite visit, OIG clinicians found the patient care environment in the TTA to be a potentially serious detriment to providing safe patient care. The Building 3 PCP shares space within the TTA, and uses one of the beds for PCP line clinic patients. The designated TTA bed is enclosed within a small space with no telephone line access, requiring the TTA RN to leave the immediate TTA patient bed space to use the telephone. Because a wall separates the TTA bed from the telephone location, the RN is unable to maintain visual contact with the patient during phone calls. Nursing administrators at FSP discussed current plans underway to rearrange bed spaces within the TTA room to ensure the RN is able to maintain uninterrupted sight of the TTA patient at all times. In addition, FSP administration anticipates a long-term solution when the Health Care Facility Improvement Plan (HCFIP) is implemented.

### **Conclusion**

FSP staff provide excellent emergency services to their patients. The layout of the TTA and the physical plant limitations imposed by it prevent a *proficient* rating for this indicator. Thus, the clinical case rating for this indicator is *adequate*.

### ***Recommendations***

The emergency services provided at FSP were appropriate and generally adequately documented. The OIG recommends that medical and nursing administrators work collaboratively to implement

the necessary changes within the TTA room to ensure that TTA health care staff are able to maintain constant unobstructed visual observation of the patient at all times, including when using the computer and making necessary telephone contacts.

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## ***HEALTH INFORMATION MANAGEMENT (MEDICAL RECORDS)***

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

***Case Review Rating:***

*Inadequate*

***Compliance Score:***

62.6%

***Overall Rating:***

*Inadequate*

### ***Case Review Results***

Folsom State Prison HIM deficiencies were present at a moderate but significant rate during case review. Out of the 232 deficiencies identified from the case reviews, 59 of them were related to HIM processes.

### **Inter-Departmental Transmission**

- Low but significant rates of deficiencies of intended orders not carried through were found across various departments. For example, the *Diagnostic Services* section details a low but regular rate of missed lab and radiology orders. Similar findings were found in *Pharmacy and Medication Administration*, where several medication errors were identified where orders may not have been transmitted to the pharmacy, or even transmitted between nursing staff in different buildings. In *Quality of Provider Performance*, there were several occasions where providers intended to implement orders, but the orders were not found in the eUHR and there was no evidence of the plan of care being processed. The OIG suspects that all these were likely inadvertent human errors exacerbated by a paper medical system.

## Hospital Records

- Most hospital records were retrieved, reviewed, and scanned into the eUHR. Of the 21 hospitalization events reviewed, 17 events had adequate retrieval, review, and scanning performance.
- The most severe deficiency noted was when hospital records (especially discharge summaries) were not retrieved and were missing from the eUHR. The reason for the high severity is because these types of records contain the most vital information for the continuity of care between the inpatient and outpatient settings. In cases 13 and 28, discharge summaries were not retrieved or found in the eUHR. However, in both of these cases, other highly significant hospital records were identified, which markedly mitigated the lack of a discharge summary.
- Similarly, hospital records that were retrieved late could place a patient at elevated medical risk. This occurs when hospital records are not available for the PCP to review at the time of the hospital follow-up appointment. In case 3, the patient was seen in the emergency room for possible seizures, but the hospital records were not retrieved or scanned for more than three weeks after discharge. This patient did not have subsequent medical care by his provider. He was the sole FSP patient reviewed that was lost to provider follow-up.
- Nearly all hospital records were signed off by a provider and reviewed. The discharge summary in case 6 was the sole discharge summary that was not signed off.

## Scanning Performance

- Scanning times for all documents were uniformly excellent.
- Mislabeled or misfiled documents can be problematic, as these errors can greatly hinder the ability to find relevant clinical information. Case reviewers did find significant numbers of mislabeled and misfiled documents in the eUHR. However, they did not find documents that were filed in the wrong patient's chart.

## Specialty Services

- Most specialty reports were processed without any significant problems. However, deficiencies in the processing of specialty consult reports occurred at a moderate rate. These findings are discussed in detail in the *Specialty Services* section. It is important to note that the deficiencies discussed in that section were usually of low severity and did not significantly impact the delivery of adequate medical care.

## **Diagnostic Reports**

- Radiology reports were left in the RIS-PACS system with no evidence of having been properly signed off and reviewed by a PCP and scanned into the eUHR. The specific deficiencies are discussed further in the *Diagnostic Services* section. This practice markedly increased the medical risk of patients, especially at the time of transfer of care.

## **Legibility**

- Illegible progress notes, signatures, or initials were found throughout this period of review from some of the physician providers. Illegible progress notes pose a significant medical risk to patients, especially when other staff must review the medical care, or if a patient is transferred to a different care team.

Health care staff at FSP, especially providers, have to contend with misfiled documents in the eUHR, and routinely look through at least three or more computer systems (to review medical records, radiology reports, and disability information). In addition, all health care staff contend with illegibility of some of the provider progress notes and orders. Combined with an underlying human oversight error rate, these problems cumulatively have the potential to increase medical risk. The mitigation of these additional deficiencies is dependent on each individual employee's computer expertise, personal efficiency, attention to detail, and ability to decipher illegible handwriting. These abilities are variable between staff members. It should be noted that FSP has successfully mitigated most of these deficiencies through the efforts of conscientious and diligent provider and nursing staff.

## ***Compliance Testing Results***

The institution received an overall score of 62.6 percent in the *Health Information Management (Medical Records)* indicator and needs to improve in the following areas:

- The institution scored a 0 percent in its labeling and filing of documents that were scanned into inmate-patients' electronic unit health records. The most common error was mislabeled documents, such as medication administration records not scanned with the proper month (MIT 4.006).
- When the OIG reviewed various medical documents such as hospital discharge reports, initial health screening forms, certain medication records, and specialty service reports to ensure that clinical staff legibly documented their names on the forms, inspectors found that only 8 of 32 samples (25 percent) showed compliance (MIT 4.007).

- Community hospital discharge reports or treatment records for FSP inmate-patients who were sent or admitted to the hospital were not always completed or reviewed within three calendar days of discharge. The institution scored only 73 percent for this test. When the OIG reviewed eUHR files for 30 patients, it could not find a discharge report at all for two patients. For six other patients, there was either no evidence that the FSP provider reviewed the report, the provider did not review the report timely, or the provider's date of review was illegible (MIT 4.008).
- Community hospital discharge reports or treatment records were not always scanned into the inmate-patient's eUHR within three calendar days of the hospital discharge. Only 15 of the 20 sampled reports (75 percent) were timely scanned. Medication administration records were also not timely scanned into the inmate-patient's eUHR files, with only 15 of those 20 sampled documents (75 percent) scanned within the required time frames. Of the ten documents scanned late, eight were scanned one or two days late and the other two were six and eight days late, respectively (MIT 4.004, 4.005).

The institution performed well in its scanning of the following health care documents:

- Miscellaneous non-dictated documents, including providers' progress notes, and inmate-patients' initial health screening forms and requests for health care services were scanned timely. Inspectors found that all 20 documents sampled (100 percent) were appropriately scanned into the patient's eUHR within three calendar days of the inmate-patient's encounter (MIT 4.001). Similarly, specialty service consultant reports were scanned into the inmate-patient's eUHR file within five calendar days for 18 of the 20 documents reviewed (90 percent). The two exceptions included a radiology report that was not found at all and a specialty report that was scanned four days late (MIT 4.003).

## ***CCHCS Dashboard Comparative Data***

As indicated below, the OIG’s compliance results were similar to Dashboard results with regard to the institution’s *proficient* level for timely scanning non-dictated medical documents and specialty documents. However, the OIG assigned FSP a score of only 75 percent for its scanning of community hospital discharge documents, whereas the Dashboard’s related results for scanning community hospital records were much higher.

### ***Health Information Management— CCHCS Dashboard and OIG Compliance Results***

<b>CCHCS DASHBOARD RESULTS</b>	<b>OIG COMPLIANCE RESULTS</b>
Availability of Health Information: Non-Dictated Medical Documents February 2015	<i>Health Information Management (4.001)</i> Non-Dictated Medical Documents February 2015
<b>95%</b>	<b>100%</b>

<b>CCHCS DASHBOARD RESULTS</b>	<b>OIG COMPLIANCE RESULTS</b>
Availability of Health Information: Specialty Notes February 2015	<i>Health Information Management (4.003)</i> Specialty Documents February 2015
<b>98%</b>	<b>90%</b>

<b>CCHCS DASHBOARD RESULTS</b>	<b>OIG COMPLIANCE RESULTS</b>
Availability of Health Information: Community Hospital Records February 2015	<i>Health Information Management (4.004)</i> Community Hospital Discharge Documents February 2015
<b>86%</b>	<b>75%</b>

## ***Recommendations***

There were some problems that placed patients at significant risk. Radiology reports from RIS-PACS should have evidence of being signed off by a provider and should be scanned into the eUHR. The OIG considers the current practice of leaving radiology reports (with no evidence of provider review) in a separate computer system that is not linked to the eUHR to be unacceptable. Also, staff should scan medication administration records and hospital discharge records into the eUHR within required time frames. While human oversight errors are impossible to eliminate, they can be reduced using various quality improvement methods. For example, crosschecking procedures could be implemented at points where there is a higher risk of communication failure. If implemented correctly, an electronic medical record can virtually eliminate errors in communication transmission. Also, providers need to review community hospital discharge reports within three calendar days of a patient's discharge. In addition, provider signature illegibility is a significant problem at FSP and should be addressed without waiting for the electronic health record. Staff should print their names or utilize name stamps in addition to their signatures or initials. Finally, mislabeled documents should be targeted for improvement even while FSP awaits the implementation of the new electronic health record system.

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## ***HEALTH CARE ENVIRONMENT***

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

***Case Review Rating:***

*Not Applicable*

***Compliance Score:***

*70.6%*

***Overall Rating:***

*Inadequate*

## ***Compliance Testing Results***

The institution received an overall score of 70.6 percent in the *Health Care Environment* indicator, scoring poorly in several key areas, as described below:

- The OIG examined emergency response bags to determine if they were inspected daily, inventoried monthly, and contained all essential items. Emergency response bags were compliant in only two of the ten clinics inspected (20 percent). Inspectors found that staff had not inventoried bags within the prior 30 days in six clinics, and oxygen tanks were either not fully charged or were inoperable in four clinics (MIT 5.111).

- Clinic common areas and exam rooms were often missing essential supplies and core equipment necessary to conduct a comprehensive exam. As a result, only two of the ten clinics (20 percent) received a passing score for this test. Missing items included glucometers and nebulization units for asthmatics in some clinics, and hemocult cards and developers in some PCP exam rooms. In addition, one clinic did not have a medication refrigerator, and three clinics had equipment that had not been calibrated within the prior 12 months (MIT 5.108).
- The OIG inspected exam rooms in the ten clinics to determine if appropriate space, configuration, supplies, and equipment allowed clinicians to perform a proper clinical exam. Inspectors found that exam rooms or treatment spaces in half of the ten clinics (50 percent) had one or two deficiencies. Specifically, as indicated in the photographs on this and the following page, examination treatment space was too small in three clinics, which included the TTA in the women's facility. Also, the placement of exam tables in three clinics did not allow the patient to lie in a fully extended supine position on the table. Another clinic had an exam table with a hole in the vinyl cover, which could harbor infectious agents if not repaired (MIT 5.110).
- The institution's clinic common areas did not always have an adequate environment conducive to providing medical services, with only six of the ten clinics (60 percent)



receiving a passing score for this area. Because the facility's TTA shares its triage area with another clinic, neither location can provide auditory privacy for inmate-patients being examined. Two other clinics have limited wheelchair accessibility (MIT 5.109).

- OIG inspectors observed clinicians' encounters with inmate-patients in nine of the institution's ten clinics and found that clinicians did not always follow good hand hygiene practices. In three of the nine clinics (67 percent), the nurse practitioner failed to wash his or her hands either before or after physical contact with the patient. For this test, inspectors were unable to observe any encounters between clinicians and patients at the women's facility TTA (MIT 5.104).



The institution performed well, scoring 100 percent in all four of the following areas:

- Clinical health care staff in all ten clinics ensured that reusable invasive and non-invasive medical equipment was properly sterilized or disinfected (MIT 5.102).
- All ten clinics followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste (MIT 5.105).
- Inspectors found that medical storage areas located in FSP's minimum support facility met the supply management process and support needs of the medical health care program (MIT 5.106).
- All ten clinics tested followed medical supply storage and management protocols (MIT 5.107).

The institution received moderate scores of 80 percent for both of the following tests:

- Although inspectors found that all ten clinics were appropriately disinfected, cleaned, and sanitary, adequate cleaning logs were not maintained for both the TTA and main clinic in the Folsom Women's Facility (MIT 5.101).

- When inspectors examined the ten clinics to verify that adequate hygiene supplies were available and sinks were operable, they found that there was no antiseptic soap available in two clinics' inmate restrooms (MIT 5.103).

### **Other Information Obtained from Non-Scored Results**

The OIG gathered information to determine if the institution's physical infrastructure is maintained in a manner that supports health care management's ability to provide timely or adequate health care. The information was based on interviews with the institution's health care management. The question is not scored and is only reported for informational purposes. When asked if all clinical areas have physical plant infrastructures sufficient to provide adequate health care services, staff indicated that while they had typical concerns associated with a 113-year-old facility, nothing was preventing them from providing adequate health care. The institution does have three significant infrastructure projects underway, which include an expansion of the new minimum support facility primary care area, a new primary care clinic for Building 1, and a new health care services building (MIT 5.999).

### ***Recommendations***

The institution should ensure that all clinics and exam rooms have wheelchair access and that triage exam areas provide auditory privacy to inmate-patients. All exam rooms should have minimal clutter and sufficient space to conduct inmate-patient examinations. Exam tables must be in good repair and positioned in the exam room to allow the patient to easily lie fully extended on the exam table. Also, FSP must ensure that each clinic has a full complement of core equipment, including a nebulization unit, glucometer, and refrigerator. Applicable equipment should be calibrated annually or more often, as needed. Exam rooms where providers work must also have hemocult cards and a developer. Clinical staff should ensure that emergency response bags are inspected monthly and that emergency oxygen tanks are maintained in a fully charged and operable condition.

All clinical staff, including nurse practitioners, must follow good hand sanitation practices both before and after coming in contact with patients. Health care management should periodically monitor staff's adherence to hand hygiene protocols and provide staff training if necessary.

## ***INTER- AND INTRA-SYSTEM TRANSFERS***

This indicator focuses on the management of inmate-patients' medical needs and continuity of patient care during the inter- and intra-facility transfer process. The OIG review includes evaluation of the ability of the institution to provide and document health screening assessments (including tuberculin screening tests), initiation of relevant referrals based on patient needs, and the continuity of medication delivery to patients received from another institution. For those patients, the clinicians also review the timely completion of pending health appointments, tests, and requests for specialty services. For inmate-patients who transfer out of the facility, the OIG evaluates the ability of the institution to document transfer information that includes pre-existing health conditions, pending appointments, tests and requests for specialty services, medication transfer packages, and medication administration prior to transfer. The patients reviewed for *Inter- and Intra-System Transfers* include endorsed inmates received from other CDCR facilities and inmates transferring out of FSP to another CDCR facility.

***Case Review Rating:***

*Adequate*

***Compliance Score:***

87.3%

***Overall Rating:***

*Adequate*

### ***Case Review Results***

A total of 22 encounters were reviewed related to *Inter- and Intra-System Transfers*, including information from both the sending and receiving institutions. Nine encounters were reviewed for inmates transferring out of FSP to other institutions, and 13 encounters were reviewed for inmates transferring into FSP from other institutions. The OIG reviewed 21 hospitalization events, each of which resulted in a transfer back to the institution. In general, the inter- and intra-system transfer processes at FSP were adequate, with the majority of transferring inmates receiving timely continuity of health care services.<sup>4</sup> Although there were rarely any major issues found in the cases reviewed, there were various deficiencies found related to delay in appointment scheduling for specialty services, missed medication doses, and incomplete nursing documentation. Specific examples of case review findings are listed below.

#### **Transfers In**

- The patient in case 44, with a history of sleep apnea and continuous positive airway pressure (CPAP) machine use prior to incarceration, transferred to FSP in September 2014. The RN did not document notifying specialty services regarding a pending report of a completed CPAP titration study. A significant delay in providing the CPAP machine occurred due to delays in receiving and reviewing the CPAP titration study report. Additionally, the patient

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<sup>4</sup> The OIG case review rating is applicable only to FSP's existing, nursing-only inter- and intra-system transfer processes. The rating is not applicable to the CCHCS systemwide transfer process, about which the OIG has significant concerns and which is also discussed in this section.

did not receive morning doses of sertraline and oxcarbazepine, both directly observed therapy, on the day after arrival at FSP, but the patient did receive the evening doses.

- In case 79, the patient transferred to FSP in August 2014 and missed the scheduled four-month follow-up urology clinic appointment due in September 2014. FSP approved the routine referral for service in September 2014, but the appointment had not yet occurred during the case review period.

## **Transfers Out**

Deficiencies found with inmates transferring out of FSP were largely due to incomplete nursing documentation of significant medical information on the Health Care Transfer Information form (CDCR Form 7371).

- In case 3, the RN did not document that the patient had a seizure disorder.
- In case 6, the RN did not document that the patient had a history of kidney removal (nephrectomy) due to cancer and chronic back pain.
- In case 78, the RN did not document that the patient was on a hepatic diet, which was the reason for the transfer out of FWF to a facility that provides special diets. The RN also did not document that six days prior to the transfer, the Twinrix vaccine series was started, which requires specific time frames for completing subsequent doses.

## **Hospitalizations**

Patients returning from hospitalizations are some of the highest risk encounters due to two factors: these patients are of higher acuity since they have just been hospitalized for a severe illness in most cases, and these patients are doubly at risk due to the potential lapses that can occur during any handoff in care. For most patients, FSP did an excellent job. Hospital return patients were processed by the TTA RN, who reviewed the discharge medications and plan of care appropriately and obtained physician orders to implement them. Most discharge summaries were appropriately obtained, reviewed by a provider, and scanned into the eUHR, further discussed in the *Health Information Management* indicator section. The primary care provider then followed up with the patients in a timely manner, most often the next day. This process worked well for the majority of hospitalization events reviewed. However, the following problem was found:

- In case 80, the patient returned from the hospital with spontaneous blood clots in the lungs (bilateral pulmonary emboli). The discharging physician intended for the patient to start enoxaparin and warfarin (blood thinners) immediately upon return to FSP. However, since the nurse and the physician on call did not review each medication order in detail, medication continuity lapsed.

## **Systemwide Transfer Challenges**

In reviewing *Inter- and Intra-System Transfers*, the OIG acknowledges systemwide challenges common to all institutions regarding pending specialty services referrals and reports and the potential for delay in needed follow-up and services. Nurses are responsible for accurately communicating pertinent information, identifying health care conditions that need treatment and monitoring, and facilitating continuity of care during the transfer process. While this is sufficient for most CDCR inmate-patients, it has not been adequate for patients with complex medical conditions or patients referred for complex specialty care. Often, the CDCR Form 7371 transfer forms are initiated by nurses who are not familiar with the patient's care or are not part of the primary care team. In addition, providers are often left out of the transfer process altogether, and patients are transferred without the provider's knowledge. Without a sending and receiving provider, the risk for lapses in care increase significantly.

## ***Compliance Testing Results***

FSP obtained a *proficient* score of 87.3 percent in the *Inter- and Intra-System Transfers* indicator, scoring above 85 percent in three of the five areas tested, as described below:

- The institution scored 100 percent when the OIG tested two inmate-patients who transferred out of the institution during the onsite inspection to determine whether their transfer packages included required medications and related documentation. Although a total of four inmates transferred-out on the testing day, the sample was limited because medications had been prescribed for only two of them (MIT 6.101).
- The OIG reviewed the Initial Health Screening (CDCR Form 7277) document for 30 inmate-patients who transferred into FSP from another CDCR institution to determine if nursing staff completed the assessment and disposition sections of the form on the same day staff completed an initial screening of the patient. Inspectors found two exceptions, resulting in a score of 93 percent. For one patient, the nurse neglected to indicate if a provider referral was necessary, and for another patient, the nurse did not sign and date the form (MIT 6.002).
- The institution scored 88 percent when the OIG tested the transfer-in patients who had an existing medication order upon arrival to determine if they received their medications without interruption. When inspectors reviewed records for the 17 applicable patients, they identified two exceptions. In one notable case, a patient had been prescribed a psychiatric medication by the sending institution. Upon transfer to FSP, the sending institution had inappropriately given the patient a 30-day supply of the medication as a keep-on-person (KOP) prescription. The sending institution also included the medication on the patient's list of medications that should be administered by nursing staff as a direct observation therapy (DOT) prescription. However, upon the patient's arrival at FSP, nursing staff failed to

identify the sending institution's error, and for over two weeks continued to attempt to administer the DOT medication to the patient, even though he refused the medication and already had a 30-day supply. For another patient who did not arrive at FSP with his KOP medication, nursing staff failed to reissue the medication to the patient upon arrival (MIT 6.003).

The institution needs to improve in the following two areas:

- The institution scored only 75 percent when the OIG tested inmate-patients who transferred out to another CDCR institution to determine whether their scheduled specialty service appointments were listed on the Health Care Transfer Information form (CDCR Form 7371). FSP did not include the inmate-patient's specialty service appointment on the transfer form for five of the 20 patients sampled (MIT 6.004).
- FSP received a score of 80 percent when the OIG tested 30 patients who transferred into FSP from another CDCR institution to determine whether they received a complete initial health screening assessment from nursing staff on their day of arrival. Nursing staff timely completed the assessment for 24 of the patients, but either neglected to answer all screening questions or neglected to document additional information required to supplement the answer to some questions for six other patients. For example, for three patients who were prescribed medications, the nursing staff failed to list the medications or make reference to where that information could be found (MIT 6.001).

### ***Recommendations***

With regard to hospitalizations, FSP can improve the return process for medication continuity. One suggestion is the creation of a special hospital return medication order that discontinues all prior outpatient medications and specifies the medication, dose, route, frequency, duration, *and start time* for each new prescription. When given verbally, nurses can be expected to verify each prescription in detail with read-back with the ordering physician. These orders can be audited to ensure completeness by both physicians and nurses. Additionally, pre-hospitalization medication administration records should be removed from the medication binder, or pre-hospital medications clearly marked as discontinued.

With regard to systemwide transfers (not specific to FSP), the majority of patients who do not have complex medical conditions or who do not require complex specialty care would be well served with the existing nursing-only transfer process. However, CCHCS should create a process to identify patients who require special transfer handling. Those patients should not be allowed to transfer without physician involvement, as a nursing-only transfer process is insufficient. The transfer process should include a clear disposition, including the specific yard to which the patient is being transferred and the line physician who will be directly responsible for the patient's continued

care. In addition, the transferring physician should dictate or type a transfer summary that is communicated to the accepting line physician prior to transfer. Transfer should only occur after the accepting line physician has reviewed the summary, had an opportunity to discuss the case with the sending physician, and formally accepted the transfer. The OIG understands that these recommendations would place a significant logistical and staffing burden on both sending and receiving institutions, and that these measures are generally not practiced in the outpatient community. However, the volume and transfer rate within CDCR is much higher than the outpatient community, and needs to be accounted for when designing an adequate transfer system.

Nurses who complete the Initial Health Screening form (CDCR Form 7277) for newly arrived inmate-patients must ensure that all form questions are answered and that they include adequate detailed responses, such as listed out medication names when called for by the form's instructions. In addition, FSP should train staff to help ensure that inmate-patients who are transferred out of the facility have their pending and scheduled specialty services appointments properly identified on the Health Care Transfer Information form (CDCR Form 7371).

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### ***PHARMACY AND MEDICATION MANAGEMENT***

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

<p><b><i>Case Review Rating:</i></b> <i>Adequate</i></p> <p><b><i>Compliance Score:</i></b> 89.3%</p> <p><b><i>Overall Rating:</i></b> <i>Adequate</i></p>
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Based on results from prior pilot inspections, the OIG has found that the most accurate evaluation of this indicator is largely derived from a detailed analysis of the OIG compliance scores in addition to the clinical case reviews. The case reviews often add robustness to the analysis of this indicator by identifying specific examples of the findings revealed by the compliance scores and by identifying problems in other processes that may not be evident when viewed solely from a compliance standpoint.

## ***Case Review Results***

Office of the Inspector General clinicians evaluate pharmacy and medication management as secondary processes as they relate to the quality of clinical care provided. Compliance testing is a more targeted approach and is heavily relied on for the overall rating for this indicator.

### **New Prescriptions**

Case review found that for the majority of cases, patients received their medications timely and as prescribed. However, there were rare cases where prescriptions were not processed correctly:

- In case 20, the provider ordered a decrease in blood thinner (warfarin) dosage, but this was not processed. Fortunately, the patient did not suffer bleeding complications.
- In case 80, the provider stopped the prescription for warfarin in preparation for a procedure on September 11, 2014, but the order was not processed. Fortunately, the patient did not undergo the procedure and did not suffer bleeding complications.
- In case 13, the provider ordered a decrease in blood pressure medication (lisinopril), but the order was not noted or processed.

### **Chronic Care Medication Continuity**

Case review did not identify any significant lapses in chronic care medication continuity.

### **Intrasystem Transfer-In Medication Continuity**

Medication continuity was maintained in the majority of transfer-in cases reviewed. There was only one exception:

- In case 44, the morning doses of sertraline and oxcarbazepine were missed the day following transfer.

### **Post-Hospitalization Medication Continuity**

Medication continuity for most patients returning from a hospitalization was adequately maintained in most cases reviewed. However, there were two significant cases that illustrate the concerns that the OIG has regarding this process:

- Case 13 involved a patient who, upon discharge from the hospital for a heart attack, received medication orders for metoprolol, atorvastatin, and ticagrelor. Case review of eUHR documentation indicated potential lapses in continuity of these medications. During the onsite inspection, OIG clinicians determined that medication continuity had in fact been

maintained after hospital discharge. However, nursing staff did not document the administration of these medications on temporary medication administration records (MARs). Additionally, about a week later, the patient missed a dose of metoprolol as it had expired, and the provider had failed to renew the medication.

- In case 80, the patient returned from hospital admission for blood clots in the lungs (pulmonary emboli) and was assessed by the TTA RN upon arrival at FSP. The RN appropriately reviewed hospital discharge paperwork, properly transcribed recommended discharge medication orders, and reviewed the discharge plan with the on-call provider. However, the medications were not administered by either the TTA RN or the housing medication pass LVN. The patient missed two doses of enoxaparin and one dose of anticoagulants (warfarin). Additionally, medications (hydrochlorothiazide and nifedipine) that had been discontinued upon return to FSP were administered the following morning, despite the order to stop them. This case is also discussed in the indicator *Inter- and Intra-System Transfers*.

### **Medication Administration**

Case review did not show any significant deficiencies in medication administration.

### **Medication Follow-up**

Case review did show that medication line nurses sometimes did not perform timely notification when patients missed medications.

- In case 5, the patient with a history of current seizure activity refused anticonvulsant medication (carbamazepine) for five consecutive days when the medication line nurse notified the provider via CDCR Form 128. The form should have been submitted when the patient missed three consecutive days of prescribed medication.
- The patient in case 18 with a history of cardiovascular disease was taking an anticoagulant (warfarin). On October 4, 2014, the medication line LVN noted that the patient was a “no show/no barriers” on the MAR but did not document attempts to contact the patient or follow up with the supervising nurse or provider regarding this missed essential medication.

### **Onsite Clinician Inspection**

During the onsite visit, OIG clinicians met with medical, nursing, and pharmacy representatives regarding case review findings. FSP administrators were well aware of these specific cases, and had conducted interdisciplinary internal discussions and root cause analysis exercises regarding the issues. Pharmacy demonstrated logging procedures and ensured that medications were well stocked in the TTA Omnicell. Nursing had implemented various educational/training interventions and

monitoring strategies with TTA nursing staff to address roles and responsibilities for maintaining the continuity of care for patients returning after hospital discharge.

## **Conclusion**

Overall pharmacy and medication administration performance is rated *adequate*, though with specific concerns regarding the good but imperfect performance related to continuity of medications for patients returning from hospitalization.

## ***Compliance Testing Results***

The institution received an overall score of 89.3 percent for the *Pharmacy and Medication Management* indicator. For discussion purposes below, this MIT is divided into three sub-indicators that consist of Medication Administration, Medication Preparation and Administration Controls, and Pharmacy Protocols.

### **Medication Administration**

For this sub-indicator, the institution received an average score of 85 percent and performed well in the following areas:

- The OIG found that the institution's administration of new medication orders was *proficient*, with a score of 98 percent. Only one of the 40 new medication orders sampled was delivered to the inmate-patient untimely; it was filled one day late (MIT 7.002).
- FSP also performed well in ensuring that inmate-patients who transferred from one housing unit to another received their medications without interruption, receiving a score of 93 percent for this test. Two of the 30 inmate-patients sampled did not receive their medication at the proper dosing interval (MIT 7.005).

The institution needs to improve in the following medication administration area:

- The institution's chronic care medication management was inadequate, receiving the lowest score for this indicator at 73 percent. The institution timely dispensed chronic care medications to only 29 of the 40 inmate-patients sampled. Specifically, 11 of the 40 patients sampled either did not receive their medications or received them late, did not receive required counseling for missed doses or received counseling late, received the wrong dosage of a medication, or erroneously received two 30-day supplies of a KOP medication within two consecutive days (MIT 7.001).

- The institution timely provided hospital discharge medications to only 23 of 30 patients sampled who had returned from a community hospital (77 percent). For two patients, there was no evidence in the eUHR whether the medications were administered or refused, and for five other patients, medications were administered one to three days late (MIT 7.003).

### **Medication Preparation and Administration Controls**

For this sub-indicator, the institution received a *proficient* score of 100 percent in each of the following six areas:

- The institution employed strong medication security controls over narcotic medications in eight clinic and medication line locations inspected that stored narcotics (MIT 7.101).
- The institution properly stored non-narcotic medications that do not require refrigeration at all ten of the applicable clinics and medication line storage locations sampled (MIT 7.102).
- The institution properly stored non-narcotic medications that require refrigeration at all 13 of the applicable clinics and medication line storage locations sampled (MIT 7.103).
- At each of the nine medication preparation and medication administration locations inspectors observed, inspectors found that nursing staff followed proper hand hygiene contamination control protocols, practiced appropriate administrative controls and protocols during medication preparation, and followed appropriate administrative controls and protocols when administering medications to inmate-patients (MIT 7.104, 7.105, 7.106).

### **Pharmacy Protocols**

For this sub-indicator, the institution received an average score of 80 percent, comprised of scores received at the institution's main pharmacy. As described below, FSP scored 100 percent in four areas but needs improvement in one area.

- In its main pharmacy, the institution follows general security, organization, and cleanliness management protocols; properly stores non-refrigerated medications; maintains adequate controls and properly accounts for narcotic medications; and follows key medication error reporting protocols. FSP scored 100 percent in each of these areas (MIT 7.107, 7.108, 7.110, 7.111).
- However, the OIG found that the main pharmacy did not properly monitor non-narcotic medications that require refrigeration. Temperature logs for several days during the month

preceding the onsite inspection showed freezer temperatures that were outside policy thresholds. As a result, the institution received a score of 0 percent for this test (MIT 7.109).

**Other Information Obtained from Non-Scored Results**

OIG inspectors followed up on four medication errors identified by OIG clinicians during their clinical case reviews to determine if the medication errors had been properly identified and reported. For each of these four cases, the institution’s pharmacist-in-charge had no record that the error was reported by staff. This test result was provided for information purposes only and was not scored (MIT 7.998).

The OIG tested inmate-patients in isolation units to determine if they had immediate access to their prescribed KOP rescue inhalers and nitroglycerin medications. Five of the six inmates tested had access to their asthmatic inhaler. The other inmate-patient had recently lost his rescue inhaler, but failed to notify staff members. When the OIG identified the problem and notified health care management, a new inhaler was immediately reissued to the patient (MIT 7.999).

***CCHCS Dashboard Comparative Data***

**Medication Administration**

The Dashboard uses five indicators from the Medication Administration Process Improvement Program (MAPIP) audit tool to calculate the average score for medication administration. The OIG compared FSP compliance scores with three of the five applicable Dashboard indicators. As indicated below, Dashboard and OIG scores were similar with regard to medication administration.

***Pharmacy and Medication Management—  
CCHCS Dashboard and OIG Compliance Results***

CCHCS DASHBOARD RESULTS	OIG COMPLIANCE RESULTS
Medication Management: Medication Administration  February 2015	Medication Administration (7.001, 7.002) (Chronic Care & New Meds) <i>Preventive Services</i> (9.001) (Administering INH Medication) February 2015
<b>88%</b>	<b>85%</b>

Note: The OIG has removed some data from the Dashboard’s reported medication administration score because these measures target psychiatric requirements, which the OIG omits from testing. Also, variances in medication administration exist; specifically, CCHCS tests medication administration of KOP medications only, while the OIG tests both KOP and NA/DOT medication administration.

## ***Recommendations***

Recommendations regarding hospital return medication continuity are discussed in the *Inter- and Intra-System Transfers* section.

Folsom State Prison needs to ensure that chronic care inmate-patients receive their medication within the required dosing intervals and that staff follow proper protocols for ensuring that counseling occurs for inmate-patients who receive missed doses. In addition, FSP should monitor pharmacy freezer temperatures daily to ensure they are maintained within the required range.

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## ***PREVENTIVE SERVICES***

This indicator assesses whether various preventive medical services are offered or provided to inmate-patients. These include cancer screenings, tuberculosis evaluation, influenza immunizations, chronic care immunizations, and, where applicable, coccidioidomycosis (valley fever) as recommended by the Centers for Disease Control and Prevention as well as the US Preventive Services Task Force.

***Case Review Rating:***

*Not Applicable*

***Compliance Score:***

*91.0%*

***Overall Rating:***

*Proficient*

## ***Compliance Testing Results***

The institution performed well in the *Preventive Services* indicator, with an overall score of 91.0 percent. The institution scored at the *proficient* level in all but one test. The stronger areas are described below:

- The institution scored 100 percent for both mammogram and pap smear screenings of inmate-patients in its women's facility. The OIG sampled 11 patients to determine if they timely received or were offered mammogram screenings and 30 patients to determine if they timely received or were offered pap smear screenings (MIT 9.006, 9.007).
- The institution scored well in administering anti-tuberculosis medications (INH) to inmate-patients with tuberculosis and monitoring their condition and treatment. Six of seven patients sampled (86 percent) received all doses of INH medication timely when inspectors reviewed their records for the most recent three-month period. All seven of the patients (100 percent) timely received their required monthly monitoring (MIT 9.001, 9.002).

- The institution also scored in the *proficient* range for conducting annual tuberculosis screenings and influenza vaccinations, scoring 97 percent for both preventive services. The OIG sampled 30 inmate-patients for tuberculosis screenings and another 30 patients for influenza vaccinations. The only exceptions were one instance where the time and date of a tuberculosis test was illegible and one instance where there was no evidence that an inmate-patient was timely offered the influenza vaccine (MIT 9.003, 9.004).
- FSP offered colorectal cancer screenings to 27 of 30 sampled inmate-patients subject to the annual screening requirement (90 percent). For three patients, there was no evidence that the patient was either offered a fecal occult blood test (FOBT) within the previous twelve months or received a normal colonoscopy within the previous ten years (MIT 9.005).

The institution scored quite low in the following key preventive services test:

- The OIG tests whether inmate-patients who suffer from a chronic care condition were offered vaccinations for influenza, pneumovax, and hepatitis. At FSP, only 16 of the 27 chronic care inmate-patients sampled (59 percent) received all recommended vaccinations at the required interval. Based on the OIG’s review of the patients’ eUHR records, 11 patients were not offered one or more of the vaccinations recommended for their chronic care conditions. Most notably, ten patients were not offered a recommended pneumovax immunization (MIT 9.008).

***CCHCS Dashboard Comparative Data:***

As indicated below, the OIG’s compliance results were 9 percentage points lower than the data reported within the CCHCS Dashboard. Although the OIG score is lower, the institution’s result for colon cancer screening is still *proficient*.

***Preventive Services—CCHCS Dashboard and OIG Compliance Results***

CCHCS DASHBOARD RESULTS	OIG COMPLIANCE RESULTS
Colon Cancer Screening February 2015	Colon Cancer Screening (9.005) February 2015
<b>99%</b>	<b>90%</b>

## ***Recommendations***

The institution must ensure the inmate-patients who suffer from chronic care conditions such as diabetes, hepatitis C, and HIV are offered the pneumovax vaccination every five years, and annually if the patient has asthma.

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## ***QUALITY OF NURSING PERFORMANCE***

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

***Case Review Rating:***

*Adequate*

***Compliance Score:***

*Not Applicable*

***Overall Rating:***

*Adequate*

## ***Case Review Results***

The OIG RN inspectors evaluated 253 nursing encounters for FSP, of which 190 were outpatient nursing encounters. Of the 190 outpatient nursing encounters, 109 were nursing sick calls, 31 were primary care nursing, 25 were RN care management, and 25 were related to medication management. Twenty-nine deficiencies were found overall for outpatient nursing, of which approximately 18 (62 percent) involved nursing sick call, 6 (21 percent) related to primary care nursing, RN care management, and medication administration, and the remaining 5 (17 percent) were for incomplete documentation for refusal of examination or treatment. There were only four significant deficiencies considered to be of such a magnitude that if left unaddressed may be likely to contribute to patient harm.

## **Nursing Sick Call**

Overall, outpatient nursing performance for nursing sick call was good. Nurses generally triaged sick call forms adequately and timely, saw patients quickly, and made proper assessments and dispositions. Sick call nurses were found to appropriately contact and coordinate primary care with the PCP. For example, during the onsite inspection, the RN in Building 3 was observed actively facilitating a same-day referral after the nursing sick call assessment for an add-on PCP evaluation. The pattern of deficiencies identified generally fell into the two broad categories of nursing documentation and nursing assessment. The majority of the documentation deficiencies were for incomplete documentation related to patients' refusal of health care examination or treatment. The majority of the nursing assessment deficiencies were due to inadequate subjective or objective physical assessment for complaints of medical symptoms.

## **Nursing Documentation Deficiencies**

The nursing documentation deficiencies were rare and deemed generally unlikely to cause patient harm. However, the following findings demonstrate deficiencies in the documentation requirements clearly established by CCHCS nursing policy and protocols, and are included as part of the institutional nursing education/training orientation.

- Although nursing staff did initiate CDCR Form 7225 for refusal of care, the specific service being refused, the counseling and education provided about the associated risks and benefits, and staff signature and title were not documented as required by CCHCS nursing policy (cases 2, 14, 17, 19, and 26).
- Incomplete documentation of subjective assessment, objective assessment, assessment conclusion per NANDA taxonomy, or signatures or titles as required by CCHCS nursing protocols occurred in cases 27, 51, 57, 58, 63, 69, and 80.

## **Nursing Assessment Deficiencies**

The majority of nursing encounters demonstrated adequate assessment. Among the few assessment deficiencies, most were determined not likely to have caused harm. However, several cases were considered more serious in nature due to an increased potential for adverse outcomes or unnecessary delays in needed health care services in the outpatient clinics. The following were examples of these cases and should be cited for quality improvement.

#### Referrals without nursing assessment:

- The patient in case 14 complained of inability to sleep due to throbbing tooth pain and swelling with onset of symptoms the previous night. The RN referred the CDCR Form 7362 directly to dental without scheduling the patient for nursing sick call assessment for possible infection. Dental received the form four days later, and a dentist saw the patient two days after the form was received.
- In case 15, the patient submitted a CDCR Form 7362 service request with a complaint of abdominal pain. The PCP evaluated the patient. The RN did not assess or document the disposition of the patient regarding the nursing sick call face-to-face RN visit.
- In case 16, the RN reviewed the CDCR Form 7362 service request for a complaint of skin infection that, per the patient, “looks like staph.” The patient described it as swollen with a pain level 8 out of 10. The RN did not assess the patient on that same day. The patient was seen the next day by the sick call RN and referred to the PCP. Clindamycin and doxycycline were started for ten days.
- In case 44, the patient complained of severe pain in the two back teeth, bleeding gums, and foul mouth odor. The RN referred the CDCR Form 7362 service request directly to dental without scheduling the patient for a nursing sick call assessment for possible infection. A dentist saw the patient three days later.

#### Initiating PCP referrals/consultation contacts:

- In case 12, the RN noted a change in the appearance of the patient’s wound bed (80 percent red and 20 percent black) compared to a previous wound assessment, and did not contact the PCP regarding the possible onset of infection.
- In case 14, on December 17, 2014, the patient complained of onset of bruising to the right foot for two days. The RN noted the presence of petechiae (small purplish hemorrhagic spots) to intact skin, but did not contact the PCP regarding the new onset of bruising or petechiae for patient taking clopidogrel and warfarin.

#### Weekend Continuity of care:

- Nursing staff saw the patient in case 12 on Friday, July 25, 2014, for daily wound care at a biopsy site. The RN documented the patient’s request to do self-care dressing changes, issued wound supplies and ointment, and provided instruction about wound care and signs and symptoms of infection. The plan of care was for follow-up on Monday. The RN should have arranged for daily wound assessment and dressing changes to continue in the TTA over the weekend.

## **Care Management**

Care management nurses routinely conducted periodic follow-up face-to-face assessment visits with chronic care patients. These nurses tracked diagnostic test status and results and monitored needs based on the patients' chronic conditions. Ongoing chronic health issues and needs were appropriately identified with referrals made to the PCP as needed.

## **Medication Administration**

Medication administration was generally timely and reliable. During the onsite inspection visit, the Building 1 (second watch) and Building 3 (third watch) medication line LVNs exemplified dedicated nursing staff with knowledge and experience in providing quality nursing services. The medication line LVNs also participated in morning huddles and were prepared to respond on scene during medical emergencies. See the *Medication Management* and *Emergency Care* sections for specific findings.

## **Emergency Care**

Nurses working in the TTA and as emergency responders at FSP were found to be knowledgeable, skillful, and experienced in emergency nursing care. Documentation demonstrated evidence of commendable nursing decision-making and exemplary performance during some very challenging cases. See *Emergency Care* for specific findings.

## **Inter- and Intra-System Transfers**

Although there were very few major nursing issues found in the cases reviewed, various deficiencies were found in nursing services related to missed medication doses for inmates transferring into FSP and incomplete nursing documentation for inmates transferring out of FSP. However, significant issues were found related to medication administration and utilization review for patients returning from hospital discharge. See *Inter- and Intra-System Transfers* and *Pharmacy and Medication Management* sections for specific findings.

## ***Onsite Clinician Inspection***

During the onsite visit by OIG RN inspectors, the nurses in outpatient settings at FSP were found to be active participants in morning huddles, coordinating and communicating care management needs of patients. For example, the supervising nurse effectively facilitated the morning huddle for the Building 1 clinic primary care teams by efficiently covering such topics as patients since the last huddle with TTA visits, transfers out and in, patients remaining in outside hospitals, significant labs or diagnostic reports, MD/RN line backlogs, and add-ons and referrals from the previous day. The morning huddle started with good attendance, including the PCP, sick call RNs, clinic LVNs, medication LVNs, and OTs. The primary care team used a huddle script containing the information discussed, and all attendees signed the script.

OIG physicians attended morning huddles for Buildings 2, 3, and 5. These huddles were physician led and were of variable quality. None of the physician-led huddles followed a formal huddle script. The supervising nurse was not present for these huddles. Attendance suffered, as the regular RN was not present at these huddles. The organization was somewhat haphazard. While each huddle did review patients who were out of the institution or who had recently returned through the TTA, not every huddle went through important details such as abnormal labs, abnormally high or low glucose or blood pressure levels, medication compliance, or sick calls. Providers did express that they were in constant communication with the nursing staff in their clinics throughout the day.

The OIG RN inspectors visited various clinical areas and freely spoke with nursing staff during walking rounds. Supervising nurses, RNs, and LVNs were knowledgeable about their duties and responsibilities, the patient populations within their assigned clinical areas, specific communication channels for making requests and reporting issues, and the nursing performance and improvement monitoring strategies currently underway at FSP. Nursing staff at all levels verbalized having no major barriers with initiating communication with PCPs, nursing supervisors, and custody staff in meeting patient care needs and providing nursing care.

Various committee meetings facilitated by nurses occurred during the OIG onsite visit. The OIG RN inspectors attended the Nursing Sub-Committee meeting, the Emergency Medical Response Review Committee (EMRRC) meeting, and the Supervising RN meeting. Assigned project leads shared PowerPoint presentations and facilitated discussions about numerous quality improvement strategies, monitoring updates, and future planned projects. Presentations demonstrated ongoing monitoring and tracking of Dashboard criteria, specialty services, public health issues, and numerous other health care services.

### ***Recommendations***

The OIG commends the strategies currently in place at FSP for evaluating individual nursing performance and overall nursing care and services. Although the case review process revealed that quality of outpatient nursing care at FSP was adequate, strategies for quality improvement are indicated for ongoing nursing education and monitoring of the following:

- Nurses should provide face-to-face assessments for all CDCR Form 7362 service requests containing complaints of medical symptoms.
- Nurses should conduct and document subjective and objective assessments for all complaints.
- Nurses should develop and document nursing diagnoses and conclusions in accord with NANDA taxonomy.

- Nurses should provide urgent or same-day nursing face-to-face assessments, as appropriate, based on the patient’s health history and current complaint(s).
- Morning huddles should be standardized throughout the institution. FSP should utilize the Building 1 huddle as a starting point. Each huddle should follow a pre-defined huddle script and hold each team member accountable for identifying potential lapses in care. To date, the most organized and thorough huddles the OIG has witnessed have been led by nurses, rather than provider staff, with the Supervising RN II in the role of clinic manager having the best results.

### ***QUALITY OF PROVIDER PERFORMANCE***

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

***Case Review Rating:***  
*Adequate*

***Compliance Score:***  
*Not Applicable*

***Overall Rating:***  
*Adequate*

### ***Case Review Results***

Office of the Inspector General clinicians reviewed over 304 FSP medical provider encounters and identified 81 deficiencies related to provider performance. Of those 81 deficiencies, 17 were considered significant. As a whole, FSP provider performance is rated *adequate*.<sup>5</sup>

### **Assessment and Decision-Making**

The large majority of provider encounters reviewed demonstrated adequate assessment and sound medical decision-making. However, there were some patterns that did emerge regarding the quality of provider care during the case review.

- The management of end-stage liver disease (ESLD) and cirrhosis was sometimes poor. For example, in case 4, despite the patient carrying a diagnosis of ESLD with sequelae including esophageal varices and thrombocytopenia, he was kept on aspirin. In case 41, a patient with a working diagnosis of ESLD and very low platelets was prescribed aspirin,

<sup>5</sup> While FSP performance in this indicator is considered adequate for the time frame reviewed, the combination of the questionable care of one identified provider, the reduction in provider staffing in December 2014, and the simultaneous Chief Medical Executive vacancy places FSP at risk for being unable to maintain the adequacy rating in this category. This indicator will bear careful re-assessment during subsequent OIG medical inspections.

which is well known to inactivate platelets and decrease blood-clotting ability. This patient ultimately died from a gastrointestinal hemorrhage. In this same case, the patient was found to have a possible liver cancer on one of his CT scans. However, the provider failed to order an expedited evaluation for this possibility.

- The evaluation and management of anemia was sometimes inadequate. In case 15, the patient had developed a stable anemia over the course of nearly a year with intermittent symptoms of burning hands and feet with an associated rash. While the provider did rule out an iron deficiency anemia, the etiology for the anemia was not properly explored. The patient ultimately required hospitalization and was diagnosed with pernicious anemia. This was a potentially preventable hospitalization.
- Providers ordered inappropriate follow-up intervals, or failed to order follow-up appointments, in cases 3, 19, 22, 23, 24, 25, 30, and 41. In case 3, the patient failed to have follow-up medical appointments and appeared to be lost to the medical system due to this deficiency. In case 25, despite a plan of care documented on the progress note, corresponding orders were not found in the eUHR.

### **Review of Records**

Providers generally reviewed diagnostic reports, specialty reports, and hospital reports timely and with adequate thoroughness. In addition to outside reports, FSP providers generally reviewed the eUHR during each patient encounter. The highest risk of miscommunication occurred at times of patient transfer, and while FSP providers generally did a good job in this area, there were a few notable exceptions:

- In case 80, the patient returned from the hospital after having been diagnosed with spontaneous bilateral pulmonary emboli (blood clots in the lungs). The nurse reviewed the discharge medication and obtained a verbal order for those medications. The ordering provider failed to specify the start date for a blood thinner (enoxaparin), and the patient missed his doses that evening and the following morning. Fortunately, the PCP caught the error the following day with no harm to the patient.
- In case 18, the patient was discharged from the hospital with recommendations to follow up on a chest wall mass, an adrenal mass, and anemia that were discovered during the hospitalization. The FSP provider did not thoroughly review the records and did not follow up on those recommendations.

## Emergency Care

Providers generally made appropriate triage decisions when patients presented emergently to the TTA. The TTA was occasionally used for physician-performed minor procedures and physician wound care management. Overall care provided was good, but there was one exception:

- In case 28, the patient was evaluated daily over the course of three days for new onset bleeding from a post-operative wound. The patient had been recently started on a blood thinner (warfarin); a blood count and warfarin level should have been checked, but the provider failed to do so.

## Chronic Care

Chronic care performance was good; most providers demonstrated adequate to good care with diabetes, anticoagulation, asthma, and hepatitis C. Appropriate monitoring, assessments, and interventions were the rule rather than the exception. Sometimes, providers did not order appropriate chronic care follow-up intervals. There were occasional lapses in judgment as demonstrated by the following cases:

- In case 25, the provider prescribed a combination of simvastatin and gemfibrozil. Gemfibrozil is contraindicated for patients taking simvastatin because it can increase simvastatin levels and increase the risk of myopathy and rhabdomyolysis. Gemfibrozil should not have been prescribed. In addition, the mildly elevated triglyceride levels did not warrant a medication intervention.
- In case 80, the patient was newly diagnosed with diabetes mellitus. The provider correctly ordered a urinalysis, which returned showing significant amounts of glucose and ketones. After review of the lab report, the provider did not reassess the patient immediately, and the patient was hospitalized less than a week later with diabetic ketoacidosis.

## Specialty Services

Reviews of the specialty services referrals revealed that FSP providers referred appropriately and diligently at all times. The Institutional Utilization Management Committee (IUMC), composed of medical providers, collaboratively ensured that only appropriate referrals were allowed. When providers saw patients for follow-up after specialty services, the reports were reviewed appropriately and appropriate actions were taken. On the other hand, the time frames in which specialty services were requested were not always appropriate. Onsite discussion with providers revealed that sometimes they requested time frames based on availability of services rather than medical necessity.

- In case 41, the patient had findings on a CT scan that were suggestive of liver cancer. The radiologist recommended a special CT scan to better determine if the findings were cancerous or not (3-phase CT). The provider ordered the test with a routine (90-day) time frame, instead of urgent (14-day), which caused a delay in care. When the 3-phase CT was not performed correctly, the radiologist requested an MRI of the liver. The provider again ordered the test with a routine time frame rather than urgent, causing a further delay in care.

## **Health Information Management**

Providers generally documented patient encounters on the same day. Emergency encounters were also documented properly, both in the TTA and when on call after hours. However, there were some problems identified:

- Illegibility was a common finding, with deficiencies appearing in cases 2, 4, 15, 20, 22, 24, 29, and 30.
- Provider orders were sometimes not found in the eUHR. These omissions occurred in cases 3 and 25, and are assumed to be errors of physician oversight.

## **Onsite Inspection**

The OIG found that most FSP providers were performing strongly. In addition, all providers were found to have mitigated existing deficiencies in *Health Information Management* and *Diagnostic Services* with their attention to detail. This performance indicated that there was solid provider leadership and that clear expectations were established and performance was monitored. Onsite interviews with provider staff confirmed that the Chief Physician and Surgeon (former Chief Medical Executive) was a firm and demanding leader who ensured the delivery of excellent quality care. He was described as fair despite this strong stance. He was also a significant reason that most health care processes ran smoothly and adequately supported the providers' practice. The Chief Physician and Surgeon was likewise praised for being a dependable resource for all patient care issues.

Communication was considered excellent among the providers themselves, and they reported emphasizing quality improvement during their regular twice-weekly provider meetings. Universally, all providers expressed significant concern regarding sufficient provider staffing levels after the reduction of 1.0 FTE position after the implementation of the acuity-based staffing model. The OIG shares this concern, which is also described in the section *Access to Care*. Several providers expressed frustration regarding the length of time necessary to extract and enter clinical data from the eUHR and other computerized resources. However, most providers expressed general job satisfaction with their positions, and overall, morale was adequate.

## **Conclusion**

An in-depth analysis of the FSP provider deficiencies identified during OIG case review revealed that 46 of the 81 provider performance deficiencies (57 percent) were attributed to a single provider. Likewise, 12 of the 17 provider performance deficiencies that were deemed significant (70 percent) were attributed to the same provider. Caution must be used in interpreting these findings, as the OIG methodology does select high-risk and high-utilization patients. This may cause skewing of the deficiencies if the majority of these patients are cared for by a single provider. Nevertheless, the OIG has concerns regarding this finding and has referred this provider to CCHCS for further analysis.

It is important to emphasize that while some of the above deficiencies illustrated in this section were quite serious, they did not represent the large majority of good care that was delivered as discovered in case review. In fact, seven of the OIG physician reviewed cases were rated *proficient*, in addition to the 15 that were rated *adequate*. After taking all factors into consideration, the OIG rated provider performance at FSP as *adequate*.

## ***Recommendations***

Certain FSP providers could benefit from continuing medical education and competency evaluation for the management of ESLD and cirrhosis, specifically regarding the use of nonsteroidal anti-inflammatory drugs (NSAIDS), including aspirin, and the role of screening esophagogastroduodenoscopy (EGD) in these patients. Certain FSP providers could likewise benefit from further education regarding the diagnostic approach and management of anemia. All providers should be reminded of their responsibility to ensure follow-up of patients is provided, specifically their role in ordering appropriate follow-up intervals and ordering specialty services within time frames appropriate for the medical condition. Providers should also be reminded of their unique role in ensuring continuity of care after the patient has been transferred to their care, either from a different institution or returning from an outside hospitalization. Transfer records must be reviewed thoroughly to ensure that no outstanding medical issues are dropped at the time of transfer and that all medications are continued appropriately. Illegibility is a major concern for some of the FSP providers, and should be addressed even prior to the implementation of the electronic health records system.

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## ***SPECIALTY SERVICES***

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

***Case Review Rating:***

*Adequate*

***Compliance Score:***

*91.4%*

***Overall Rating:***

*Proficient*

### ***Case Review Results***

Office of the Inspector General clinicians reviewed at least 115 events related to *Specialty Services*, including at least 74 specialty consultations or procedures. Twenty deficiencies were found in this category, all of which were related to health information management.

#### **Primary Care Provider—Specialty Performance**

Case review found that patients were generally referred to specialists appropriately by their providers. Occasionally, providers inappropriately requested routine services when urgent services were needed. These episodes are discussed further in the *Quality of Provider Performance* indicator. FSP provided follow-up appointments for those specialty consults in a timely manner.

#### **Specialty Access**

Case review found that specialty services were provided within excellent time frames for both routine and urgent services. In case 30, there was a significant delay in care when the patient was referred to a tertiary care center. However, the onsite inspection revealed that the delays in care in this case were due to the tertiary care center rather than FSP specialty processes.

#### **Health Information Management**

Case review found that specialty reports were generally retrieved, sent for PCP review, and scanned timely. However, this was not always the case, and a pattern of problems with specialty reports was identified.

- Specialty reports were sometimes not retrieved or were not found in the eUHR. This deficiency was identified in cases 7, 13, 27, and 41.

- Specialty reports were sometimes retrieved but delayed. This deficiency was identified in cases 17, 29, and 41.
- Specialty reports were sometimes not available to the provider at the time of the appointment intended to review the specialty recommendations or procedure. This deficiency was identified in cases 15 and 27.
- Specialty reports were sometimes not reviewed by a provider on time. This deficiency was identified in cases 15, 17, and 29.
- Specialty reports were sometimes not signed off by a provider. This deficiency was identified in cases 17, 30, and 41.
- Infrequently, specialists were not provided with diagnostic results required for them to make proper judgments. This deficiency was identified in cases 4 and 30.

While there were occasional problems with the management of health information with respect to *Specialty Services*, the majority of the reviewed specialty services were found to be without problems. Moreover, the occasional lapses that were identified did not significantly impact the delivery of adequate medical care. Taking all factors into account, the case review rating for this indicator is *adequate*.

### ***Compliance Testing Results***

The institution received a *proficient* overall score of 91.4 percent in the *Specialty Services* indicator, scoring in the *proficient* range for all but one test.

As indicated below, FSP scored 100 percent for four of the seven tests conducted:

- For all 15 of the inmate-patients sampled (100 percent), their routine specialty service appointment (or service) occurred within 90 calendar days of the provider's order (MIT 14.003).
- For 14 of the 15 inmate-patients sampled (93 percent), their high-priority specialty service appointment (or service) occurred within 14 calendar days of the provider's order. One patient's appointment was originally scheduled timely, but was rescheduled and ultimately provided 25 days late. The OIG also found that providers reviewed the specialists' reports within three business days for all 15 of those patients sampled (100 percent) (MIT 14.001, 14.002).

- The institution received a score of 100 percent when the OIG tested the timeliness of FSP's denials of providers' specialty services requests for 20 inmate-patients. Similarly, FSP scored 100 percent when the OIG tested whether providers communicated the denial status to the inmate-patient within 30 calendar days (MIT 14.006, 14.007).

The institution performed adequately in the following area:

- When inmate-patients are approved or scheduled for specialty services appointments from one institution and then transfer to another institution, policy requires that the receiving institution ensure that a patient's appointment is timely rescheduled or scheduled and held. For 16 of the 20 patients sampled (80 percent), the patient received his or her specialty service appointment within the required action date. However, four other patients received their appointments from 3 to 37 days late (MIT 14.005).

The institution needs to improve in the following key area:

- The OIG found that when the institution ordered routine specialty services, providers did not always review the specialists' reports within three business days. Only ten of the 15 reports sampled (67 percent) were timely reviewed by a provider. In three instances, the provider reviewed the specialist's report four to ten days late, and in two instances, the OIG found no conclusive evidence that the provider reviewed the report at all (MIT 14.004).

### ***Recommendations***

FSP specialty report management was adequate, but had some room for improvement. The OIG recommends that FSP review the deficiencies identified in this indicator and perform quality improvement training with the goal of improving the reliability of retrieving specialty reports in a timely fashion, ensuring providers review and sign off the reports, and ensuring they are available to the provider at the time of the PCP follow-up appointment.

Also, the institution must ensure inmate-patients who transfer to FSP with a previously approved specialty service request receive their appointments within the required time frame.

## SECONDARY (ADMINISTRATIVE) QUALITY INDICATORS OF HEALTH CARE

The last two quality indicators involve health care administrative systems and processes. Testing in these areas applied only to the compliance component of the process. Therefore, there is no case review assessment associated with either of the two indicators. As part of the compliance component for the first indicator below, the OIG did not score several questions. Instead, the OIG presented the findings for informational purposes only. For example, the OIG described certain local processes in place at FSP.

To test both the scored and non-scored areas within these two secondary quality indicators, OIG inspectors interviewed key institutional employees and reviewed documents during their onsite visit to FSP in January 2015. The OIG's inspectors also reviewed documents obtained from the institution and from CCHCS prior to the start of the inspection.

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### ***INTERNAL MONITORING, QUALITY IMPROVEMENT, AND ADMINISTRATIVE OPERATIONS***

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

***Case Review Rating:***

*Not Applicable*

***Compliance Score:***

*50.8%*

***Overall Rating:***

*Inadequate*

### ***Compliance Testing Results***

The institution scored poorly in the *Internal Monitoring, Quality Improvement, and Administrative Operations* indicator, receiving an overall score of 50.8 percent. Although FSP received a score of 100 percent in three of the nine test areas applicable to the institution, it scored 0 percent in three others.

All low-scoring areas are described below:

- Office of the Inspector General inspectors reviewed six recent months of Quality Management Committee (QMC) meeting minutes to determine if the QMC met monthly to

evaluate program performance and take action when improvement opportunities were identified. Meeting minute packages for each of the six months included Dashboard and other data summary reports for various programs. However, FSP's meeting minutes did not address whether the QMC used the data to evaluate and discuss each program's performance, identify where improvements were needed, and identify improvement action plans. Consequently, the institution received a score of 0 percent for this test (MIT 15.003).

- When the OIG inspected documentation for 12 emergency medical response incidents reviewed by the Emergency Medical Response Review Committee (EMRRC) during the prior six-month period, inspectors found that the required review event checklist form was not included for any of the incidents reviewed. Inspectors also determined that one critical incident was not reviewed timely by the EMRRC and key elements of the case were not documented in meeting minutes for two other incidents. As a result, FSP received a score of 0 percent for this test (MIT 15.007).
- When the OIG reviewed the summary reports and related documentation for three medical emergency response drills conducted in the prior quarter, inspectors found that none of drills included an Incident Summary (CDCR Form 837-C) completed by involved custody staff. The medical report of injury or unusual occurrence (CDCR Form 7219) was also missing from one of the three sampled drills. Therefore, the institution received a score of 0 percent for this test (MIT 15.101).
- To determine if the institution adequately reported adverse/sentinel events (ASE), the OIG reviewed two ASEs that required a root cause analysis and had occurred at FSP during the prior six-month period. Inspectors found that one event was reported approximately two weeks late to CCHCS's ASE Committee. As a result, the institution received a score of 50 percent for this test (MIT 15.002).
- Medical staff sent the Initial Inmate Death Report (CDCR Form 7229A) to CCHCS's Death Review Unit timely in one of two cases tested, resulting in a score of 50 percent. In the other case, the death was reported approximately 30 minutes late (MIT 15.103).
- When the OIG reviewed FSP's 2014 Performance Improvement Work Plan, inspectors found that the institution improved or reached its performance objectives for four of its seven quality improvement initiatives (57 percent). It did not identify the status of all performance objectives for the remaining three initiatives (MIT 15.005).

The institution scored 100 percent in the following three test areas:

- The OIG reviewed the institution's medical appeal data and found that FSP promptly processed inmate medical appeals timely in each of the most recent 12 months. Based on data received from the institution, only one of 620 medical appeals was categorized as overdue during that period (MIT 15.001).
- OIG inspectors determined that FSP takes adequate steps to ensure the accuracy of its Dashboard data reporting (MIT 15.004).
- When the OIG sampled ten second-level medical appeals, inspectors found that the institution's response addressed all of the patients' appealed issues (MIT 15.102).

#### **Other Information Obtained From Non-Scored Areas**

- The OIG gathered informational data regarding two death review summaries and found that both summaries were not timely completed by CCHCS's Death Review Committee. The Death Review Committee is required to submit its summary to the institution within 35 business days of the death. The Death Review Committee submitted one summary report to the institution 245 days late. Inspectors noted that the committee had completed its summary report 229 days earlier, but had neglected to send it to the institution. The other report had only recently surpassed the due date at the time of the OIG's inspection (February 18, 2015), and was still pending submission (MIT 15.996).
- Inspectors met with the institution's coordinator for health care appeals and the Chief Executive Officer to inquire about FSP's protocols for tracking appeals. On a weekly basis, the coordinator provides management with a workload report. The report breaks down the number of appeals and their category and status. The coordinator works closely with the institution's CEO to resolve any issues. According to the CEO, the management team members discuss the workload report data at their weekly meetings and develop strategies to address and remedy adverse trends. When problematic areas are substantiated, management will assign staff to determine if there is a root cause needing to be addressed (MIT 15.997).
- Informational data gathered regarding the institution's practices for implementing local operating procedures (LOPs) indicated that the institution has a good process in place for developing LOPs. The Health Program Specialist (HPS) monitors existing LOPs to ensure they are current. The HPS also monitors new and revised CCHCS policies and procedures to determine whether they impact existing LOPs or require a new LOP. The HPS consults with management to revise existing LOPs or develop new ones, as needed, and executive management reviews and approves final new and revised LOPs. Currently, the institution

has implemented 29 of the 37 applicable stakeholder recommended LOPs (78 percent) (MIT 15.998).

- The OIG discusses the institution’s health care staffing resources in the *About the Institution* section on page 2.

***CCHCS Dashboard Comparative Data:***

Both the Dashboard and OIG testing results show that FSP has a high level of compliance for timely processing its medical appeals.

***Internal Monitoring, Quality Improvement, and Administrative Operations—  
CCHCS Dashboard and OIG Compliance Results***

CCHCS DASHBOARD RESULTS	OIG COMPLIANCE RESULTS
<p style="text-align: center;">Timely Appeals</p> <p style="text-align: center;">February 2015</p>	<p style="text-align: center;">Medical Appeals—Timely Processing (15.001)</p> <p style="text-align: center;">12-months ending December 2014</p>
<b>100%</b>	<b>100%</b>

Note: The CCHCS Dashboard data includes appeal data for the American Disability Act, mental health, dental, and staff complaint areas, whereas the OIG excluded these appeal areas.

***Recommendations***

The institution’s QMC members should ensure that QMC meeting minutes are more robust regarding program performance, areas needing improvement, and actions needed to address those improvements. Also, management should require staff to address the status of performance objectives for all quality improvement initiatives in its annual Performance Improvement Work Plan. In addition, the Emergency Medical Response Review Committee (EMRRC) should use the review checklist form to conduct its incident package reviews. Further, when conducting medical emergency response drills, staff should include the staff Incident Summary (CDCR Form 837-C) and the medical report of injury or unusual occurrence (CDCR Form 7219) in their drill packets. Finally, due to their critical nature, the institution must ensure that all adverse/sentinel events and inmate death notifications are reported timely to the Adverse/Sentinel Event Committee and the department’s Death Review Unit, respectively.

## ***JOB PERFORMANCE, TRAINING, LICENSING, AND CERTIFICATIONS***

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

***Case Review Rating:***

*Not Applicable*

***Compliance Score:***

86.5%

***Overall Rating:***

*Proficient*

### ***Compliance Testing Results***

The institution received an overall *proficient* score of 86.5 percent in the *Job Performance, Training, Licensing, and Certifications* indicator.

For six of the indicator's eight tests, the institution scored 100 percent. Those tests included the following:

- The OIG found that all nursing staff and the pharmacist-in-charge are current with their professional licenses and certification requirements. Similarly, all providers are current with their professional licenses (MIT 16.105, 16.001).
- The institution's pharmacy and providers who prescribe controlled substances are current with their Drug Enforcement Agency registration (MIT 16.106).
- Inspectors found that nursing supervisors had completed the required number of nursing reviews for all five of the nurses the OIG sampled (MIT 16.101).
- When the OIG reviewed training records for ten nursing staff who administer medications, inspectors found that all ten had current clinical competency validations. In addition, inspectors confirmed that all nursing staff hired within the last year timely received new employee orientation training (MIT 16.102, 16.107).

While the institution scored well in areas above, the following two areas still need to be improved:

- The institution does not perform complete structured clinical performance appraisals for its primary care providers. The OIG reviewed performance evaluation packets for the institution's eight providers and found that FSP did not complete required 360-Degree

Evaluations for the PCPs, who are all subject to the requirement. The institution had met all other performance review requirements for its providers. Due to the absence of the 360-Degree Evaluations, the institution received a score of 25 percent for this test (MIT 16.103).

- The OIG tested provider, nursing, and custody staff records to determine if the institution ensures that those staff members have current emergency response certifications. While the institution's provider and nursing staff were all compliant, custody staff was not. Specifically, three non-managerial custody officers and nine custody managers did not have a current certification on file. It should be noted that while the California Penal Code exempts those custody managers who primarily perform managerial duties from medical emergency response certification training, CCHCS policy does not allow for such an exemption. The institution received a score of 67 percent for this test (MIT 16.104).

### ***Recommendations***

Medical managers who evaluate a provider's clinical performance should conduct a 360-Degree Evaluation as part of the provider's annual performance evaluation. In addition, the institution must ensure that all custody staff, including custody managers, receive and maintain a current emergency response certification.

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## **POPULATION-BASED METRICS**

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

### ***What is HEDIS?***

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

performance of health care plans. HEDIS data is often used to produce health plan report cards, analyze quality improvement activities, and benchmark performance.

### ***Methodology***

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

### ***Comparison of Population-Based Metrics***

For Folsom State Prison, 11 HEDIS measures were selected and are listed below in *Table 1 – FSP Results Compared to State and National HEDIS Scores*. Multiple health plans publish their HEDIS performance measures at the State and national levels. The OIG has provided selected results for several health plans in both categories for comparative purposes. In addition, the OIG selected California’s Medi-Cal Managed Care Program as the population most similar to that of the CDCR inmate population. As indicated below in *Table 2 – FSP Results Compared to Medi-Cal Minimum and Maximum Performance*, the California Department of Health Care Services (DHCS) annually establishes a minimum performance level (MPL) and a high performance level (HPL) for each of its required performance measures. Where applicable, the OIG compared FSP’s results to the Medi-Cal MPL and HPL levels.

### ***Results of Population-Based Metric Comparison***

#### **Comprehensive Diabetes Care**

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

When compared statewide, FSP performed at a level exceeding the Medi-Cal high performance levels (Table 2) in each of the five diabetic measures selected. When compared to Kaiser Permanente (Table 1), FSP performed slightly lower with respect to blood pressure control for diabetic patients and outperformed Kaiser in all other diabetic measures. In fact, the percentage of

diabetic patients at FSP whose diabetes was considered to be under poor control was significantly lower than the percentages reported by Kaiser in the same area.

When compared nationally, FSP outperformed HMO averages for Medicaid, Commercial, and Medicare in each of the five diabetic measures listed. When compared to the Department of Veterans Affairs (VA), FSP outperformed the VA in all applicable measures except eye exams. In fact, FSP had a significantly smaller percentage of patients under poor diabetic control. For diabetic patient eye exams, FSP scored 7 percentage points lower than the VA.

## **Immunizations**

Comparative data for immunizations (Table 1) was only fully available for the VA, and partially available for Kaiser Permanente (statewide) and Commercial (national). With respect to administering influenza shots to adults aged 50 and older, FSP outperformed the VA, Kaiser Permanente, and Commercial. OIG inspectors noted that 15 percent of the patients tested for influenza shots were offered the shot but refused it, and only 6 percent of sampled patients had no record of being offered or receiving the shot. With respect to pneumococcal vaccinations, FSP's performance was 6 percentage points lower than the VA's performance. However, similar to the influenza immunizations, OIG inspectors found that 10 percent of the patients sampled had been timely offered the pneumococcal vaccination but refused it.

## **Cancer Screening**

With respect to breast cancer and cervical cancer screenings (Table 1), FSP outperformed both statewide measures (Medi-Cal and Kaiser Permanente) and applicable national performance measures (Medicaid, Commercial, Medicare, and VA). For colorectal cancer screening, FSP performed slightly lower than Kaiser Permanente statewide. Nationally, FSP performed much higher than Commercial and Medicare, and six percentage points lower than the VA.

## **Summary**

Compared statewide, FSP's population-based performance exceeded the Medi-Cal and Kaiser Permanente performance in almost all measures evaluated except diabetic blood pressure control and colorectal cancer screening, in which case FSP scored slightly lower. On a national level, FSP outperformed the Medicaid, Commercial, and Medicare performance in all measures and outperformed the VA in seven of ten measures. The three areas where FSP did not surpass the VA were: eye exams for diabetic patients, pneumococcal vaccinations, and colorectal cancer screenings. Differences varied by only 6 or 7 percentage points. Overall, FSP's performance reflects a high-performing chronic care program, corroborated by the institution's *adequate* scores in the *Quality of Provider Performance* and *Quality of Nursing Performance* indicators, and its *proficient* scores in the *Access to Care* and *Preventive Services* indicators. With regard to FSP's performance in the immunization measures, the institution should make interventions to lower the rate of refusal for influenza shots and pneumococcal vaccinations.

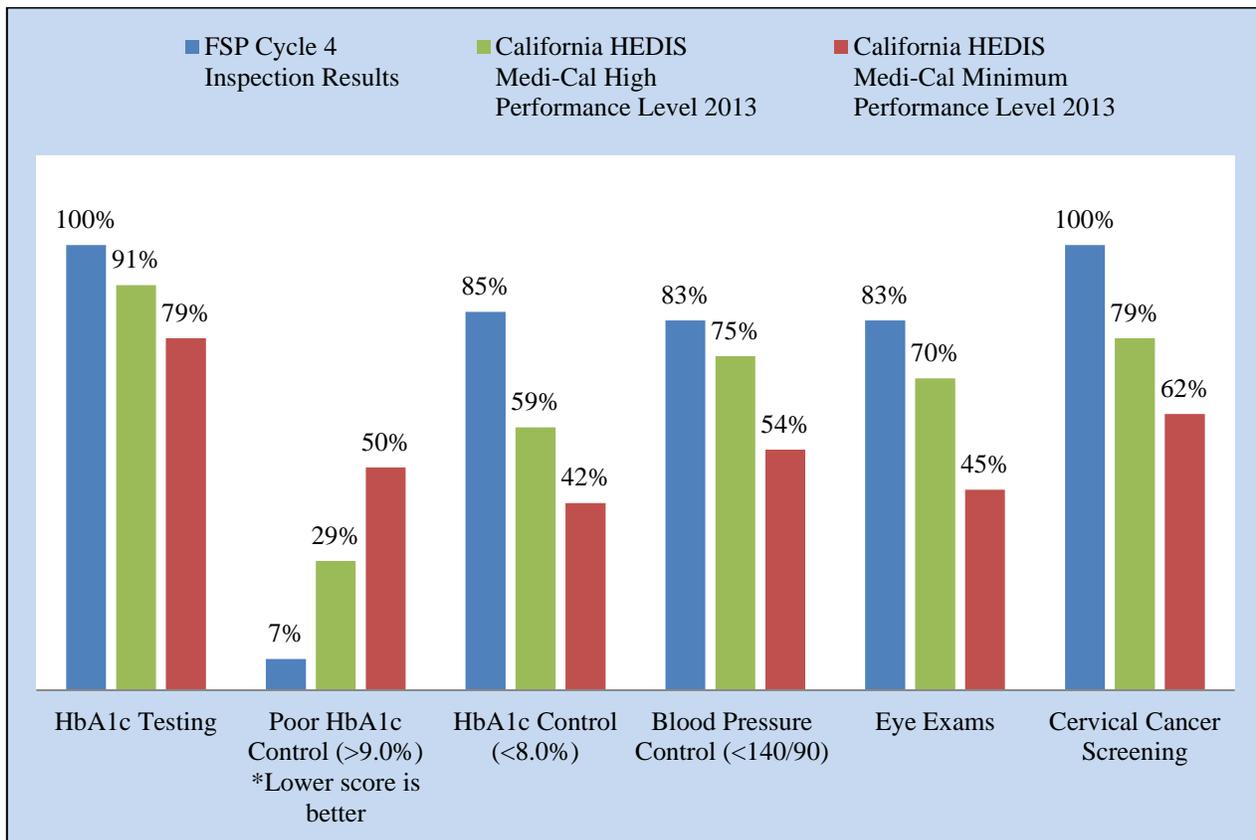
**Table 1 - FSP Results Compared to State and National HEDIS Scores**

Clinical Measures	Institution	California			National			
	FSP Cycle 4 Results <sup>1</sup>	HEDIS Medi- Cal 2013 <sup>2</sup>	Kaiser (No.CA) HEDIS Scores 2014 <sup>3</sup>	Kaiser (So.CA) HEDIS Scores 2014 <sup>3</sup>	HEDIS Medicaid 2013 <sup>4</sup>	HEDIS Comm- ercial 2013 <sup>4</sup>	HEDIS Medicare 2013 <sup>4</sup>	VA Average 2012 <sup>5</sup>
<b>Comprehensive Diabetes Care</b>								
HbA1c Testing	<b>100%</b>	83%	95%	94%	84%	90%	92%	99%
Poor HbA1c Control (>9.0%) <sup>6,7</sup>	<b>7%</b>	40%	18%	21%	46%	31%	25%	19%
HbA1c Control (<8.0%) <sup>6</sup>	<b>85%</b>	49%	70%	67%	46%	59%	66%	-
Blood Pressure Control (<140/90)	<b>83%</b>	63%	82%	85%	60%	65%	66%	80%
Eye Exams	<b>83%</b>	51%	69%	82%	54%	56%	69%	90%
<b>Immunizations</b>								
Influenza Shots - Adults (50–64) <sup>8</sup>	<b>81%</b>	-	59%	55%	-	50%	-	65%
Influenza Shots - Adults (65+)	<b>77%</b>	-	-	-	-	-	-	76%
Immunizations: Pneumococcal	<b>87%</b>	-	-	-	-	-	-	93%
<b>Cancer Screening</b>								
Breast Cancer Screening (50–74) <sup>9</sup>	<b>96%</b>	-	88%	88%	58%	74%	71%	87%
Cervical Cancer Screening <sup>10</sup>	<b>100%</b>	65%	86%	87%	-	-	-	93%
Colorectal Cancer Screening	<b>76%</b>	-	78%	80%	-	63%	64%	82%

1. Unless otherwise stated, data was collected in January 2015 by reviewing medical records from a sample of FSP's population of applicable inmate-patients. These random statistical sample sizes were based on a 95 percent confidence level with a 15 percent maximum margin of error.
2. HEDIS Medi-Cal data was obtained from the California Department of Health Care Services 2013 *HEDIS Aggregate Report for the Medi-Cal Managed Care Program*.
3. Data was obtained from Kaiser Permanente November 2014 reports for the Northern and Southern California regions.
4. National HEDIS data for Medicaid, Commercial, and Medicare is based on HMO data obtained from the 2014 *State of Health Care Quality Report*, available on the NCQA website: [www.ncqa.org](http://www.ncqa.org).
5. The Department of Veterans Affairs (VA) data was obtained from the *VHA Facility Quality and Safety Report - Fiscal Year 2012 Data*.
6. For this indicator, the entire applicable FSP population was tested.
7. For this measure only, a lower score is better. For Kaiser, the OIG derived the Poor HbA1c Control indicator using the reported data for the <9.0% HbA1c control indicator.
8. The Kaiser and Commercial HEDIS data is for the age range 18–64.
9. The Kaiser HEDIS data age range is 52–74 and the VA is 50–69.
10. Kaiser used its 2013 HEDIS data for cervical cancer screening.

**Table 2 - FSP Results Compared to Medi-Cal Minimum and Maximum Performance**

Clinical Measures	FSP Cycle 4 Inspection Results	California HEDIS Medi-Cal High Performance Level 2013	California HEDIS Medi-Cal Minimum Performance Level 2013
<b>Comprehensive Diabetes Care</b>			
HbA1c Testing	<b>100%</b>	91%	79%
Poor HbA1c Control (>9.0%) <i>*Lower score is better</i>	<b>7%</b>	29%	50%
HbA1c Control (<8.0%)	<b>85%</b>	59%	42%
Blood Pressure Control (<140/90)	<b>83%</b>	75%	54%
Eye Exams	<b>83%</b>	70%	45%
<b>Cancer Screening</b>			
Cervical Cancer Screening	<b>100%</b>	79%	62%



## APPENDIX A—COMPLIANCE TEST RESULTS

<b>Folsom State Prison</b> <b>Range of Summary Scores: 50.8%–91.4%</b>	
<b>Indicator</b>	<b>Overall Score (Yes %)</b>
<i>Access to Care</i>	87.8%
<i>Diagnostic Services</i>	73.8%
<i>Emergency Services</i>	Not Applicable
<i>Health Information Management (Medical Records)</i>	62.6%
<i>Health Care Environment</i>	70.6%
<i>Inter- and Intra-System Transfers</i>	87.3%
<i>Pharmacy and Medication Management</i>	89.3%
<i>Prenatal and Post-Delivery Services</i>	Not Applicable
<i>Preventive Services</i>	91.0%
<i>Quality of Nursing Performance</i>	Not Applicable
<i>Quality of Provider Performance</i>	Not Applicable
<i>Reception Center Arrivals</i>	Not Applicable
<i>Specialized Medical Housing (OHU, CTC, SNF, Hospice)</i>	Not Applicable
<i>Specialty Services</i>	91.4%
<i>Internal Monitoring, Quality Improvement, and Administrative Operations</i>	50.8%
<i>Job Performance, Training, Licensing, and Certifications</i>	86.5%

Reference Number	Access to Care	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
1.001	<b>Chronic care follow-up appointments:</b> Was the inmate-patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is the shorter?	34	6	40	85.00%	0
1.002	<b>For endorsed inmate-patients received from another CDCR institution:</b> If the nurse referred the inmate-patient to a provider during the initial health screening, was the inmate-patient seen within the required time frame?	6	15	21	28.57%	8
1.003	<b>Clinical appointments:</b> Did a registered nurse review the inmate-patient's request for service the same day it was received?	36	4	40	90.00%	0
1.004	<b>Clinical appointments:</b> Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed?	40	0	40	100%	0
1.005	<b>Clinical appointments:</b> If the registered nurse determined a referral to a primary care provider was necessary, was the inmate-patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter?	19	0	19	100%	21
1.006	<b>Sick call follow-up appointments:</b> If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified?	7	0	7	100%	33
1.007	<b>Upon the inmate-patient's discharge from the community hospital:</b> Did the inmate-patient receive a follow-up appointment with a primary care provider within the required time frame?	27	1	28	96.43%	2
1.008	<b>Specialty service follow-up appointments:</b> Do specialty service primary care physician follow-up visits occur within required time frames?	27	3	30	90.00%	0
1.101	<b>Clinical appointments:</b> Do inmate-patients have a standardized process to obtain and submit Health Care Services Request Forms?	6	0	6	100%	0
<b>Overall percentage:</b>					<b>87.78%</b>	

Reference Number	<i>Diagnostic Services</i>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
2.001	<b>Radiology orders:</b> Was the radiology service provided within the time frame specified in the provider's order?	10	0	10	100%	0
2.002	<b>Radiology orders:</b> Did the primary care provider review and initial the diagnostic report within specified time frames?	0	10	10	0.0%	0
2.003	<b>Radiology orders:</b> Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	10	0	10	100%	0
2.004	<b>Laboratory orders:</b> Was the laboratory service provided within the time frame specified in the provider's order?	9	1	10	90.00%	0
2.005	<b>Laboratory orders:</b> Did the primary care provider review and initial the diagnostic report within specified time frames?	9	1	10	90.00%	0
2.006	<b>Laboratory orders:</b> Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	10	0	10	100%	0
2.007	<b>Pathology:</b> Did the institution receive the final diagnostic report within the required time frames?	7	3	10	70.00%	0
2.008	<b>Pathology:</b> Did the primary care provider review and initial the diagnostic report within specified time frames?	6	1	7	85.71%	3
2.009	<b>Pathology:</b> Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	2	5	7	28.57%	3
<b>Overall percentage:</b>					<b>73.81%</b>	

Reference Number	<i>Emergency Services</i>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
3	Assesses reaction times and responses to emergency situations. The OIG RN clinicians will use detailed information obtained from the institution's incident packages to perform focused case reviews.	<b>Not Applicable</b>				

Reference Number	<i>Health Information Management (Medical Records)</i>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated progress notes, initial health screening forms, and health care service request forms scanned into the eUHR within three calendar days of the inmate-patient encounter date?	20	0	20	100%	0
4.002	Are dictated/transcribed documents scanned into the eUHR within five calendar days of the inmate-patient encounter date?	Not Applicable				
4.003	Are specialty documents scanned into the eUHR within five calendar days of the inmate-patient encounter date?	18	2	20	90.00%	0
4.004	Are community hospital discharge documents scanned into the eUHR within three calendar days of the inmate-patient date of hospital discharge?	15	5	20	75.00%	0
4.005	Are medication administration records (MARs) scanned into the eUHR within the required time frames?	15	5	20	75.00%	0
4.006	During the eUHR review, did the OIG find that documents were correctly labeled and included in the correct inmate-patient's file?	0	12	12	0.0%	0
4.007	Did clinical staff legibly sign health care records, when required?	8	24	32	25.00%	0
4.008	<b>For inmate-patients discharged from a community hospital:</b> Did the preliminary hospital discharge report include key elements, and did a provider review the report within three calendar days of discharge?	22	8	30	73.33%	0
<b>Overall percentage:</b>					<b>62.62%</b>	

Reference Number	<i>Health Care Environment</i>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
5.101	<b>Infection control:</b> Are clinical health care areas appropriately disinfected, clean, and sanitary?	8	2	10	80.00%	0
5.102	<b>Infection control:</b> Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	10	0	10	100%	0
5.103	<b>Infection control:</b> Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	8	2	10	80.00%	0
5.104	<b>Infection control:</b> Do clinical health care staff adhere to universal hand hygiene precautions?	6	3	9	66.67%	0
5.105	<b>Infection control:</b> Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	10	0	10	100%	0
5.106	<b>Warehouse, Conex, and other non-clinic storage areas:</b> Does the medical supply management process adequately support the needs of the medical health care program?	1	0	1	100%	0
5.107	<b>Clinical areas:</b> Does each clinic follow adequate medical supply storage and management protocols?	10	0	10	100%	0
5.108	<b>Clinical areas:</b> Do clinic common areas and exam rooms have essential core medical equipment and supplies?	2	8	10	20.00%	0
5.109	<b>Clinical areas:</b> Do clinic common areas have an adequate environment conducive to providing medical services?	6	4	10	60.00%	0
5.110	<b>Clinical areas:</b> Do clinic exam rooms have an adequate environment conducive to providing medical services?	5	5	10	50.00%	0
5.111	<b>Emergency response bags:</b> Are TTA and clinic emergency medical response bags inspected daily and inventoried monthly, and do they contain essential items?	2	8	10	20.00%	0
5.999	<b>For Information Purposes Only:</b> Does the institution's health care management believe that all clinical areas have physical plant infrastructures sufficient to provide adequate health care services?	Information Only				
<b>Overall percentage:</b>					<b>70.61%</b>	

Reference Number	<i>Inter- and Intra-System Transfers</i>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
6.001	<b>For endorsed inmate-patients received from another CDCR institution:</b> Did nursing staff complete the initial health screening and answer all screening questions on the same day the inmate-patient arrived at the institution?	24	6	30	80.00%	0
6.002	<b>For endorsed inmate-patients received from another CDCR institution:</b> When required, did the RN complete the assessment and disposition section of the health screening form; refer the inmate-patient to the TTA, if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening?	28	2	30	93.33%	0
6.003	<b>For endorsed inmate-patients received from another CDCR institution:</b> If the inmate-patient had an existing medication order upon arrival, were medications administered or delivered without interruption?	15	2	17	88.24%	13
6.004	<b>For inmate-patients transferred out of the facility:</b> Were scheduled specialty service appointments identified on the Health Care Transfer Information Form 7371?	15	5	20	75.00%	0
6.101	<b>For inmate-patients transferred out of the facility:</b> Do medication transfer packages include required medications along with the corresponding Medical Administration Record and Medication Reconciliation?	2	0	2	100%	2
<b>Overall percentage:</b>					<b>87.31%</b>	

Reference Number	<b>Pharmacy and Medication Management</b>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.001	Did the inmate-patient receive all chronic care medications within the required time frames, or did the institution follow departmental policy for refusals or no-shows?	29	11	40	72.50%	0
7.002	Did health care staff administer or deliver new order prescription medications to the inmate-patient within the required time frames?	39	1	40	97.50%	0
7.003	<b>Upon the inmate-patient's discharge from a community hospital:</b> Were all medications ordered by the institution's primary care provider administered or delivered to the inmate-patient within one calendar day of return?	23	7	30	76.67%	0
7.004	<b>For inmate-patients received from a county jail or COCF:</b> Were all medications ordered by the institution's reception center provider administered or delivered to the inmate-patient within the required time frames?	Not Applicable				
7.005	<b>Upon the inmate-patient's transfer from one housing unit to another:</b> Were medications continued without interruption?	28	2	30	93.33%	0
7.006	<b>For en route inmate-patients who lay over at the institution:</b> If the temporarily housed inmate-patient had an existing medication order, were medications administered or delivered without interruption?	Not Applicable				
7.101	<b>All clinical and medication line storage areas for narcotic medications:</b> Does the institution employ strong medication security controls over narcotic medications assigned to its clinical areas?	8	0	8	100%	10
7.102	<b>All clinical and medication line storage areas for non-narcotic medications:</b> Does the institution properly store non-narcotic medications that do not require refrigeration in assigned clinical areas?	10	0	10	100%	8
7.103	<b>All clinical and medication line storage areas for non-narcotic medications:</b> Does the institution properly store non-narcotic medications that require refrigeration in assigned clinical areas?	13	0	13	100%	5
7.104	<b>Medication preparation and administration areas:</b> Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes?	9	0	9	100%	0
7.105	<b>Medication preparation and administration areas:</b> Does the institution employ appropriate administrative controls and protocols when preparing medications for inmate-patients?	9	0	9	100%	0

7.106	<b>Medication preparation and administration areas:</b> Does the institution employ appropriate administrative controls and protocols when administering medications to inmate-patients?	9	0	9	100%	0
7.107	<b>Pharmacy:</b> Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and satellite pharmacies?	1	0	1	100%	0
7.108	<b>Pharmacy:</b> Does the institution's pharmacy properly store non-refrigerated medications?	1	0	1	100%	0
7.109	<b>Pharmacy:</b> Does the institution's pharmacy properly store refrigerated or frozen medications?	0	1	1	0.0%	0
7.110	<b>Pharmacy:</b> Does the institution's pharmacy properly account for narcotic medications?	1	0	1	100%	0
7.111	<b>Pharmacy:</b> Does the institution follow key medication error reporting protocols?	24	0	24	100%	0
7.998	<b>For Information Purposes Only—Medication Errors:</b> During eUHR compliance testing and case reviews, did the OIG find that medication errors were properly identified and reported by the institution?	Information Only				
7.999	<b>For Information Purposes Only—Pharmacy:</b> Do inmate-patients in isolation housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications?	Information Only				
<b>Overall percentage:</b>					<b>89.33%</b>	

Reference Number	<i>Prenatal and Post-Delivery Services</i>	Scored Answers				N/A
		Yes	No	+	Yes %	
8	This indicator is not applicable to this institution.	<b>Not Applicable</b>				

Reference Number	<i>Preventive Services</i>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
9.001	<b>Inmate-patients prescribed INH:</b> Did the institution administer the medication to the inmate-patient as prescribed?	6	1	7	85.71%	0
9.002	<b>Inmate-patients prescribed INH:</b> Did the institution monitor the inmate-patient monthly for the most recent three months he or she was on the medication?	7	0	7	100%	0
9.003	<b>Annual TB screening:</b> Was the inmate-patient screened for TB within the last year?	29	1	30	96.67%	0
9.004	Were all inmate-patients offered an influenza vaccination for the most recent influenza season?	29	1	30	96.67%	0
9.005	<b>All inmate-patients from the age of 50 through the age of 75:</b> Was the inmate-patient offered colorectal cancer screening?	27	3	30	90.00%	0
9.006	<b>Female inmate-patients from the age of 50 through the age of 74:</b> Was the inmate-patient offered a mammogram in compliance with policy?	11	0	11	100%	0
9.007	<b>Female inmate-patients from the age of 21 through the age of 65:</b> Was the inmate-patient offered a pap smear in compliance with policy?	30	0	30	100%	0
9.008	Are required immunizations being offered for chronic care inmate-patients?	16	11	27	59.26%	0
9.009	Are inmate-patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	Not Applicable				
<b>Overall percentage:</b>					<b>91.04%</b>	

Reference Number	<b><i>Quality of Nursing Performance</i></b>	Scored Answers				N/A
		Yes	No	Yes %		
10	The quality of nursing performance will be assessed during case reviews, conducted by OIG clinicians, and is not applicable for the compliance portion of the medical inspection. The methodologies OIG clinicians use to evaluate the quality of nursing performance are presented in a separate inspection document entitled <i>OIG MIU Retrospective Case Review Methodology</i> .					

Reference Number	<b><i>Quality of Provider Performance</i></b>	Scored Answers				N/A
		Yes	No	Yes %		
11	The quality of provider performance will be assessed during case reviews, conducted by OIG clinicians, and is not applicable for the compliance portion of the medical inspection. The methodologies OIG clinicians use to evaluate the quality of provider performance are presented in a separate inspection document entitled <i>OIG MIU Retrospective Case Review Methodology</i> .					

Reference Number	<b><i>Reception Center Arrivals</i></b>	Scored Answers				N/A
		Yes	No	Yes %		
12	This indicator is not applicable to this institution.					

Reference Number	<b><i>Specialized Medical Housing (OHU, CTC, SNF, Hospice)</i></b>	Scored Answers				N/A
		Yes	No	Yes %		
13	This indicator is not applicable to this institution.					

Reference Number	<i>Specialty Services</i>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	Did the inmate-patient receive the high-priority specialty service within 14 calendar days of the PCP order?	14	1	15	93.33%	0
14.002	Did the PCP review the high-priority specialty service consultant report within three business days after the service was provided?	15	0	15	100%	0
14.003	Did the inmate-patient receive the routine specialty service within 90 calendar days of the PCP order?	15	0	15	100%	0
14.004	Did the PCP review the routine specialty service consultant report within three business days after the service was provided?	10	5	15	66.67%	0
14.005	<b>For endorsed inmate-patients received from another CDCR institution:</b> If the inmate-patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames?	16	4	20	80.00%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	20	0	20	100%	0
14.007	Following the denial of a request for specialty services, was the inmate-patient informed of the denial within the required time frame?	19	0	19	100%	1
<b>Overall percentage:</b>					<b>91.43%</b>	

Reference Number	<i>Internal Monitoring, Quality Improvement, and Administrative Operations</i>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.001	Did the institution promptly process inmate medical appeals during the most recent 12 months?	12	0	12	100%	0
15.002	Does the institution follow adverse/sentinel event reporting requirements?	1	1	2	50.0%	0
15.003	Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified?	0	6	6	0.0%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	1	0	1	100%	0
15.005	For each initiative in the Performance Improvement Work Plan (PIWP), has the institution performance improved or reached the targeted performance objective(s)?	4	3	7	57.14%	0
15.006	For institutions with licensed care facilities: Does the local governing body (LGB), or its equivalent, meet quarterly and exercise its overall responsibilities for the quality management of patient health care?	Not applicable				0
15.007	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	0	12	12	0.0%	0
15.101	Did the institution complete a medical emergency response drill for each watch and include participation of health care and custody staff during the most recent full quarter?	0	3	3	0.0%	0
15.102	Did the institution's second level medical appeal response address all of the inmate-patient's appealed issues?	10	0	10	100%	0
15.103	Did the institution's medical staff review and submit the initial inmate death report to the Death Review Unit in a timely manner?	1	1	2	50.00%	0
15.996	<b>For Information Purposes Only:</b> Did the CCHCS Death Review Committee submit its inmate Death Review Summary to the institution timely?	Information Only				
15.997	<b>For Information Purposes Only:</b> Identify the institution's protocols for tracking medical appeals.	Information Only				
15.998	<b>For Information Purposes Only:</b> Identify the institution's protocols for implementing health care local operating procedures (LOPs).	Information Only				
15.999	<b>For Information Purposes Only:</b> Identify the institution's health care staffing resources.	Information Only				
<b>Overall percentage:</b>					<b>50.79%</b>	

Reference Number	<i>Job Performance, Training, Licensing, and Certifications</i>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
16.001	Do all providers maintain a current medical license?	9	0	9	100%	0
16.101	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	5	0	5	100%	0
16.102	Are nursing staff who administer medications current on their clinical competency validation?	10	0	10	100%	0
16.103	Are structured clinical performance appraisals completed timely?	2	6	8	25.00%	0
16.104	Are staff current with required medical emergency response certifications?	2	1	3	66.67%	0
16.105	Are nursing staff and the pharmacist-in-charge current with their professional licenses and certifications?	5	0	5	100%	1
16.106	Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	1	0	1	100%	0
16.107	Are nursing staff current with required new employee orientation?	1	0	1	100%	0
<b>Overall percentage:</b>					<b>86.46%</b>	

## APPENDIX B—CLINICAL DATA

Sample Set	Total
Anticoagulation	3
Death Review/Sentinel Events	2
Diabetes	3
Emergency Services - CPR	2
Emergency Services - Non-CPR	5
High Risk	5
Hospitalization	5
Intra-System Transfers-In	3
Intra-System Transfers-Out	3
Nursing Sick Call	40
Specialty Services	5
	<b>76</b>

**Table B-2 Chronic Care Diagnoses**

<b>Diagnosis</b>	<b>Total</b>
Anemia	7
Anticoagulation	6
Arthritis/Degenerative Joint Disease	8
Asthma	14
COPD	3
Cancer	6
Cardiovascular Disease	13
Chronic Kidney Disease	9
Chronic Pain	8
Cirrhosis/End Stage Liver Disease	7
Deep Venous Thrombosis/Pulmonary Embolism	2
Diabetes	17
Gastroesophageal Reflux Disease	12
Gastrointestinal Bleed	2
Hepatitis C	21
Hyperlipidemia	21
Hypertension	42
Mental Health	11
Migraine Headaches	2
Rheumatological Disease	2
Seizure Disorder	6
Sleep Apnea	3
Thyroid Disease	3
	<b>225</b>

<b>Table B-3 Event - Program</b>	
<b>Program</b>	<b>Total</b>
Diagnostic Services	139
Emergency Care	64
Hospitalization	38
Outpatient Care	503
Intra-System Transfers-In	12
Intra-System Transfers-Out	8
Specialty Services	96
Specialized Medical Housing <sup>6</sup>	1
	<b>861</b>

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<sup>6</sup> FSP did have one event for Specialized Medical Housing, even though they do not have an OHU or CTC. This patient required an OHU level of care and on the date of the event was transferred to another institution for specialized housing.

## APPENDIX C—COMPLIANCE SAMPLING METHODOLOGY

<b>Folsom State Prison</b>			
<b>Quality Indicator</b>	<b>Sample Category (number of patients)</b>	<b>Data Source</b>	<b>Filters</b>
<i>Access to Care</i>	Chronic Care (30—Basic Level) (40—Intermediate Level)	Master Registry	<ul style="list-style-type: none"> <li>Chronic care conditions (at least one condition per inmate-patient—any risk level)</li> <li><b>Randomize</b></li> </ul>
	Nursing Sick Call (5 per clinic) (minimum of 30)	MedSATS	<ul style="list-style-type: none"> <li>Clinic (each clinic tested)</li> <li>Appt. date (2–9 months)</li> <li><b>Randomize</b></li> </ul>
	Returns from Community Hospital (30)	Inpatient Claims Data	<ul style="list-style-type: none"> <li>See <i>Health Information Management (Medical Records)</i> (returns from community hospital)</li> </ul>
<i>Diagnostic Services</i>	Radiology (10)	Radiology Logs	<ul style="list-style-type: none"> <li>Appt. Date (90 days–9 months)</li> <li><b>Randomize</b></li> <li>Abnormal</li> </ul>
	Laboratory (10)	Quest	<ul style="list-style-type: none"> <li>Appt. date (90 days–9 months)</li> <li>Order name (CBC or CMPs only)</li> <li><b>Randomize</b></li> <li>Abnormal</li> </ul>
	Pathology (10)	InterQual	<ul style="list-style-type: none"> <li>Appt. date (90 days–9 months)</li> <li>Service (pathology related)</li> <li><b>Randomize</b></li> </ul>
<i>Health Information Management (Medical Records)</i>	Timely Scanning (20 each)	OIG Qs: 1.001, 1.002, 1.006, & 9.004	<ul style="list-style-type: none"> <li>Non-dictated documents</li> <li>First five inmate-patients selected for each question</li> </ul>
		OIG Q: 1.001	<ul style="list-style-type: none"> <li>Dictated documents</li> <li>First 20 inmate-patients selected</li> </ul>
		OIG Qs: 14.002 & 14.004	<ul style="list-style-type: none"> <li>Specialty documents</li> <li>First 10 inmate-patients selected for each question</li> </ul>
		OIG Q: 4.008	<ul style="list-style-type: none"> <li>Community hospital discharge documents</li> <li>First 20 inmate-patients selected for the question</li> </ul>
		OIG Q: 7.001	<ul style="list-style-type: none"> <li>MARs</li> <li>First 20 inmate-patients selected</li> </ul>
	Legible Signatures and Review (40)	OIG Qs: 4.008, 6.001, 6.002, 7.001, 12.001, 12.002 & 14.002	<ul style="list-style-type: none"> <li>First 8 inmates sampled for each question</li> <li>One source document per inmate-patient</li> </ul>
	Complete and Accurate Scanning	Documents for any tested inmate	<ul style="list-style-type: none"> <li>Any incorrectly scanned eUHR document identified during OIG eUHR file review, e.g., mislabeled, misfiled, illegibly scanned, or missing</li> </ul>
	Returns from Community Hospital (30)	Inpatient Claims Data	<ul style="list-style-type: none"> <li>Date (2–8 months)</li> <li>Most recent 6 months provided (within date range)</li> <li>Rx count</li> <li>Discharge date</li> <li><b>Randomize</b> (each month individually)</li> <li>First 5 inmate-patients from each of the 6 months (if not 5 in a month, supplement from another, as needed)</li> </ul>

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
<i>Health Care Environment</i>	Clinical Areas (number varies by institution)	OIG Inspector Onsite Review	<ul style="list-style-type: none"> <li>Identify and inspect onsite all clinical areas.</li> <li>Clinical areas at FSP: MSF, FWF, TTA-Main, TTA-FWF, ASU, R&amp;R-Main, R&amp;R-FWF, Bldg. 1 (A &amp; C Sides), 2,3,4,5</li> </ul>
<i>Inter- and Intra-System Transfers</i>	Intra-System transfers (30)	SOMS	<ul style="list-style-type: none"> <li>Arrival date (3–9 months)</li> <li>Arrived from (another CDCR facility)</li> <li>Rx count</li> <li><b>Randomize</b></li> </ul>
	Specialty Service Send-outs (20)	MedSATS	<ul style="list-style-type: none"> <li>Date of Transfer (3–9 months)</li> <li><b>Randomize</b></li> </ul>
<i>Pharmacy and Medication Management</i>	Chronic Care Medication (30—Basic Level) (40—Intermediate Level)	OIG Q: 1.001	<i>See Access to Care</i> <ul style="list-style-type: none"> <li>(At least one condition per inmate-patient—any risk level)</li> <li><b>Randomize</b></li> </ul>
	New Medication Orders (30—Basic Level) (40—Intermediate Level)	Master Registry	<ul style="list-style-type: none"> <li>Rx Count</li> <li><b>Randomize</b></li> <li>Ensure no duplication of inmate-patients tested in chronic care medications</li> </ul>
	Intra-Facility moves (30)	MAPIP Transfer Data	<ul style="list-style-type: none"> <li>Date of transfer (2–8 months)</li> <li>To location/from location (yard to yard and to/from ASU)</li> <li>Remove any to/from MHCB</li> <li>NA/DOT meds (high–low)—<i>inmate-patient must have NA/DOT meds to qualify for testing</i></li> <li><b>Randomize</b></li> </ul>
	En Route (10)	SOMS	<ul style="list-style-type: none"> <li>Date of transfer (2–8 months)</li> <li>Sending institution (another CDCR facility)</li> <li><b>Randomize</b></li> <li>Length of stay (minimum of 2 days)</li> <li>NA/DOT meds</li> </ul>
	Returns from Community Hospital (30)	Inpatient Claims Data	<ul style="list-style-type: none"> <li><i>See Health Information Management (Medical Records) (returns from community hospital)</i></li> </ul>
	Medication Preparation and Administration Areas	OIG Inspector Onsite Review	<ul style="list-style-type: none"> <li>Identify and inspect onsite clinical areas that prepare and administer medications</li> </ul>
	Pharmacy	OIG Inspector Onsite Review	<ul style="list-style-type: none"> <li>Identify and inspect onsite pharmacies</li> </ul>
	Medication Error Reporting	OIG Inspector Review	<ul style="list-style-type: none"> <li>Any medication error identified during OIG eUHR file review, e.g., case reviews and/or compliance testing</li> </ul>
<i>Prenatal and Post-delivery Services</i>	Recent Deliveries (5) <i>N/A at this institution</i>	OB Roster	<ul style="list-style-type: none"> <li>Delivery date (2–12 months)</li> <li><b>Most recent</b> deliveries (within date range)</li> </ul>
	Pregnant Arrivals (5) <i>N/A at this institution</i>	OB Roster	<ul style="list-style-type: none"> <li>Arrival date (2–12 months)</li> <li><b>Earliest</b> arrivals (within date range)</li> </ul>

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
<b>Preventive Services</b>	Chronic Care Vaccinations (30—Basic Level) (40—Intermediate Level)  <i>Not all conditions require vaccinations</i>	OIG Q: 1.001	<ul style="list-style-type: none"> <li>Chronic care conditions (at least 1 condition per inmate-patient—any risk level)</li> <li><b>Randomize</b></li> <li>Condition must require vaccination(s)</li> </ul>
	INH (all applicable up to 30)	Maxor	<ul style="list-style-type: none"> <li>Dispense date (past 9 months)</li> <li>Time period on INH (at least a full 3 months)</li> <li><b>Randomize</b></li> </ul>
	Colorectal Screening (30)	SOMS	<ul style="list-style-type: none"> <li>Arrival date (at least 1 year prior to inspection)</li> <li>Date of birth (51 or older)</li> <li><b>Randomize</b></li> </ul>
	Influenza Vaccinations (30)	SOMS	<ul style="list-style-type: none"> <li>Arrival date (at least 1 year prior to inspection)</li> <li><b>Randomize</b></li> <li>Filter out inmate-patients tested in chronic care vaccination sample</li> </ul>
	TB Code 22, annual TST (15)	SOMS	<ul style="list-style-type: none"> <li>Arrival date (at least 1 year prior to inspection)</li> <li>TB Code (22)</li> <li><b>Randomize</b></li> </ul>
	TB Code 34, annual screening (15)	SOMS	<ul style="list-style-type: none"> <li>Arrival date (at least 1 year prior to inspection)</li> <li>TB Code (34)</li> <li><b>Randomize</b></li> </ul>
	Mammogram (30)	SOMS	<ul style="list-style-type: none"> <li>Arrival date (at least 2 years prior to inspection)</li> <li>Date of birth (age 52–74)</li> <li><b>Randomize</b></li> </ul>
	Pap Smear (30)	SOMS	<ul style="list-style-type: none"> <li>Arrival date (at least three years prior to inspection)</li> <li>Date of birth (age 24–53)</li> <li><b>Randomize</b></li> </ul>
	Valley Fever (number will vary)  <i>N/A at this institution</i>	Cocci Transfer Status Report	<ul style="list-style-type: none"> <li>Reports from past 2–8 months</li> <li>Institution</li> <li>Ineligibility date (60 days prior to inspection date)</li> <li><b>All</b></li> </ul>
<b>Reception Center Arrivals</b>	RC (20)  <i>N/A at this institution</i>	SOMS	<ul style="list-style-type: none"> <li>Arrival date (2–8 months)</li> <li>Arrived from (county jail, return from parole, etc.)</li> <li><b>Randomize</b></li> </ul>
	<i>N/A at this institution</i>		
<b>Specialized Medical Housing</b>	OHU, CTC, SNF, Hospice (10 per housing area) <i>N/A at this institution</i>	CADDIS	<ul style="list-style-type: none"> <li>Admit date (1–6 months)</li> <li>Type of stay (no MH beds)</li> <li>Length of stay (minimum of 5 days)</li> <li><b>Randomize</b></li> </ul>

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
<i>Specialty Services Access</i>	High-Priority (10)	MedSATS	<ul style="list-style-type: none"> <li>• Appt. date (3–9 months)</li> <li>• <b>Randomize</b></li> </ul>
	Routine (10)	MedSATS	<ul style="list-style-type: none"> <li>• Appt. date (3–9 months)</li> <li>• Remove optometry, physical therapy or podiatry</li> <li>• <b>Randomize</b></li> </ul>
	Specialty Service Arrivals (20)	MedSATS	<ul style="list-style-type: none"> <li>• Sending institution</li> <li>• Date of transfer (3–9 months)</li> <li>• Sent to (another CDCR facility)</li> <li>• <b>Randomize</b></li> </ul>
	Denials (20)*	InterQual	<ul style="list-style-type: none"> <li>• Review date (3–9 months)</li> <li>• <b>Randomize</b></li> </ul>
	*Ten InterQual Ten MARs	IUMC/MAR Meeting Minutes	<ul style="list-style-type: none"> <li>• Meeting date (9 months)</li> <li>• Denial upheld</li> <li>• <b>Randomize</b></li> </ul>
<i>Internal Monitoring, Quality Improvement and Administrative Operations</i>	Medical Appeals (all)	Monthly Medical Appeals Reports	<ul style="list-style-type: none"> <li>• Medical appeals (12 months)</li> </ul>
	Adverse/Sentinel Events (5)	Adverse/Sentinel Events Report	<ul style="list-style-type: none"> <li>• Adverse/sentinel events (2–8 months)</li> </ul>
	QMC Meetings (12)	Quality Management Committee Meeting Minutes	<ul style="list-style-type: none"> <li>• Meeting minutes (12 months)</li> </ul>
	Performance Improvement Plans (12)	Performance Improvement Work Plan	<ul style="list-style-type: none"> <li>• Performance Improvement Work Plan with updates (12 months)</li> </ul>
	Local Governing Body (12)	Local Governing Body Meeting Minutes	<ul style="list-style-type: none"> <li>• Meeting minutes (12 months)</li> </ul>
	EMRRC (6)	EMRRC Meeting Minutes	<ul style="list-style-type: none"> <li>• Meeting minutes (6 months)</li> </ul>
	Medical Emergency Response Drills (3)	OIG Inspector Onsite Review	<ul style="list-style-type: none"> <li>• Most recent full quarter</li> <li>• Each watch</li> </ul>
	2 <sup>nd</sup> Level Medical Appeals (10)	OIG Inspector Onsite Review	<ul style="list-style-type: none"> <li>• Medical appeals denied (6 months)</li> </ul>
	Death Reports (10)	OIG Inspector Onsite Review	<ul style="list-style-type: none"> <li>• Death reports (12 months)</li> </ul>
	Local Operating Procedures (all)	OIG Inspector Onsite Review	<ul style="list-style-type: none"> <li>• Review all</li> </ul>

<b>Quality Indicator</b>	<b>Sample Category (number of patients)</b>	<b>Data Source</b>	<b>Filters</b>
<i><b>Job Performance and Training, Licensing and Certifications</b></i>	RN Review Evaluations (5)	OIG Inspector Onsite Review	<ul style="list-style-type: none"> <li>• Current Supervising RN reviews</li> </ul>
	Nursing Staff Validations (10)	OIG Inspector Onsite Review	<ul style="list-style-type: none"> <li>• Review annual competency validations</li> <li>• <b>Randomize</b></li> </ul>
	Provider Annual Evaluation Packets (all)	OIG Inspector Onsite Review	<ul style="list-style-type: none"> <li>• All required performance evaluation documents</li> </ul>
	Medical Emergency Response Certifications (all)	OIG Inspector Onsite Review	<ul style="list-style-type: none"> <li>• All staff <ul style="list-style-type: none"> <li>○ Providers (ACLS)</li> <li>○ Nursing (BLS/CPR)</li> <li>○ Custody (CPR/BLS)</li> </ul> </li> </ul>
	Nursing staff and Pharmacist-in-Charge Professional Licenses and Certifications (all)	OIG Inspector Onsite Review	<ul style="list-style-type: none"> <li>• All licenses and certifications</li> </ul>
	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations (all)	OIG Inspector Onsite Review	<ul style="list-style-type: none"> <li>• All current DEA registrations</li> </ul>
	Nursing Staff New Employee Orientations (all)	OIG Inspector Onsite Review	<ul style="list-style-type: none"> <li>• New employees (within the last 12 months)</li> </ul>

# **CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE**

April 15, 2015

Robert A. Barton, Inspector General  
Office of the Inspector General  
P.O. Box 348780  
Sacramento, CA 95834-8780

Dear Mr. Barton:

The purpose of this letter is to inform you that the Office of the Receiver has reviewed the draft report of the Office of the Inspector General (OIG) Medical Inspection Results for Folsom State Prison (FSP) conducted from January 2015 to March 2015. California Correctional Health Care Services (CCHCS) acknowledges and accepts all OIG findings. Noted deficiencies will be incorporated into the FSP Performance Improvement Work Plan which includes specific strategies and actions that focus on core processes and root causes for each of the deficiencies noted.

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

Sincerely,



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

cc: Clark Kelso, Receiver

Diana Toche, Undersecretary, California Department of Corrections and Rehabilitation  
Richard Kirkland, Chief Deputy Receiver  
Jared Goldman, Counsel to the Receiver  
Christine Berthold, Deputy Inspector General, Senior, OIG  
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