# Avenal State Prison
# Medical Inspection Report
# Cycle 5

**August 2018**

**Fairness** ◆ **Integrity** ◆ **Respect** ◆

**Service** ◆ **Transparency**

# Office of the Inspector General
# AVENAL STATE PRISON
# Medical Inspection Report
# Cycle 5

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# TABLE OF CONTENTS

# LIST OF TABLES AND FIGURES

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# FOREWORD

Pursuant to California Penal Code Section 6126 et seq., which assigns the Office of the Inspector General (OIG) responsibility for oversight of the California Department of Corrections and Rehabilitation (CDCR), the OIG conducts a comprehensive inspection program to evaluate the delivery of medical care at each of CDCR's 35 adult prisons. The OIG **explicitly** makes no determination regarding the constitutionality of care in the prison setting. That determination is left to the Receiver and the federal court. The assessment of care by the OIG is just one factor in the court's determination whether care in the prisons meets constitutional standards.

The OIG's inspections are mandated by the Penal Code and not aimed at specifically resolving the court's questions on constitutional care. To the degree that they provide another factor for the court to consider, the OIG is pleased to provide added value to the taxpayers of California.

In Cycle 5, for the first time, the OIG will be inspecting institutions delegated back to CDCR from the Receivership. There is no difference in the standards used for assessment of a delegated institution versus an institution not yet delegated. The Receiver delegated Avenal State Prison back to CDCR in October 2016.

This fifth cycle of inspections will continue evaluating the areas addressed in Cycle 4, which included clinical case review, compliance testing, and a population-based metric comparison of selected Healthcare Effectiveness Data Information Set (HEDIS) measures. In agreement with stakeholders, the OIG made changes to both the case review and compliance components. The OIG found that in every inspection in Cycle 4, larger samples were taken than were needed to assess the adequacy of medical care provided. As a result, the OIG reduced the number of case reviews and sample sizes for compliance testing. Also, in Cycle 4, compliance testing included two secondary (administrative) indicators (*Internal Monitoring, Quality Improvement, and Administrative Operations*; and *Job Performance, Training, Licensing, and Certifications*). For Cycle 5, these have been combined into one secondary indicator, *Administrative Operations*.

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# EXECUTIVE SUMMARY

The OIG completed the Cycle 5 medical inspection of Avenal State Prison (ASP) in August 2018. The vast majority of our inspection findings were based on ASP's health care delivery between December 2016 and October 2017. Our policy compliance inspectors performed an onsite inspection in August 2017. After reviewing the institution's health care delivery, our case review clinicians performed an onsite inspection in January 2018.

**OVERALL RATING:**

*Adequate*

Our clinician team, consisting of expert physicians and nurse consultants, reviewed cases (patient medical records) and interpreted our policy compliance results to determine the quality of health care the institution provided. Our compliance team, consisting of registered nurses, monitored the institution's compliance with its medical policies by answering a predetermined set of policy compliance questions.

Our clinician team reviewed 50 cases that contained 580 patient-related events. Our compliance team tested 86 policy questions by observing ASP's processes and examining 386 patient records and 1,042 data points. We distilled the results from both the case review and compliance testing into 13 health care indicators, and have listed the individual indicators and ratings applicable for this institution in the *ASP Executive Summary Table* on the following page. Our experts made a considered and measured opinion that the overall quality of health care at ASP was *adequate*.

# ASP Executive Summary Table

| Inspection Indicators | Case Review Rating | Compliance Rating | Cycle 5 Overall Rating | Cycle 4 Rating |
|---|---|---|---|---|
| **1—Access to Care** | *Proficient* | *Proficient* | **Proficient** | *Adequate* |
| **2—Diagnostic Services** | *Proficient* | *Adequate* | **Proficient** | *Adequate* |
| **3—Emergency Services** | *Proficient* | *Not Applicable* | **Proficient** | *Adequate* |
| **4—Health Information Management** | *Proficient* | *Inadequate* | **Adequate** | *Adequate* |
| **5—Health Care Environment** | *Not Applicable* | *Inadequate* | **Inadequate** | *Proficient* |
| **6—Inter- and Intra-System Transfers** | *Adequate* | *Proficient* | **Adequate** | *Adequate* |
| **7—Pharmacy and Medication Management** | *Adequate* | *Inadequate* | **Inadequate** | *Inadequate* |
| **8—Prenatal and Post-Delivery Services** | *Not Applicable* | *Not Applicable* | *Not Applicable* | *Not Applicable* |
| **9—Preventive Services** | *Not Applicable* | *Proficient* | **Proficient** | *Inadequate* |
| **10—Quality of Nursing Performance** | *Adequate* | *Not Applicable* | **Adequate** | *Adequate* |
| **11—Quality of Provider Performance** | *Adequate* | *Not Applicable* | **Adequate** | *Adequate* |
| **12—Reception Center Arrivals** | *Not Applicable* | *Not Applicable* | *Not Applicable* | *Not Applicable* |
| **13—Specialized Medical Housing** | *Adequate* | *Proficient* | **Adequate** | *Adequate* |
| **14—Specialty Services** | *Proficient* | *Adequate* | **Proficient** | *Adequate* |
| **15—Administrative Operations (Secondary)** | *Not Applicable* | *Proficient* | **Proficient** | *Inadequate\** |

\*In Cycle 4, there were two secondary (administrative) indicators. This score reflects the average of those two scores.

## *Expert Clinician Case Review Results*

Our clinicians reviewed the care of patients with high medical needs and included a review of more than 580 patient care events.[1] The vast majority of our case review covered the period between February 2017 and October 2017. Of the 13 indicators applicable to ASP, our clinicians rated 10; 5 were *proficient*, and 5 were *adequate.* When determining the overall adequacy of care, we paid particular attention to the clinical nursing and provider quality indicators, as adequate health care staff can sometimes overcome suboptimal processes and programs. However, the opposite is not true; inadequate health care staff cannot provide adequate care, even though the established processes and programs may be adequate. We identify inadequate medical care based on the risk of significant harm to the patient, not the actual outcome.

**Program Strengths — Clinical**

- ASP performed well with *Access to Care.* During the daily clinic huddles, the medical staff collaborated to ensure they scheduled all the follow-up appointments the patients needed.

- ASP completed virtually all laboratory and diagnostic tests appropriately. The staff retrieved and scanned the diagnostic reports into the medical records timely.

- Treatment and Triage Area (TTA) providers made appropriate assessments, interventions, and decisions during urgent or emergent medical situations.

- ASP providers and nurses provided excellent care for their OHU patients.

- ASP did well providing specialty appointments to patients. The staff retrieved and scanned the specialty reports into the medical records timely.

**Program Weaknesses — Clinical**

- The pharmacy and nursing staff did not always ensure that patients received critical medications. This problem was evident in the *Inter- and Intra-System Transfers*, *Pharmacy and Medication Management*, and *Specialized Medical Housing* indicators.

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

## *Compliance Testing Results*

Of the 13 health care indicators applicable to ASP, our compliance inspectors[2] evaluated ten. Of these, five were *proficient*, two were *adequate*, and three were *inadequate*. The vast majority of our compliance testing was of medical care that occurred between December 2016 and August 2017. There were 86 individual compliance questions within those ten indicators, generating 1,042 data points that tested ASP's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[3] *Appendix A — Compliance Test Results* provides details for the 86 questions.

**Program Strengths — Compliance**

The following are some of ASP's strengths based on its compliance scores on individual questions in all the health care indicators:

- ASP medical staff did an excellent job of following appropriate policies and procedures when they admitted patients to the outpatient housing unit (OHU); this performance included the completion of timely nursing and provider assessments.

- The institution performed well offering and providing preventive medical services to its patients, including health screening and immunizations.

- ASP did well with some of the inter- and intra-facility transfer processes, including providing initial health screenings for newly arrived patients and listing pending specialty appointments for those patients transferring out of the institution.

- Nurses received and reviewed patients' Health Care Services Request forms timely. In addition, nurses conducted face-to-face triage encounters for all patients sampled within the required time frames.

- Patients at ASP received their chronic care appointments and hospital discharge follow-up appointments within the required time frames.

**Program Weaknesses — Compliance**

The following are some of the weaknesses identified by ASP's compliance scores on individual questions in all the health care indicators:

- Clinical staff at ASP did not maintain proper hand hygiene practices during patient encounters.

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[2] The OIG's compliance inspectors are trained registered nurses with expertise in CDCR policies regarding medical staff and processes.

[3] The OIG used its own clinicians to provide clinical expert guidance for testing compliance in certain areas where CCHCS policies and procedures did not specifically address an issue.

- The institution's medical warehouse did not follow its supply management processes sufficiently and stored medical supplies beyond the manufacturers' guidelines.

- Medical clinics at ASP lacked properly calibrated medical equipment and medical supplies needed to provide standard medical care.

- ASP stored medications beyond the manufacturers' guidelines in its main pharmacy and medication line storage locations.

## *Recommendation*

- ASP's pharmacist in charge (PIC) and chief nurse executive (CNE) should implement quality improvement measures to adjust their pharmacy and nursing administration processes and ensure medications are available when patients need them. In this inspection, the institution did not reliably give needed medications to patients who transferred from other institutions, returned from the hospital, or needed intravenous antibiotics.

## *Population-Based Metrics*

In general, ASP performed well as measured by population-based metrics. In comprehensive diabetes care, ASP outperformed all state and national health care plans in the four of five diabetic measures; however, ASP scored lower than one health care plan for diabetic eye exams.

Regarding immunization measures, only partial data was available for Pneumococcal immunizations, and immunizations for the older adult population. ASP scored higher than all other health care plans for influenza immunizations for younger adults. ASP had the lowest score for all other health care plans for colorectal cancer screening.

Compared to other health care plans with reported population-based metrics, ASP performed well in most clinical measures reviewed. The institution may improve its scores for colorectal cancer screenings by reducing patient refusals through educating patients on the benefits of these preventive services.

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# INTRODUCTION

Pursuant to California Penal Code Section 6126 et seq., 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. The OIG conducted a clinical case review and a compliance inspection, ensuring a thorough, end-to-end assessment of medical care within CDCR.

Avenal State Prison (ASP) was the 24th medical inspection of Cycle 5. During the inspection process, the OIG assessed the delivery of medical care to patients using the primary clinical health care indicators applicable to the institution. The *Administrative Operations* indicator is secondary because it does not reflect the actual clinical care provided.

## ABOUT THE INSTITUTION

Avenal State Prison, located in the city of Avenal in Kings County, opened in 1987. ASP is designated as a low-medium security institution and currently provides housing for both general population and sensitive needs yard (SNY) custody inmates; it is comprised of six separate, semi-autonomous facilities. The institution operates seven clinics where staff members handle non-urgent requests for medical services, including six facility clinics and one specialty clinic. ASP also conducts screenings in its receiving and release clinical area; treats patients needing urgent or emergency care in its triage and treatment area (TTA); and treats patients who require assistance with the activities of daily living, but who do not require inpatient care, in its outpatient housing unit (OHU). California Correctional Health Care Services (CCHCS) has designated ASP as a "basic" care institution. Basic institutions are in rural areas away from tertiary care centers and specialty care providers whose services would likely be used frequently by higher-risk patients. Basic institutions have the capability to provide limited specialty medical services and consultation for a generally healthy inmate population.

On August 17, 2015, the institution received national accreditation from the Commission on Accreditation for Corrections. This accreditation program is a professional peer review process based on national standards set by the American Correctional Association.

Based on staffing data the OIG obtained from the institution, ASP's vacancy rate among medical managers, primary care providers, supervisors, and rank-and-file nurses was 8 percent in August 2017, with the highest vacancy percentages among primary care providers.

# ASP Health Care Staffing Resources as of August, 2017

| Description | Management | | Primary Care Providers | | Nursing Supervisors | | Nursing Staff | | Totals | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Number | % | Number | % | Number | % | Number | % | Number | % |
| *Authorized Positions* | 5 | 6% | 7.5 | 8% | 9.5 | 10% | 68.9 | 76% | 90.9 | 100% |
| *Filled Positions* | 5 | 100% | 6.5 | 87% | 9.5 | 100% | 63 | 91% | 84 | 92% |
| *Vacancies* | 0 | 0% | 1 | 13% | 0 | 0% | 5.9 | 9% | 6.9 | 8% |
| | | | | | | | | | | |
| *Recent Hires (within 12 months)* | 0 | 0% | 1 | 15% | 3 | 32% | 4 | 6% | 8 | 10% |
| *Staff Utilized from Registry* | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% |
| *Redirected Staff (to Non-Patient Care Areas)* | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% |
| *Staff on Extended Leave* | 0 | 0% | 0 | 0% | 0 | 0% | 1 | 2% | 1 | 1% |

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

As of August 28, 2017, the Master Registry for ASP showed that the institution had a total population of 3,784. Within that total population, 0.1 percent were designated as high medical risk, Priority 1 (High 1), and 0.6 percent were designated as high medical risk, Priority 2 (High 2). Patients' assigned risk levels are based on the complexity of their required medical care related to their specific diagnoses, frequency of higher levels of care, age, and abnormal laboratory tests and procedures. High 1 has at least two high-risk conditions; High 2 has only one. Patients at high medical risk are more susceptible to poor health outcomes than those at medium or low medical risk. Patients at high medical risk also typically require more health care services than do patients with lower assigned risk levels. The chart below illustrates the breakdown of the institution's medical risk levels at the start of the OIG medical inspection.

# ASP Master Registry Data as of August 28, 2017

| Medical Risk Level | # of Patients | Percentage |
|---|---|---|
| High 1 | 2 | 0.1% |
| High 2 | 22 | 0.6% |
| Medium | 1,558 | 41.2% |
| Low | 2,202 | 58.2% |
| **Total** | **3,784** | **100.0%** |
| | | |

# OBJECTIVES, SCOPE, AND METHODOLOGY

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

To maintain a metric-oriented inspection program that evaluates medical care delivery consistently at each state prison, the OIG identified 15 indicators (14 primary (clinical) indicators and one secondary (administrative) indicator) of health care to measure. The primary quality indicators cover clinical categories directly relating to the health care provided to patients, whereas the secondary quality indicator addresses the administrative functions that support a health care delivery system. The *ASP Executive Summary Table* on page *iv* of this report identifies these 15 indicators.

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 registered nurses. The case review results alone, the compliance test results alone, or a combination of both these information sources may influence an indicator's overall rating. For example, the OIG derives the ratings for the primary quality indicators *Quality of Nursing Performance* and *Quality of Provider Performance* entirely from the case review done by clinicians, while the ratings for the primary quality indicators *Health Care Environment* and *Preventive Services* are derived entirely from compliance testing done by registered nurse inspectors. As another example, primary quality indicators such as *Diagnostic Services* and *Specialty Services* receive ratings derived from both sources.

The OIG does not inspect for efficiency or cost-effectiveness of medical operations. Consistent with the OIG's agreement with the Receiver, this report only addresses the quality of CDCR's medical operations and its compliance with quality-related policies. Moreover, if the OIG learns of a patient needing immediate care, the OIG notifies the chief executive officer of health care services and requests a status report. Additionally, if the OIG learns of significant departures from community standards, it may report such departures to the institution's chief executive officer or to CCHCS. Because these matters involve confidential medical information protected by state and federal privacy laws, the OIG does not include specific identifying details related to any such cases in the public report.

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

## CASE REVIEWS

The OIG added case reviews to the Cycle 4 medical inspections at the recommendation of its stakeholders, which continues in the Cycle 5 medical inspections. The following exhibit provides definitions that describe this process.

## Exhibit 1. Case Review Definitions

*Case = Sample = Patient*
An appraisal of the medical care provided to one patient over a specific period, which can comprise detailed or focused case reviews.

*Detailed Case Review*
A review that includes all aspects of one patient's medical care assessed over a six-month period. This review allows the OIG clinicians to examine many areas of health care delivery, such as access to care, diagnostic services, health information management, and specialty services.

*Focused Case Review*
A review that focuses on one specific aspect of medical care. This review tends to concentrate on a singular facet of patient care, such as the sick call process or the institution's emergency medical response.

*Case Review Event*
A direct or indirect interaction between the patient and the health care system. Examples of direct interactions include provider encounters and nurse encounters. An example of an indirect interaction includes a provider reviewing a diagnostic test and placing additional orders.

*Case Review Deficiency*
A medical error in procedure or in clinical judgment. Both procedural and clinical judgment errors can result in policy non-compliance, elevated risk of patient harm, or both.

*Adverse Deficiency*
A medical error that increases the risk of, or results in, serious patient harm. Most health care organizations refer to these errors as *adverse events*.

The OIG's clinicians perform a retrospective case review of selected patient files to evaluate the care given by an institution's primary care providers and nurses. Retrospective case review is a well-established review process used by health care organizations that perform peer reviews and patient death reviews. Currently, CCHCS uses retrospective case review as part of its death review process and in its pattern-of-practice reviews. CCHCS also uses a more limited form of retrospective case review when performing appraisals of individual primary care providers.

## *Patient Selection for Retrospective Case Reviews*

Because retrospective case review is time consuming and requires qualified health care professionals to perform it, the OIG must carefully select a sample of patient records for clinician review. Accordingly, the group of patients the OIG targeted for case review carried the highest clinical risk and utilized the majority of medical services. The majority of patients selected for retrospective case review were high-utilizing patients with chronic care illnesses who were classified as high or medium risk. The reason the OIG targeted these patients for review is twofold:

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

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

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

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

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

3. Patient cases generated during death reviews, sentinel events (unexpected occurrences involving death or serious injury, or risk thereof), and hospitalizations are more likely to comprise high-risk patients.

### *Benefits and Limitations of Targeted Subpopulation Review*

Because the patients selected utilize the broadest range of services offered by the health care system, the OIG's retrospective case review provides adequate data for a qualitative assessment of the most vital system processes (referred to as "primary quality indicators"). Retrospective case 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 institution's ability to *respond* with adequate medical care to this subpopulation is a crucial and vital indicator of how the institution provides health care to its whole patient population. Simply put, if the institution's medical system does not *respond* adequately 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 medical *conditions* or *outcomes* from the retrospective case reviews to the general population. For example, if the high-risk diabetic patients reviewed have poorly controlled diabetes, one cannot conclude that all the diabetics' conditions are poorly controlled. Similarly, if the high-risk diabetic patients under review have poor outcomes, one cannot conclude that the entire diabetic population is having similarly poor outcomes. The OIG does not extrapolate *conditions* or *outcomes*, but instead extrapolates the institution's *response* for those patients needing the most care because the *response* yields valuable system information.

In the above example, if the institution responds by providing appropriate diabetic monitoring, medication therapy, and specialty referrals for the high-risk patients reviewed, then it is reasonable to infer that the institution is also responding appropriately to all the diabetics in the prison. However, if these same high-risk patients needing monitoring, medications, and referrals are not getting those needed services, it is likely that the institution is not providing appropriate diabetic services.

### *Case Review Sampling Methodology*

Using a pre-defined case review sampling algorithm, OIG analysts apply various filters to each institution's patient population. The various filters include medical risk status, number of prescriptions, number of specialty appointments, number of clinic appointments, and other health-related data. The OIG uses these filters to narrow down the population to those patients with the highest utilization of medical resources (see Chart 1, next page). To prevent selection bias, the OIG ensures that the same clinicians who perform the case reviews do not participate in the sample selection process.

# Chart 1. Case Review Sample Selection

### Sample Selection

Analysts apply filters to the **population** to obtain **samples (S)** with high utilization. Six permutations, or arrangements, of case review types are possible for each sample.

| MD | RN |
|----|----|
| D  | F  |

| MD | RN |
|----|----|
| D  | D  |

| MD | RN |
|----|----|
| F  | D  |

| MD |
|----|
| D  |

| RN |
|----|
| D  |

| RN |
|----|
| F  |

Population

S  S  S  S  S  S

Case = Sample = Patient

MD = Provider
RN = Registered Nurse
D = Detailed Review
F = Focused Review
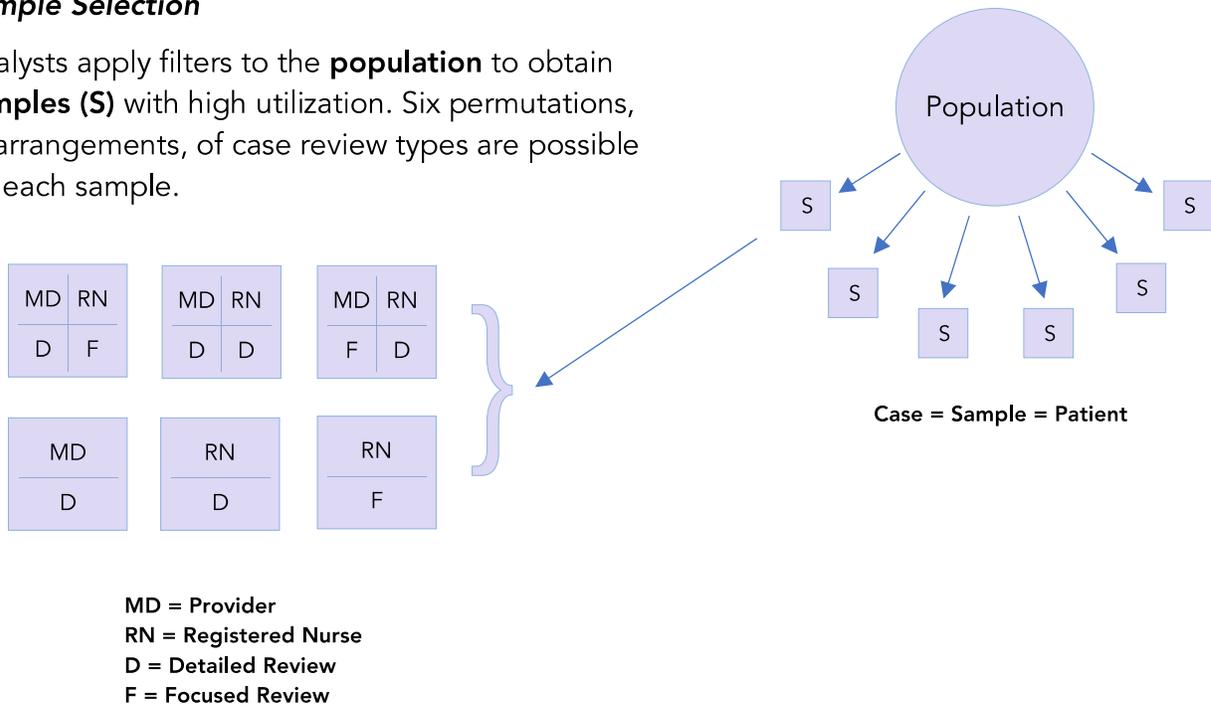
The OIG's case sample sizes matched those of other qualitative research. The empirical findings, supported by expert statistical consultants, showed adequate conclusions after 10 to 15 cases had undergone comprehensive, or detailed, clinician review. In qualitative statistics, this phenomenon is known as "saturation." The OIG found the Cycle 4 medical inspection sample size of 30 for detailed physician reviews far exceeded the saturation point necessary for an adequate qualitative review. At the end of Cycle 4 inspections, the OIG re-analyzed the case review results using half the number of cases; there were no significant differences in the ratings. To improve inspection efficiency while preserving the quality of the inspection, the OIG reduced the number of the samples for Cycle 5 medical inspections to the current levels. For most basic institutions, the OIG samples 20 cases for detailed physician review. For intermediate institutions and several basic institutions with larger high-risk populations, the OIG samples 25 cases. For California Health Care Facility, the OIG samples 30 cases for detailed physician review.

## Breadth of Case Reviews

As indicated in *Appendix B, Table B–1: ASP Sample Sets*, the OIG clinicians evaluated medical records for 50 unique patients. *Appendix B, Table B–4: ASP Case Review Sample Summary* clarifies that both nurses and physicians reviewed 11 of those cases, for 61 case reviews in total. Physicians performed detailed reviews of 20 cases, and nurses performed detailed reviews of 13 cases, totaling

33 detailed case reviews. For detailed case reviews, physicians or nurses looked at all encounters occurring in approximately six months of medical care. Nurses and physicians also performed focused reviews of an additional 28 cases. These reviews generated 580 clinical events for review (*Appendix B, Table B–3: ASP Event—Program*).

While the sample method specifically pulled only 4 chronic care patient records, i.e., 4 diabetes patients (*Appendix B, Table B–1: ASP Sample Sets*), the 50 unique patients sampled included patients with 121 chronic care diagnoses, including 2 additional patients with diabetes (for a total of 5) (*Appendix B, Table B–2: ASP Chronic Care Diagnoses*). The OIG's sample selection tool allowed evaluation of many chronic care programs because the complex and high-risk patients selected from the different categories often had multiple medical problems. While the OIG did not evaluate every chronic disease or health care staff member, the OIG did assess for adequacy the overall operation of the institution's system and staff.

## *Case Review Testing Methodology*

A physician, a nurse consultant, or both clinician inspectors review each case. The OIG clinician inspector can perform one of two different types of case review: detailed or focused (see Exhibit 1, page 5, and Chart 1, page 8)*.* As the OIG clinician inspector reviews the medical record for each sample, the inspector records pertinent interactions between the patient and the health care system. These interactions are also known as case review *events*. When an OIG clinician inspector identifies a medical error, the inspector also records these errors as case review *deficiencies*. If a deficiency is of such magnitude that it caused, or had the potential to cause, serious patient harm, then the OIG clinician records it as an *adverse deficiency* (see Chart 2, next page).

# Chart 2. Case Review Testing and Deficiencies

## Case Review Testing

The OIG clinicians examine the chosen samples, performing a **detailed case review** or a **focused case review**, to determine the events that occurred.

**Sample = Patient = Case**

Sample → Events → No Deficiency

Events → Deficiency

A sample leading to events
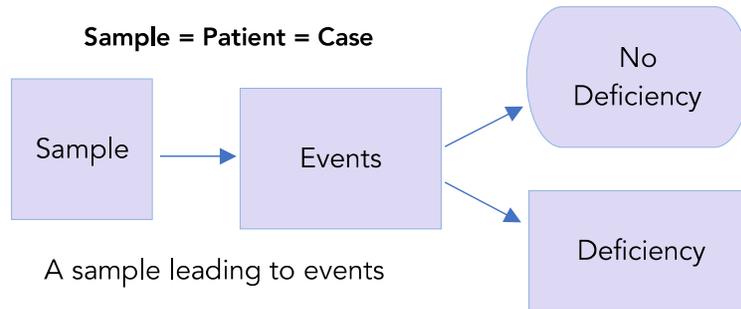
## Deficiencies

Not all events lead to deficiencies (medical errors); however, if there are errors, then the OIG clinicians determine whether any are **adverse**.

Sample → Events → Deficiency* → Adverse Deficiency

A sample leading to events with deficiencies observed

* If a deficiency is serious enough, the OIG clinician labels it **adverse**.
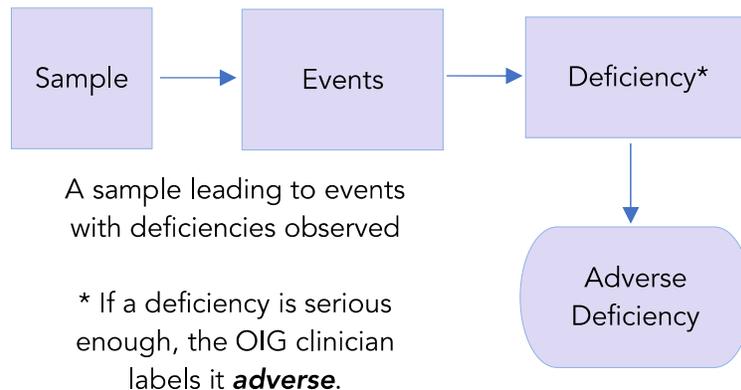
When the OIG clinician inspectors have reviewed all cases, they analyze the deficiencies. OIG inspectors search for similar types of deficiencies to determine if a repeating pattern of errors existed. When the same type of error occurs multiple times, the OIG inspectors identify those errors as findings. When the error is frequent, the likelihood is high that the error is regularly recurring at the institution. The OIG categorizes and summarizes these deficiencies in one or more health care quality indicators in this report to help the institution focus on areas for improvement.

Additionally, the OIG physicians also rate each of the detailed physician cases for adequacy based on whether the institution met the patient's medical needs and if it placed the patient at significant risk of harm. The cumulative analysis of these cases gives the OIG clinicians additional perspective to help determine whether the institution is providing adequate medical services or not.[4]

Based on the collective results of clinicians' case reviews, the OIG clinicians rated each quality indicator *proficient* (excellent), *adequate* (passing), or *inadequate* (failing). A separate confidential *ASP Supplemental Medical Inspection Results: Individual Case Review Summaries* report details the case reviews the OIG clinicians conducted and is available to specific stakeholders. For further details regarding the sampling methodologies and counts, see *Appendix B — Clinical Data, Table B-1; Table B-2; Table B-3;* and *Table B-4*.

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[4] Regarding individual provider performance, the OIG did not design the medical inspection to be a focused search for poorly performing providers; rather, the inspection assesses each institution's systemic health care processes. Nonetheless, while the OIG does not purposefully sample cases to review each provider at the institution, the cases usually involve most of the institutions' providers. Providers should only escape OIG case review if institutional managers assigned poorly performing providers the care of low-utilizing and low-risk patients, or if the institution had a relatively high number of providers.

# COMPLIANCE TESTING

## *Sampling Methods for Conducting Compliance Testing*

Our nurse inspectors attained answers to 86 objective medical inspection test (MIT) questions designed to assess the institution's compliance with critical policies and procedures applicable to the delivery of medical care. To conduct most tests, inspectors randomly selected samples of patients for whom the testing objectives were applicable and reviewed their electronic unit health records. In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed health records for 381 individual patients and analyzed specific transactions within their records for evidence that critical events occurred. Inspectors also reviewed management reports and meeting minutes to assess certain administrative operations. In addition, during the week of August 28, 2017, field registered nurse inspectors conducted a detailed onsite inspection of ASP's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,042 scored data points to assess care.

In addition to the scored questions, the OIG obtained information from the institution that it did not score. This included, for example, information about ASP's plant infrastructure, protocols for tracking medical appeals and local operating procedures, and staffing resources.

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

## *Scoring of Compliance Testing Results*

After compiling the answers to the 86 questions for the ten applicable indicators, the OIG derived a score for each quality indicator by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Based on those results, the OIG assigned a rating to each quality indicator of *proficient* (greater than 85.0 percent), *adequate* (between 75.0 percent and 85.0 percent), or *inadequate* (less than 75.0 percent).

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

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

To derive an overall assessment rating of the institution's medical inspection, the OIG evaluated the various rating categories assigned to each of the quality indicators applicable to the institution, giving more weight to the rating results of the primary quality indicators, which directly relate to the health care provided to patients. Based on that analysis, OIG experts made a considered and measured overall opinion about the quality of health care observed.

## POPULATION-BASED METRICS

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

# MEDICAL INSPECTION RESULTS

The OIG's case review and clinician teams use quality indicators to assess the clinical aspects of health care. The *ASP Executive Summary Table* on page *iv* of this report identifies the 13 indicators applicable to this institution. The following chart depicts their union and intersection:

**Chart 3. Inspection Indicator Review Distribution**



Case Review

- 3 — Emergency Services
- 10 — Quality of Nursing Performance
- 11 — Quality of Provider Performance

1 — Access to Care
2 — Diagnostic Services
4 — Health Information Management
6 — Inter- and Intra-System Transfers
7 — Pharmacy and Medication Management
13 — Specialized Medical Housing
14 — Specialty Services

Compliance

- 5 — Health Care Environment
- 9 — Preventive Services
- 15 — Administrative Operations
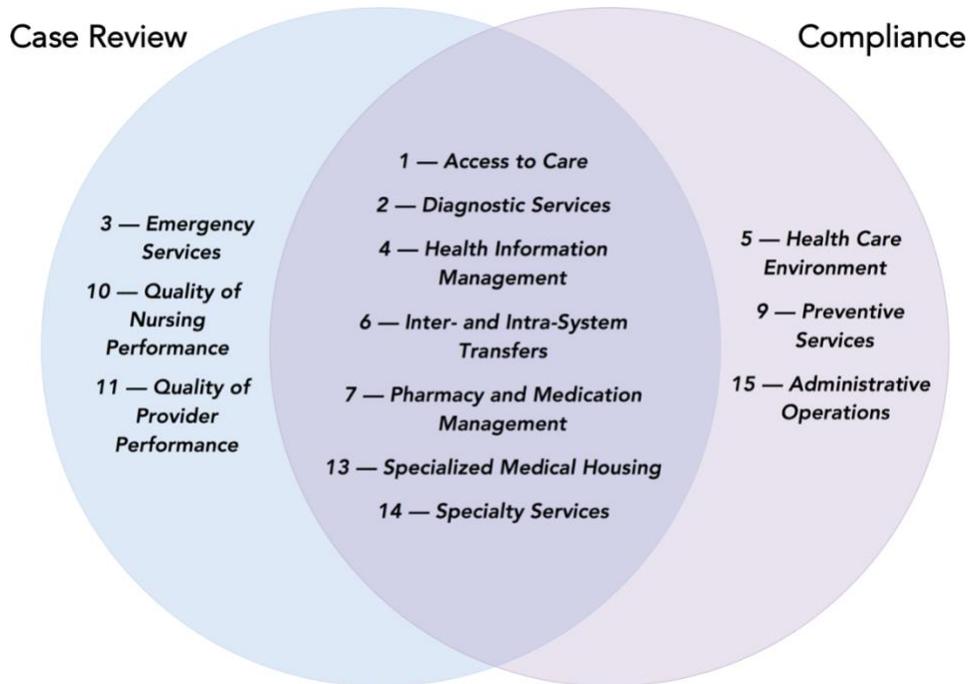
The *Administrative Operations* indicator is a secondary indicator; therefore, the OIG did not rely upon this indicator when determining the institution's overall score. Based on the analysis and results in all the primary indicators, the OIG experts made a considered and measured opinion that the quality of health care at ASP was **adequate**.

**Summary of Case Review Results:** The clinical case review component assessed 10 of the 12 primary (clinical) indicators applicable to ASP. Of these 10 indicators, OIG clinicians rated 5 *proficient* and 5 *adequate*.

The OIG physicians rated the overall adequacy of care for each of the 20 detailed case reviews they conducted. Of these 20 cases, 2 were *proficient*, 14 were *adequate*, and 4 were *inadequate*. In the 580 events reviewed, there were 69 deficiencies, of which 17 were considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

**Adverse Deficiencies Identified During Case Review:** Adverse deficiencies are medical errors that markedly increased the risk of, or resulted in, serious patient harm. Medical care is a complex and dynamic process with many moving parts, subject to human error even within the best health

care organizations. All major health care organizations typically identify and track adverse deficiencies for the purpose of quality improvement. Adverse deficiencies are not typically representative of medical care delivered by the organization. The OIG normally identifies adverse deficiencies for the dual purposes of quality improvement and the illustration of problematic patterns of practice found during the inspection. Because of the anecdotal nature of these deficiencies, the OIG cautions against drawing inappropriate conclusions regarding the institution based solely on adverse deficiencies.

There were two adverse deficiencies in the case reviews at ASP.

- In case 2, the patient returned from the hospital, but the provider did not address a 19mm lung nodule, which could have been cancer. By overlooking the findings, the provider placed the patient at risk of delayed diagnosis and treatment of possible cancer. Fortunately, ASP addressed the problem after the OIG informed the institution of the situation, and the nodule was benign. We also discuss this case in the *Quality of Provider Performance* indicator.

- In case 22, a provider reviewed several laboratory tests showing high potassium levels and an electrocardiogram (EKG, a test to measure the heart's electrical activity) which showed that the patient was at risk for a dangerous heart rhythm disturbance. When the potassium rose to a critically high level, the provider did not treat the dangerous potassium levels or obtain a repeat EKG to determine if the patient needed emergent treatment. These errors placed the patient at risk of serious complications such as arrhythmia and death. Fortunately, ASP addressed the problem after the OIG informed the institution of the situation. We also discuss this case in the *Quality of Provider Performance* indicator.

**Summary of Compliance Results**: The compliance component assessed 10 of the 13 indicators applicable to ASP. Of these ten indicators, OIG inspectors rated five *proficient*, two *adequate*, and three *inadequate*. We detail the test questions used to assess compliance for each indicator in *Appendix A*.

# 1 — ACCESS TO CARE

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

> *Case Review Rating:*
> *Proficient*
> *Compliance Score:*
> *Proficient*
> *(90.4%)*
>
> *Overall Rating:*
> *Proficient*

## Case Review Results

We reviewed 419 provider, nurse, specialty, and hospital events that required a follow-up appointment and identified 12 deficiencies relating to *Access to Care,* of which 5 were significant. The case review rating for *Access to Care* was *proficient*.

### Provider-to-Provider Follow-up Appointments

Provider-ordered follow-up appointments are important elements of access to care. ASP performed well with these appointments. We identified only one minor deficiency, and most appointments occurred timely.

### RN Sick Call Access

ASP performed well with sick call access. ASP scheduled most sick call appointments timely. Nursing sick call appointments had no backlog. We reviewed 52 sick call events and identified only one minor scheduling delay.

### RN-to-Provider Referrals

Sick call nurses assess patients and make referrals to a provider when needed. ASP had difficulty with scheduling timely RN-to-provider appointments. Of the seven occurrences in which an RN referred the patient to a provider, we found three deficiencies, two of which were significant:

- In case 15, the RN requested a provider appointment within 14 days to evaluate the patient's chronic back pain. This appointment did not occur.

- In case 34, the RN requested a provider appointment within 14 days to evaluate the patient's arthritic pain. The appointment occurred six weeks later.

**RN Follow-up Appointments**

ASP performed well with scheduling and completing RN appointments generated by providers or other nurses. Most RN appointments occurred within the time frames specified, and there were only two minor delays.

**Intra-System Transfers**

ASP performed well with ensuring timely provider and RN appointments for patients who transferred in from other CDCR facilities. Of the six patients reviewed who transferred into ASP, five patients received provider and RN appointments within 30 days. One patient's appointment occurred three days late. All pending specialty appointments occurred timely.

**Follow-up After Hospitalization**

Providers should see patients returning from hospitalization within a time frame that ensures patient safety and optimal clinical outcomes, but in no case later than five days from the discharge date. ASP performed well with these appointments. We reviewed 17 hospital returns, and all follow-up appointments occurred timely.

**Specialized Medical Housing**

ASP providers completed history and physical examinations timely for all newly admitted Outpatient Housing Unit (OHU) patients and saw the patients regularly. There were no deficiencies in this area.

**Access to Specialty Services**

We found that most specialty appointments took place within the requested time frame. There were only two deficiencies in this area, one of which was a significant delay:

- In case 48, a provider ordered a follow-up with a lung specialist within two weeks. The appointment did not occur until one month later.

**Provider Follow-up After Specialty Service Visits**

Providers should evaluate all patients within 14 days after a routine specialty service visit, or earlier if indicated. ASP performed well with these appointments, but we identified two significant deficiencies:

- In case 22, an orthopedic surgeon saw the patient, but the patient did not receive a follow-up with the primary provider until six weeks later.

- In case 31, after an ophthalmologist saw the patient, there was no follow-up appointment with the primary provider.

**Follow-up After Urgent/Emergent Care**

ASP performed well scheduling provider follow-ups after TTA events. All appointments occurred within the specified time frame.

**Clinician Onsite Inspection**

During the onsite visit, clinic nurses reported seeing about 10 patients each day in the RN clinics, and providers reported seeing about 14 patients each day. Each of the six clinics had a designated office technician who attended daily clinic huddles and coordinated with the providers to ensure that they scheduled important follow-up appointments. Staff reported that there were no provider or nursing appointment backlogs.

**Case Review Conclusion**

ASP performed well in the *Access to Care* indicator. Most provider, nursing, and specialty appointments occurred timely. We rated ASP *proficient* in this area.

## *Compliance Testing Results*

The institution earned a *proficient* compliance score of 90.4 percent in the *Access to Care* indicator. The following tests earned scores in the *proficient* range:

- We reviewed recent appointments for 25 patients with chronic care conditions and found that 22 (88.0 percent) received timely routine appointments. One patient's appointment was five days late, one patient's appointment was 117 days late, and one patient did not receive a chronic care appointment at all (MIT 1.001).

- We sampled 30 Health Care Services Request forms (CDCR Form 7362) submitted by patients across all facility clinics. Nursing staff reviewed all service request forms the same day they collected them (MIT 1.003). Nursing staff also completed timely face-to-face triage encounters for all 30 patients (MIT 1.004).

- We sampled 12 health care services request forms on which the nurse referred the patient for a provider appointment. Eleven (11) patients (91.7 percent) received a timely appointment. The one exception was a patient for whom there was no evidence that an appointment occurred at all (MIT 1.005).

- Of the three sampled patients who a nurse referred to and was seen by a provider, and for whom that provider subsequently ordered a follow-up appointment, all three patients received their follow-up appointments timely (MIT 1.006).

- Patients had access to health care services request forms at all six housing units we inspected (MIT 1.101).

Three tests earned *adequate* scores:

- Primary care provider visits timely occurred for 19 of 25 sampled patients who either transferred into ASP with a pre-existing chronic care condition requiring provider follow-up or received a new provider referral during intake screening (76.0 percent). For three patients, appointments occurred 2, 10, and 11 days late. For four patients, appointments occurred 2 to 46 days late. For the remaining two patients, a provider's follow up appointment did not occur at all (MIT 1.002).

- Fourteen of 17 sampled patients who returned from a community hospital (82.4 percent) received a timely provider follow-up appointment upon their return to ASP. Two patients received their follow-up appointments one and two days late. For the remaining patient, there was no evidence that the provider addressed his hospital return (MIT 1.007).

- We sampled 29 patients who received provider-ordered specialty services; 22 of them (75.9 percent) received a timely follow-up appointment with the provider. Six patients received follow-up appointments from 2 to 21 days late. One patient's follow-up appointment was 72 days late (MIT 1.008).

## 2 — *DIAGNOSTIC SERVICES*

This indicator addresses whether ASP provided timely radiology and laboratory services to patients, whether primary care providers timely reviewed the results, and whether providers communicated the results to patients within the required time frame. For pathology services, the OIG determines whether the institution received a final pathology report and whether the provider timely reviewed and communicated the pathology results to the patient. Case reviews in addition evaluate the appropriateness of the diagnostic test(s) and of the clinical response to the results.

> *Case Review Rating:*
> *Proficient*
>
> *Compliance Score:*
> *Adequate*
> *(75.4%)*
>
> *Overall Rating:*
> *Proficient*

For this indicator, the case review and compliance review processes yielded different results, with the case reviewers assigning a *proficient* rating and the compliance testing resulting in an *adequate* score. The main reason for the lower compliance score was that providers did not properly communicate laboratory and pathology results to their patients. However, the case reviews showed that while providers did not consistently send result notifications to their patients, they discussed the results with their patients during their appointments. Because the deficient notification process did not increase the risk of harm, we determined that the overall rating for this indicator was *proficient*.

## Case Review Results

We reviewed 56 events in diagnostic services and found only one minor deficiency. The case review rating of the *Diagnostic Services* indicator at ASP was *proficient*.

**Test Completion**

ASP had an effective laboratory process, completing most laboratory tests timely. ASP also had an effective diagnostic procedure process, completing most x-rays, ultrasounds, CT scans, and MRI scans timely. We found no deficiencies.

**Health Information Management**

Health Information Management timely retrieved and scanned most laboratory reports, diagnostic procedure reports, and pathology reports into the medical records. We found only one minor deficiency, a mislabeled diagnostic report.

**Clinician Onsite Inspection**

Each of the main clinics had an assigned phlebotomist to ensure timely laboratory draws. ASP also had an effective tracking process to ensure timely diagnostic procedures.

**Case Review Conclusion**

We rated the *Diagnostic Services* indicator at ASP *proficient*, finding only one minor deficiency, a mislabeled diagnostic report. ASP completed laboratory and other diagnostic tests as requested, retrieving and scanning them timely into the medical record.

## *Compliance Testing Results*

The institution earned an *adequate* compliance score of 75.4 percent in the *Diagnostic Services* indicator, which encompasses radiology, laboratory, and pathology services. For clarity, we discuss each type of diagnostic service separately below.

**Radiology Services**

- ASP performed ordered radiology services for all ten patients sampled timely (MIT 2.001). Providers then timely reviewed the corresponding diagnostic services reports for six of the ten patients (60.0 percent); providers reviewed one patient's report three days late. For the remaining three patients, we found no evidence the providers reviewed their reports (MIT 2.002). Among the original ten patients sampled, one transferred out of the institution before the primary care provider could communicate the radiology results. Providers timely communicated test results to eight of the remaining nine patients (88.9 percent); a provider communicated one patient's test result 73 days late (MIT 2.003).

**Laboratory Services**

- ASP timely performed all ten sampled laboratory services, and providers also reviewed the resulting reports timely (MIT 2.004, 2.005). Providers communicated the corresponding laboratory reports timely to only one of the ten patients (10.0 percent). For the remaining nine patients, the written communications they received from their provider failed to identify the laboratory tests referenced (MIT 2.006).

**Pathology Services**

- The institution retrieved the final pathology report timely for nine of ten patients sampled (90.0 percent). For one patient, the institution received the pathology report 22 days late (MIT 2.007). Providers then timely reviewed the pathology reports for nine of the ten patients sampled (90.0 percent). A provider did not review one patient's final pathology report (MIT 2.008). Lastly, providers communicated final pathology results timely to only four of the ten patients sampled (40.0 percent). For three patients, providers communicated their pathology results one, 25, and 84 days late. For the remaining three patients, providers did not identify the type of test reported in their written communications (MIT 2.009).

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

> *Case Review Rating:*
> *Proficient*
>
> *Compliance Score:*
> *Not Applicable*
>
> *Overall Rating:*
> *Proficient*

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

## Case Review Results

We reviewed 14 cases that yielded 21 urgent/emergent events. There were 11 deficiencies, the majority of which were nurse documentation deficiencies. Only one of these deficiencies were significant. The case review rating of the *Emergency Services* indicator at ASP was *proficient*.

**CPR Response**

The CPR response was appropriate in the three cases reviewed. We identified minor documentation deficiencies related to a late medication entry (case 4) and incomplete documentation of CPR (case 5). These minor deficiencies did not affect patient care.

**Provider Performance**

ASP providers performed well in emergency services. Providers were readily available and made appropriate decisions. There were no provider deficiencies. ASP providers effectively utilized outside diagnostic services before sending patients to community emergency departments.

- In case 20, medical staff sent a patient with abdominal pain to an offsite radiology service, where a CT scan revealed appendicitis. The patient went from the offsite radiology service directly to a community hospital for surgical intervention. If the CT scan had been normal, the patient might have been returned to the institution safely, thus potentially avoiding an unnecessary emergency room visit. This thoughtfully planned intervention was a good practice.

**Nursing Performance**

ASP nurses performed well in emergency care. Nursing performance during emergency responses was suitable and proper. Nurses made timely and accurate patient assessments, interventions, and reassessments. ASP nurses normally collaborated with the providers to provide good emergency care. However, there were three nursing assessment deficiencies in the 14 applicable cases reviewed:

- In case 6, the patient complained of stomach pain, but the nurse did not listen for bowel sounds or examine the abdomen.

- In case 18, the patient was in the TTA for symptoms of dizziness, nausea, cough, and chills. Before releasing the patient back to his regular housing unit, the TTA RN did not check to see if the patient's symptoms had improved.

- In case 19, the patient re-injured his hand while playing softball. The initial nurse did not record which hand or fingers were involved and did not record the extent of the laceration.

**Nursing Documentation**

Nursing documentation was not always complete or appropriate. There were nine deficiencies in which nurses did not record the full details of the interventions they provided during emergency response events. These deficiencies included poor documentation of intravenous fluid administration, full details of CPR, the location of the emergency event, the effectiveness of medication or treatments, the patient's condition on TTA discharge, and the description of wounds. Most of these documentation deficiencies were not significant, except the following:

- In case 5, the TTA nurse did not record important details of the emergency response, including when staff performed CPR, when the patient began to breathe on his own, whether there was a pulse, when or how much the nurse gave of a second dose of naloxone (medication to reverse opioid overdose), or when the paramedics arrived or left with the patient.

- In case 18, the TTA nurse did not record when the patient arrived in the TTA, whether breathing treatments were effective, or how much intravenous fluid the nurse gave the patient.

**Emergency Medical Response Review Committee**

The Emergency Medical Response Review Committee (EMRRC) was an active working committee at ASP. Medical and nursing administrative staff reviewed emergency response "codes" daily. The EMRRC discussed significant clinical issues, environmental issues (such as parking exemptions for emergency transport vehicles), policy changes and policy reinforcement (such as a policy that prohibited the use of verbal orders). Clinical managers conducted surprise monthly training drills at

different areas throughout the institution. The nursing instructor completed training drill report summaries that included participants' comments and suggestions for improvements.

**Clinician Onsite Inspection**

ASP staffed the TTA appropriately with two nurses assigned during each shift for 24-hour coverage. The TTA nursing staff was knowledgeable and experienced in emergency procedures. ASP assigned a provider to the TTA during daytime hours, and on-call providers were available after hours. The TTA had two beds with sufficient medical supplies and equipment to handle emergency medical responses. The housing unit custody staff and TTA nursing staff communicated effectively via radios during emergent events.

**Case Review Conclusion**

Clinical and custody staff provided effective and timely emergency responses, assessments, and treatments. Clinical staff made sound decisions based on patients' clinical conditions, including chest pain, racing heart rate, loss of consciousness, drug overdose, and physical injury. In most of the cases, TTA staff provided appropriate assessments, interventions, and monitoring during emergency medical responses. While ASP nurses could improve with their consistency in making good assessments and recording accurate documentation, the ASP providers consistently made good decisions and they were able to mitigate the errors successfully. We rated the *Emergency Services* indicator at ASP *proficient.*

Health information management is a crucial link in delivering 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, organized, and available in the electronic health record system (EHRS); whether the various medical records (internal and external, e.g., hospital and specialty reports and progress notes)

> *Case Review Rating:*
> *Proficient*
> *Compliance Score:*
> *Inadequate*
> *(72.9%)*
>
> *Overall Rating:*
> *Adequate*

are obtained and scanned timely into the EHRS; whether records routed to clinicians include legible signatures or stamps; and whether hospital discharge reports include key elements and are timely reviewed by providers.

For this indicator, the case review and compliance review processes yielded different results, with the case reviewers assigning a *proficient* rating and the compliance testing resulting in an *inadequate* score. The main reason for the *inadequate* score was that ASP had problems with mislabeled and misfiled documents as well as difficulty with retrieving outside hospital discharge summaries and ensuring prompt provider review. The processing of hospital discharge summaries is a key component of good patient care, and ASP can improve substantially in that area. We determined that the most appropriate rating for this indicator was *adequate*.

## Case Review Results

During the Cycle 5 case review, we reviewed 580 clinical events and identified three health information management deficiencies, only one of which was significant. The case review rating of the *Health Information Management* indicator was *proficient.*

### Interdepartmental Transmission

We did not identify any problems when staff transmitted health information between departments within the institution.

### Hospital Records

We reviewed 17 offsite emergency department and hospital visits. ASP timely retrieved, reviewed, and scanned hospital records into the medical record. There was one significant deficiency:

- In case 4, after the patient returned from an emergency department visit, ASP did not scan the hospital report into the medical record until 11 months later.

**Missing Documents (Progress Notes and Forms)**

ASP scanned most nursing and provider progress notes into the medical record. We identified only two minor deficiencies related to missing provider orders.

**Laboratory, Diagnostic, and Pathology Reports**

ASP retrieved and scanned laboratory results, diagnostic procedure reports, and pathology reports into the medical records. There were no deficiencies.

**Specialty Services Reports**

ASP timely retrieved and scanned specialty services reports into the medical record. We identified no deficiencies.

**Legibility**

Providers and nurses dictated most progress notes, which increases legibility.

**Scanning Performance**

ASP timely scanned and correctly labeled most documents. We identified one minor deficiency related to a mislabeled diagnostic report.

**Clinician Onsite Inspection**

ASP medical record staff retrieved and scanned medical records as soon as they received them. ASP staff filed X-ray, ultrasound, CT scan, MRI scan, and bone scan reports in a separate database; nevertheless, providers reviewed the reports and acknowledged them in their progress notes.

**Case Review Conclusion**

We identified only rare health information deficiencies in the case reviews and rated the *Health Information Management* indicator *proficient.*

## *Compliance Testing Results*

The institution received an *inadequate* compliance score of 72.9 percent in this indicator, with the following two tests showing room for improvement:

- ASP scored 33.3 percent in its labeling and filing of documents scanned into patients' electronic medical records. For this test, once we identify 24 mislabeled or misfiled documents, we deduct the maximum points, and the resulting score is zero. During this inspection, ASP mislabeled 16 documents (MIT 4.006).

- Among 17 sampled patients admitted to a community hospital and then returned to the institution, ASP's providers timely reviewed only nine corresponding hospital discharge

reports within three calendar days of the discharge date (52.9 percent). Providers reviewed four reports either one or two days late and reviewed one other report 23 days late. A provider did not review another report at all. For yet another report, the provider initialed and dated the first page of the hospital packet but did not evidence review by initialing and dating the actual hospital discharge report. For the final patient, we found no evidence of the hospital discharge documents in the electronic medical record (MIT 4.007).

Two tests received *adequate* scores:

- Staff scanned 16 of 20 specialty service consultant reports into the patients' electronic medical records within five calendar days (80.0 percent). However, four documents were scanned two to four days late (MIT 4.003).

- ASP timely scanned 13 of the 16 sampled community hospital discharge reports or treatment records into patients' electronic medical records (81.3 percent); three reports were scanned 2 to 22 days late (MIT 4.004).

Two tests received *proficient* scores:

- The institution timely scanned nine of ten sampled non-dictated health care documents (90.0 percent) into patients' electronic medical records. One non-dictated health care document was scanned one day late (MIT 4.001).

- ASP scored 100 percent for scanning the one applicable dictated or transcribed provider progress note into the Electronic Unit Health Record (eUHR) timely (MIT 4.002).

# 5 — *HEALTH CARE ENVIRONMENT*

This indicator addresses the general operational aspects of the prison's clinics, including certain elements of infection control and sanitation, medical supplies and equipment management, availability of auditory and visual privacy for inmate-patient visits, and the adequacy of facility infrastructure for conducting comprehensive medical examinations. For most institutions, the rating for this component relies entirely on compliance testing results from the visual observations that inspectors make during on-site visits.

> *Case Review Rating:*
> *Not Applicable*
> *Compliance Score:*
> *Inadequate*
> *(52.3%)*
>
> *Overall Rating:*
> *Inadequate*

## *Compliance Testing Results*

The institution received an *inadequat*e compliance score of 52.3 percent in the *Health Care Environment* indicator, showing room for improvement in the following areas:

- We observed clinician encounters with patients in nine clinics. Clinicians followed good hand hygiene practices in only two clinic locations (22.2 percent). At seven clinic locations, clinicians failed to wash their hands before or after patient contact or before applying gloves (MIT 5.104).

- The non-clinic bulk medical supply storage areas did not follow the supply management process and did not support the needs of the health care program, resulting in a score of zero for this test. We noted the following deficiencies: managers expressed concern that crash cart medical supplies were still pending receipt after ordering them several months prior, and we found medical supplies that were kept beyond manufacturers' guidelines (*Figure 1*) and stored directly on the floor (MIT 5.106).



*Figure 1: Expired medical supplies (these electrodes expired more than a year before the inspection)*

- Only two of the ten clinics inspected followed adequate medical supply storage and management protocols (20.0 percent). We found eight clinics had one or more of the following deficiencies: staff reported that there was no system in place to replenish medical supplies on a regular basis; clinics stored medical supplies beyond manufacturers' guidelines; and medical supplies were not clearly identifiable (MIT 5.107).

- Only four of the ten clinic locations (40.0 percent) met compliance requirements for essential core medical equipment and supplies. The remaining six clinics were missing one or more functional pieces of properly calibrated core equipment or other medical supplies necessary to conduct a comprehensive exam. The missing items included an exam table, an oto-ophthalmoscope, a sharps container, lubricating jelly, and tongue depressors. In addition, several digital thermometers did not have calibration stickers or had expired calibration stickers (MIT 5.108).

- Only two of nine clinic exam rooms we observed (22.2 percent) had appropriate space, configuration, supplies, and equipment to allow clinicians to perform a proper clinical examination. The remaining seven clinics had one or more of the following deficiencies: exam rooms did not have a portable screen available for visual privacy; clinicians have impeded access to an examination table; and staff stored personal belongings in the same area with exam room supplies (MIT 5.110).

- We examined emergency response bags (EMRBs) to determine if staff inspected the bags daily and inventoried them monthly, and whether they contained all essential items. EMRBs were compliant in only one of the eight applicable clinical locations (12.5 percent). We found one or more of the following deficiencies at seven locations: staff had failed to inventory the EMRB within the last 30 days; staff failed to verify that the bag's compartments were sealed and intact; several EMRBs were missing oxygen tank wrenches (*Figure 2*) needed for the operation of the oxygen tanks; and the crash cart was missing minimum levels of the medical supplies (MIT 5.111).



*Figure 2: EMRB missing oxygen tank wrenches needed for operation*

One test scored in the *adequate* range:

- Clinic staff appropriately disinfected, cleaned, and sanitized eight of the ten clinics examined (80.0 percent). Clinic staff did not properly maintain the remaining two clinics; we found filled trash bins that staff had not emptied the day prior (MIT 5.101).

Four tests earned *proficient* scores:

- Clinical health care staff at eight of the nine applicable clinics (88.9 percent) ensured that they properly sterilized or disinfected reusable invasive and non-invasive medical

equipment. Clinical staff in one clinic failed to mention disinfecting the examination table before the start of shift as part of their daily start-up protocol (MIT 5.102).

- We examined ASP's ten clinics to verify that adequate hygiene supplies were present and sinks were operable; all clinics were compliant (MIT 5.103).

- When inspecting for proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste, we found nine of the ten clinics (90.0 percent) compliant. In one clinic, we found the sharps container inaccessible at the time of inspection (MIT 5.105).

- All ten clinics had an environment conducive to providing medical services (MIT 5.109).

**Non-Scored Results**

We gathered information to determine if the staff maintained the institution's physical infrastructure in a manner that supported health care management's ability to provide timely or adequate health care. We did not score this question. When we interviewed health care managers, they did not have concerns about the facility's infrastructure or its effect on the staff's ability to provide adequate health care. At the time of inspection, ASP did not have any infrastructure projects (MIT 5.999).

This indicator focuses on the management of patients' medical needs and continuity of patient care during the inter- and intra-facility transfer process. The patients reviewed for *Inter- and Intra-System Transfers* include inmates received from other CDCR facilities and inmates transferring out of Avenal State Prison to another CDCR facility. The OIG review includes evaluation of the institution's ability to provide and document health screening assessments, initiation of relevant referrals based on patient needs, and the

> **Case Review Rating:**
> *Adequate*
> **Compliance Score:**
> *Proficient*
> *(91.4%)*
>
> **Overall Rating:**
> *Adequate*

continuity of medication delivery to patients arriving from another institution. For those patients, the OIG clinicians also review the timely completion of pending health appointments, tests, and requests for specialty services. For patients who transfer out of the facility, the OIG evaluates the institution's documentation of transfer information that should include preexisting health conditions, pending appointments, tests and requests for specialty services, medication transfer packages, and medication administration prior to transfer. OIG clinicians also evaluate the care provided to patients returning to the institution from an outside hospital and assess whether the implementation of the hospital assessment and treatment plans was appropriate.

For this indicator, the case review and compliance review processes yielded different results, with the case reviewers assigning an *adequate* rating and the compliance testing resulting in a *proficient* score. After in-depth analysis of the compliance data across various indicators, we determined that the *proficient* score was not representative of ASP's transfer performance. Although our compliance testing methodology resulted in a *proficient* score, pertinent compliance tests found in other indicators revealed that ASP had room for improvement in several critical areas: ensuring timely provider follow-ups after hospitalization, retrieving and reviewing hospital discharge summaries, and maintaining medication continuity for patients returning from the hospital or transferring from another CDCR institution. Considering all the relevant case review and compliance factors, we determined the rating for this indicator was *adequate*.

## Case Review Results

We reviewed 15 cases requiring outside hospitalization and emergency room events, 6 cases in which patients arrived from other CDCR institutions, and 9 cases in which patients transferred out to other institutions. These reviews resulted in 52 events related to the inter and intra-system transfer processes. There were eight deficiencies, three of which were significant. Computer system issues caused breaks in medication continuity in two of these cases. The case review rating of the *Inter- and Intra-System Transfers* indicator at ASP was *adequate*.

### Transfers In

The nurses at ASP performed thorough screening examinations for the six newly-arrived patients we reviewed. Nurses asked their patients if they had any current medical complaints and explained

how to request health services. LVNs evaluated new chronic care patients timely and provided written information relevant to their medications and diagnoses. While nurses usually performed appropriate screening, there was one case in which the nurse did not:

- In case 24, the R&R nurse did not assess the diabetic patient's vital signs and blood glucose level upon the patient's arrival at ASP. The nurse noted the patient was high-priority for medical provider assessment but scheduled the patient for a 30-day follow-up appointment instead of the policy-required 7-day appointment.

Medication administration records revealed that patients normally received their medications without lapses, but two cases demonstrated significant exceptions. In cases 2 and 25, computer problems caused significant lapses in the administration of essential medications. These patients did not receive medications timely for blood pressure, depression, anxiety, and valley fever. In both cases, the R&R nurses did not use the established procedures to reconcile and ensure continuity of medications for transferring patients when the electronic medical records system was "down," or not working.

- In case 2, the patient received his prescribed medications three days late.

- In case 25, the patient did not receive his antihypertensive and antifungal medications for two weeks.

**Transfers Out**

Case reviewers evaluated nine cases in which ASP transferred patients to other institutions. ASP performed very well in this area; there were no deficiencies. Nurses diligently recorded necessary medical equipment, such as canes, walkers, and hearing-impaired vests in their documentation. Nurses also noted that their patients' medical conditions were stable before transfer out. Nurses conscientiously recorded all current medications and gave their patients a five-day supply of medications before transfers.

Nurses ensured communication of pending specialty appointments to receiving institutions. For example, a nurse sent an email to the receiving institution concerning a pending general surgery appointment for evaluating a scalp lesion. Nurses also informed the receiving institution of pending vaccinations.

**Hospitalizations**

Patients returning from hospitalizations are some of the highest-risk encounters due to two factors. First, these patients usually require hospitalization for a severe illness or injury, and second, they are at risk due to potential lapses in care that can occur during any transfer.

ASP performed well in this area. Nurses in the TTA scheduled timely follow-up appointments for patients returning from hospitalizations or emergency room visits and consulted with the providers after reviewing hospital discharge recommendations. ASP timely retrieved, reviewed, and scanned

hospital records into the medical record. However, there was one significant deficiency related to delayed scanning of a hospital record:

- In case 4, the patient returned from an emergency department visit because of loss of consciousness. ASP did not scan the hospital report into the medical record until 11 months later.

**Clinician Onsite Inspection**

TTA nurses assessed all patients who returned from hospitalizations. They provided appropriate verbal instructions and written materials to educate patients and gave patients the opportunity to discuss and ask questions. The receiving and release nurses were knowledgeable about their job duties and the transfer process.

**Case Review Conclusion**

ASP performed sufficiently regarding the *Inter- and Intra-System Transfers* indicator, but the institution had some difficulty maintaining medication continuity for patients transferring in from other CDCR institutions. The case review rating of this indicator was *adequate.*

## *Compliance Testing Results*

The institution earned a *proficient* compliance score of 91.4 percent in the *Inter- and Intra-System Transfers* indicator, with the following tests scoring in the *proficient* range:

- For 22 of 25 sampled patients who transferred into ASP from other CDCR institutions (88.0 percent), nursing staff completed an Initial Health Screening (CDCR Form 7277) on the same day the patient arrived. For one patient, nursing staff neglected to record an answer for one of the screening questions. For another patient, nursing staff did not explain an affirmative answer to one of the screening questions. For one final patient, nursing staff did not document a complete set of vital signs (MIT 6.001).

- Nursing staff timely completed the assessment and disposition section of the screening form for all 25 patients sampled (MIT 6.002).

- We inspected the transfer packet of one patient who was transferred out of the facility and determined that the packet included required medications and support documentation (MIT 6.101).

- We sampled seven patients who transferred from ASP to other CDCR institutions to determine whether staff at ASP listed their scheduled specialty service appointments on the Health Care Transfer Information form (CDCR Form 7371). Nursing staff documented previously approved and pending specialty service appointments for six patients but failed to do so for one other (85.7 percent) (MIT 6.004).

The institution received an *adequate* score on one test:

- Among 12 applicable patients sampled who transferred into ASP from other CDCR institutions with an existing medication order, 10 patients received their medications without interruption (83.3 percent). One patient missed one dose of a directly observed therapy (DOT) medication; the other patient incurred a one-week interruption of a keep-on-person (KOP) medication (MIT 6.003).

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

> *Case Review Rating:*
> *Adequate*
> *Compliance Score:*
> *Inadequate*
> *(65.5%)*
>
> *Overall Rating:*
> *Inadequate*

For this indicator, the case review and compliance review processes yielded different results, with the case reviewers assigning an *adequate* rating and the compliance testing resulting in an *inadequate* score. The main reason for the *inadequate* score was that ASP had severe problems with two compliance sub-indicators: Observed Medication Practices and Storage Controls; and Pharmacy Protocols, both of which received *inadequate* scores. We determined that the most appropriate rating for this indicator was *inadequate*.

## Case Review Results

We evaluated 26 events related to medications and found 6 deficiencies, 4 of which were significant. The case review rating for this indicator was *adequate*.

**Medication Continuity**

There were two significant deficiencies related to lapses in medication continuity for newly arrived patients. The *Inter- and Intra-System Transfers* indicator discusses those deficiencies.

**Medication Administration**

Nursing staff accurately and timely administered prescribed KOP and nurse-administered medications.

**Pharmacy Availability of Medications**

ASP pharmacy staff did not always ensure that essential medications such as antibiotics, seizure medications, and blood pressure medications were available. There was one significant deficiency:

- In case 50, the provider ordered an important blood thinner to prevent blood clots after the patient sustained a leg fracture. The institution did not provide the blood thinner for two days.

- In case 52, medical staff prescribed the patient intravenous antibiotics for a jaw infection. The patient did not receive the medication for one day because the antibiotic was not available, placing the patient at risk for undertreated infection.

**Clinician Onsite Inspection**

During the onsite visit, the patient care teams discussed medication issues in the morning huddles. Staff discussed patients that refused their medications while the pharmacist advised providers of expiring medications that needed to be renewed.

**Case Review Conclusion**

ASP performed acceptably regarding *Pharmacy and Medication Management*, though there was room for improvement with medication continuity for newly-arrived patients and the availability of essential medications. The case review rating for this indicator was *adequate*.

## *Compliance Testing Results*

The institution received an *inadequate* compliance score of 65.5 percent in the *Pharmacy and Medication Management* indicator. For discussion purposes below, we divide this indicator into three sub-indicators: medication administration, observed medication practices and storage controls, and pharmacy protocols.

**Medication Administration**

In this sub-indicator, the institution received a *proficient* score of 87.7 percent. The following two tests earned scores in the *proficient* range:

- ASP ensured that all 25 patients sampled who transferred from one housing unit to another received their ordered medications without interruption (MIT 7.005).

- We found that 23 of 25 patients sampled (92.0 percent) timely received their newly ordered medication. For one patient, nursing staff administered his medication one day late, and for the other, nursing staff did not document a reason for the patient's refusal of his medication (MIT 7.002).

The following two tests earned scores in the *adequate* range:

- Clinical staff timely provided new and previously prescribed medications to 13 of 17 patients who returned from a community hospital (76.5 percent). Three patients received their ordered medications one to two days late. One other patient never received his ordered nurse-administered medication (MIT 7.003).

- Among 17 sampled patients, 14 (82.4 percent) timely received their ordered chronic care medications. Three patients received multiple supplies of their chronic care medications within a shorter than normal replenishment period (MIT 7.001).

**Observed Medication Practices and Storage Controls**

In this sub-indicator, the institution received an *inadequate* score of 65.8 percent. Three of the six tests in the sub-indicator received *inadequate* scores, as follows:

- ASP safely stored non-refrigerated, non-narcotic medications in two of the ten applicable clinic and medication line storage locations (20.0 percent). In eight locations, we identified one or more of the following deficiencies: the medication area lacked a designated area for return-to-pharmacy medications; external and internal medications were not properly separated when stored; medication storage areas were unlocked; multi-use medication was not labeled with the date it was opened; and a personal food item was stored in the same area as medications (MIT 7.102).

- ASP safely stored refrigerated, non-narcotic medications in two of eight applicable clinics and medication line storage locations (25.0 percent). In six locations, we identified one or more of the following deficiencies: the medication area lacked a designated area for return-to-pharmacy refrigerated medications; staff did not complete temperature logbooks; staff did not label previously opened multi-dose medications with the date they were first opened; and clinics stored medications beyond manufacturers' guidelines (MIT 7.103).

- We interviewed nursing staff and inspected narcotics storage areas at applicable clinic and pill line locations to assess narcotics security controls. Nursing staff implemented strong medication security controls over narcotic medications in six of nine locations (66.7 percent). In two clinics, two licensed nursing staff did not perform a controlled substance inventory on multiple dates. In another clinic, a licensed nurse did not counter-sign the narcotics log for the disposal of a controlled substance (MIT 7.101).

One test in this sub-indicator earned an *adequate* score:

- We observed the medication preparation and administration processes at six applicable medication line locations. The nursing staff was compliant regarding proper hand hygiene and contamination control protocols at five locations (83.3 percent). At one location, the medication nurse did not wash or sanitize hands before administering medications (MIT 7.104).

Two tests earned *proficient* scores:

- Nursing staff at all six of the applicable inspected medication line locations employed appropriate administrative controls and followed appropriate protocols during medication preparation (MIT 7.105).

- In all six medication areas, ASP employed appropriate administrative controls and protocols when their staff distributed medications to their patients (MIT 7.106).

**Pharmacy Protocols**

In this sub-indicator, the institution received an *inadequate* score of 47.2 percent. All three tests in this sub-indicator received *inadequate* scores, as follows:

- In its main pharmacy, ASP did not safely store non-refrigerated medications. The main pharmacy stored these medications beyond the manufacturers' guidelines (MIT 7.108).

- The institution's pharmacist in charge (PIC) did not properly account for narcotic medications stored in ASP's pharmacy or review monthly inventories of controlled substances in the institution's clinical and medication line storage locations, resulting in a score of zero on this test. We identified the following deficiencies: staff did not inventory all controlled substances in the pharmacy monthly; staff responsible for completing the medication area inspection checklist (CDCR Form 7477) did not document the results on the form; and the PIC did not properly complete several Form 7477s and had missed names, signatures, or dates on each inventory record (MIT 7.110).

- We examined 25 medication error follow-up reports. Only 9 of the PIC's 25 reports were timely or correctly processed (36.0 percent). The medication error statistical reports for September 2016, October 2016, and June 2017 were submitted to the chief of pharmacy services two to three business days late, accounting for 15 of the untimely reports. For the last report, the packet was missing the medication error follow-up review form (CDCR Form 7541) (MIT 7.111).

Two tests in this sub-indicator warned *proficient* scores:

- In its main pharmacy, the institution followed general security, organization, and cleanliness management protocols and safely stored and monitored medications that required refrigeration (MIT 7.107, 7.109).

**Non-Scored Tests**

In addition to our testing of reported medication errors, we follow up on any significant medication errors that were found during compliance testing to determine whether the institution properly identified and reported the errors. We provide these results for information purposes only. At ASP, we did not find any applicable medication errors, and ASP did not have any patients in administrative segregation (MIT 7.998, 7.999).

## 8 — *PRENATAL AND POST-DELIVERY SERVICES*

This indicator evaluates the institution's capacity to provide timely and appropriate prenatal, delivery, and postnatal services to pregnant patients. This includes the ordering and monitoring of indicated screening tests, follow-up visits, referrals to higher levels of care, e.g., high-risk obstetrics clinic, when necessary, and postnatal follow-up.

As ASP does not have female patients, this indicator does not apply.

*Case Review Rating:*
*Not Applicable*
*Compliance Score:*
*Not Applicable*

*Overall Rating:*
*Not Applicable*

# 9 — PREVENTIVE SERVICES

This indicator assesses whether the institution offered or provided various preventive medical services to patients. These include cancer screenings, tuberculosis screenings, and influenza and chronic care immunizations. This indicator also assesses whether certain institutions take preventive actions to relocate patients identified as being at higher risk for contracting coccidioidomycosis (valley fever).

> **Case Review Rating:**
> *Not Applicable*
> **Compliance Score:**
> *Proficient*
> *(93.8%)*
>
> **Overall Rating:**
> *Proficient*

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

## Compliance Testing Results

The institution scored in the *proficient* range in this indicator with a compliance score of 93.8 percent. Six of the seven applicable tests scored in the *proficient* range:

- All 12 patients sampled received their ordered doses of tuberculosis (TB) medications in the most recent three-month period reviewed (MIT 9.001).

- All 12 patients sampled taking TB medications received required monthly or weekly monitoring timely (MIT 9.002).

- ASP timely administered or offered influenza vaccinations during the most recent influenza season to all 25 patients sampled (MIT 9.004).

- ASP offered colorectal cancer screenings to all 25 sampled patients subject to the annual screening requirement (MIT 9.005).

- We tested whether ASP offered patients who suffered from a chronic care condition the required vaccinations for influenza, pneumonia, and hepatitis. The institution timely offered vaccinations to all ten applicable sampled patients (MIT 9.008).

- We tested 20 patients identified as medically restricted and ineligible to reside at ASP due to their elevated risk for contracting valley fever to determine if they transferred out of the institution within 60 days of their ineligibility. We found that ASP timely transferred 18 of those 20 patients (90.0 percent). ASP transferred one patient three days late; one other patient remained housed at ASP for over 124 days by the time of OIG's inspection (MIT 9.009).

One test received an *inadequate* score:

- We sampled 30 patients to determine whether those patients received TB screenings within the last year and during their birth month as CCHCS policy requires. Of the 30 patients sampled, 20 received their TB screening as required (66.7 percent). While the remaining ten patients did receive TB screening within the last year, their screenings did not occur during their birth month (MIT 9.003).

The *Quality of Nursing Performance* indicator is a qualitative evaluation of the institution's nursing services. The evaluation is completed entirely by OIG nursing clinicians within the case review process, and, therefore, does not have a score under the compliance testing component. OIG nurses conduct case reviews that include reviewing face-to-face encounters related to nursing sick call requests identified on the Health Care Services Request form, urgent walk-in visits, referrals for medical services by custody staff, RN

> **Case Review Rating:**
> *Adequate*
> **Compliance Score:**
> *Not Applicable*
>
> **Overall Rating:**
> *Adequate*

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

## Case Review Results

We reviewed 238 nursing encounters, 115 of which were in the outpatient setting. Most outpatient nursing encounters were for sick call requests, walk-in visits, and RN follow-up visits. In all, there were 32 deficiencies identified in nursing care performance, 2 of which were significant. The *Quality of Nursing Performance* indicator at ASP was *adequate*.

**Nursing Assessment**

Although nurses at ASP usually evaluated patients appropriately by including both subjective (patient interview) and objective (physical findings) assessments, some nurses often did not perform focused assessments of patients' complaints or reassess abnormal findings. We identified examples of these findings in cases 6, 13, 17, 18, 20, 24, 42, and the following:

- In case 15, the patient reported "issues with walking" and numbness. The sick call nurse did not evaluate the patient's gait.

- In case 19, the patient underwent surgery two weeks previously, and he reported constant shoulder pain and numbness in three fingers since the surgery. The sick call nurse did not evaluate the range of motion in the patient's shoulder.

- In case 47, the patient reported difficulty swallowing. The sick call nurse did not ask the patient about throat pain or the ability to swallow food and fluids and did not examine the patient's tongue, throat, or lymph nodes.

**Nursing Intervention**

When a nurse assesses a patient appropriately, the nurse should implement appropriate interventions for the patient. There were some occasions in which nurses did not inform or consult with a provider when needed or did not carry out providers' orders. These errors occurred in cases 2, 35, 51, and the following:

- In case 35, the patient began to have joint pain and was worried that his valley fever illness was returning. The nurse gave the patient ibuprofen but failed to notify or refer the patient to a provider.

- In case 44, the TTA nurse evaluated the patient for a painful and swollen calf. The patient reported pain for about a month, and his right calf was slightly larger in diameter than the left calf. A doppler scan revealed good blood flow, but the patient needed additional evaluation to rule out the possibility of a dangerous blood clot. The TTA nurse referred the patient for follow-up with the clinic sick call nurse within three days, but should have referred the patient to the TTA provider the same day or the clinic provider the following day.

- In case 45, the patient had a toe wound, and the provider ordered daily wound checks and dressing changes for two weeks. Nurses completed wound checks and dressing changes only twice during that two-week period.

**Nursing Documentation**

Most nursing documentation in reviewed cases was sufficiently accurate and complete. For example, OHU nursing documentation generally included thorough physical assessments, descriptive characteristics of wounds, changes in patient status, medication compliance, provider contacts, and subjective information directly from the patient. Nonetheless, ASP nurses often did not record their medical care correctly. Documentation deficiencies occurred in cases 1, 5, 18, 29, 30, 34, 45, 51, and the following:

- In case 6, the first medical responder did not document the location of the emergency medical response.

- In case 19, the LVN saw the patient in the clinic with a laceration on his hand. The LVN did not identify which hand had the laceration, the size or appearance of the laceration, or mention that the LVN sent the patient to the TTA. Medical staff subsequently sent the patient to the community hospital emergency department for laceration repair.

- In case 34, the patient requested a steroid injection for hand pain. The sick call nurse did not contact the patient or record the intended treatment plan, the referral plan, or any other acknowledgment of the patient's request. Although the nurse recorded no documentation, the patient received the steroid injection three days later.

**Nursing Sick Call**

ASP nurses usually performed well with sick call. ASP's sick call process was timely and met the needs of most patients regarding access to health care services. Although sick call nurses generally provided appropriate nursing evaluation and intervention, there were several cases in which the nurse did not properly evaluate or address the patient's complaints or health issues.

- In case 13, the sick call nurse assessed the patient's temperature, pulse, and respiratory rates during the clinic visit but did not check the blood pressure of this patient with hypertension.

- In case 18, the patient requested information about his medication. The sick call nurse did not evaluate the patient, record the referral to follow up with the provider, or record the final disposition of the patient's sick call request.

**Urgent/Emergent Care**

ASP nurses usually provided effective and timely emergency responses. The TTA nursing staff were knowledgeable about emergency procedures. However, those nurses did not consistently make appropriate assessments and had some difficulty recording their care accurately. We discuss this performance further in the *Emergency Services* indicator.

**Specialized Medical Housing**

Nursing care and documentation were exceptional in the OHU. We reviewed 47 nursing encounters and identified only three minor nursing documentation deficiencies. Nurses conducted pertinent daily patient assessments and observations specific to the patient's diagnosis and treatment plans. We discuss this performance further in the S*pecialized Medical Housing* indicator.

**Post-Hospital Returns**

Nurses in the TTA usually scheduled timely follow-up appointments for patients returning from an outside hospital or emergency room. They consulted with the providers after reviewing hospital discharge recommendations for follow-up care. ASP retrieved, reviewed, and scanned the hospital records into the ASP medical record timely. The *Health Information Management* indicator includes additional details.

**Inter- and Intra-System Transfers**

For most patients, ASP nurses coordinated care appropriately during the transfer process. We also discuss nursing performance in this area in the *Inter- and Intra-System Transfers* indicator.

**Offsite Specialty Services Returns**

ASP nurses also provided appropriate care to patients returning from community specialty appointments. We further discuss this performance in the *Specialty Services* indicator.

**Clinician Onsite Inspection**

We met with ASP nurse managers during the onsite visit. The nurse managers researched the cases we presented and were well prepared to address them. The primary care clinic huddle process was well established and demonstrated a multidisciplinary team approach.

**Case Review Conclusion**

ASP nurses usually provided care that was timely and appropriate. However, there was room for improvement in their assessment, intervention, documentation, emergency care, and in ensuring medication continuity for patients transferring in from other CDCR institutions. Though ASP nurses demonstrated several error patterns, most of the deficiencies did not severely increase the risk of patient harm. The overall *Quality of Nursing Performance* indicator at ASP was *adequate*.

In this indicator, the OIG physicians provide a qualitative evaluation of the adequacy of provider care at the institution. OIG physicians evaluated the appropriateness of evaluations, diagnoses, and management plans for programs including, but not limited to, nursing sick call, chronic care programs, TTA, specialized medical housing, and specialty services. Only OIG physicians perform assessments of provider care. There is no compliance testing component for the Provide Performance Quality indicator.

> **Case Review Rating:**
> *Adequate*
> **Compliance Score:**
> *Not Applicable*
>
> **Overall Rating:**
> *Adequate*

## *Case Review Results*

We reviewed 133 medical provider encounters and identified 15 deficiencies related to provider performance. Of those 15 deficiencies, five were significant. We rated the *Quality of Provider Performance* indicator *adequate*.

**Assessment and Decision-Making**

ASP providers usually made appropriate assessments and documented sound medical plans. However, providers frequently made minor mistakes in this area. These deficiencies occurred in cases 8, 13, 14, 22, 27, 49, and 53. Despite a strong pattern of errors, most of these deficiencies were not significant and did not place the patient at increased risk of harm. There was one exception:

- In case 22, a provider reviewed several laboratory tests showing high potassium levels and an electrocardiogram (EKG, a test to measure the heart's electrical activity) that showed that the patient was at risk for a dangerous heart rhythm disturbance. When the potassium rose to a critically high level, the provider did not treat the dangerous potassium levels or obtain a repeat EKG to determine if the patient needed emergent treatment. These errors placed the patient at risk of serious complications such as arrhythmia and death. Fortunately, ASP addressed the problem after we informed the institution of the situation.

**Review of Records**

In most cases, providers reviewed their patients' records properly, especially when the patients returned from a hospital or specialist. Insufficient record review occurred in only three cases (2, 5, and 48). A significant review error occurred in the following case:

- In case 2, the patient returned from the hospital, but the provider did not address a 19 mm lung nodule, which could have been cancer. By overlooking the findings, the provider placed the patient at risk of delayed diagnosis and treatment of cancer. Fortunately, ASP addressed the problem after we informed the institution of the situation, and the nodule was benign.

**Emergency Care**

ASP providers were readily available for consultation with the TTA nursing staff when patients presented emergently to the TTA. ASP providers made excellent decisions during emergent events. We did not identify any provider emergency care deficiencies.

**Chronic Care**

ASP providers performed well in managing chronic medical conditions such as hypertension, hyperlipidemia, asthma, hepatitis C infection, and seizure disorder. ASP providers could improve with their diabetic care, as there were two significant deficiencies:

- In case 8, the patient had diabetes requiring long-acting insulin. Patients taking long-acting insulin require monitoring of fasting (morning) blood glucose levels. In this case, the provider monitored blood glucose levels only once daily in the afternoon, which was insufficient. The provider should have monitored fasting blood glucose levels to adjust the long-acting insulin dose properly. Also, the provider should not have prescribed a long-acting oral medication because of the increased risk of low blood sugar when the patient was taking other insulins at the same time.

- In case 53, the patient's blood tests showed poor diabetic control that had deteriorated over the six-month review period. The patient required close monitoring and timely insulin adjustment. The long-acting insulin is typically titrated every three to seven days until average fasting blood glucose is in the target range. However, the provider evaluated the patient only two times in the review period and did not adjust the patient's insulin. The provider's lack of intervention placed the patient at risk for complications of uncontrolled diabetes such as cardiovascular disease, stroke, and blindness. The provider also set an inappropriately high blood sugar target range for the patient.

**Specialty Services**

ASP providers performed extremely well in this area. When their patients required specialty care, ASP providers referred appropriately and with the correct priority. The providers also reviewed specialty reports timely. There was only one significant deficiency, which we discuss further in the *Specialty Services* indicator.

**Specialized Medical Housing**

Providers visited OHU patients timely and made appropriate assessments and sound medical plans. We did not identify any provider deficiencies in specialized medical housing.

**Health Information Management**

ASP providers recorded their outpatient, TTA, and specialty housing encounters timely. Providers dictated most progress notes, and handwritten records were usually legible.

**Clinician Onsite Inspection**

At the time of our inspection, there were no provider vacancies. The providers were enthusiastic about their work and satisfied with the institution's nursing, diagnostic, and specialty services. ASP assigned each provider to only one clinic to enhance the continuity of care. On average, providers saw 15 patients per day. Providers led productive morning huddles, which nurses, care coordinators, custody staff, and office technicians attended. The care teams discussed significant TTA encounters and hospital returns that occurred the previous day.

After the morning huddles, the medical staff attended a population health management meeting and analyzed patient health metric data. By analyzing the data, the staff hoped to improve the clinical outcomes of patients with chronic conditions such as diabetes and hypertension.

**Case Review Conclusion**

ASP providers performed well in multiple aspects of patient care, including emergency care, chronic care, hospital returns, and specialized medical housing. The providers could improve with their assessment and decision-making, review of records, and diabetic care. We rated the *Quality of Provider Performance* indicator *adequate.*

## 12 — *RECEPTION CENTER ARRIVALS*

This indicator focuses on the management of medical needs and continuity of care for patients arriving from outside the CDCR system. The OIG review includes evaluation of the ability of the institution to provide and document initial health screenings, initial health assessments, continuity of medications, and completion of required screening tests; address and provide significant accommodations for disabilities and health care appliance needs; and identify health care conditions needing treatment and monitoring.

> *Case Review Rating:*
> *Not Applicable*
> *Compliance Score:*
> *Not Applicable*
>
> *Overall Rating:*
> *Not Applicable*

The patients reviewed for reception center cases are those received from non-CDCR facilities, such as county jails.

ASP does not have a reception center; therefore, this indicator does not apply.

## 13 — SPECIALIZED MEDICAL HOUSING

This indicator addresses whether the institution follows appropriate policies and procedures when admitting inmate-patients to onsite inpatient facilities, including completion of timely nursing and provider assessments. The chart review assesses all aspects of medical care related to these housing units, including quality of provider and nursing care. Avenal's only specialized medical housing unit is an outpatient housing unit (OHU).

> *Case Review Rating:*
> *Adequate*
> *Compliance Score:*
> *Proficient*
> *(100%)*
>
> *Overall Rating:*
> *Adequate*

For this indicator, the case review and compliance review processes yielded different results, with the case reviewers assigning an *adequate* rating and the compliance testing resulting in a *proficient* score. The main reason for the *adequate* score: Despite excellent provider and nurse OHU performance, ASP did not consistently make critical medications available to patients when they needed them. Because this resulted in an increased risk of harm, we determined that the most suitable rating for this indicator was *adequate*.

## Case Review Results

The specialized medical housing unit at ASP was a 28-bed OHU, and ASP used all beds for medical patients. There were no negative pressure rooms. We reviewed 7 OHU cases, which yielded 64 events. The events reviewed included 9 provider and 47 nursing encounters. We identified five deficiencies, one of which was a significant pharmacy deficiency in case 52. The case review rating of the *Specialized Medical Housing* indicator was *adequate*.

**Provider Performance**

The providers visited OHU patients timely and made appropriate assessments and sound medical plans. The providers did very well, as there were no deficiencies related to provider performance.

**Nursing Performance**

We reviewed 47 nursing encounters and found nursing care and documentation exceptional despite rare deficiencies.

We reviewed patients admitted to the OHU for abdominal and back surgical wounds with staples/sutures, leg fractures (two long bones), jaw bone infection, drug overdoses, and complaints of weakness. Nurses conducted pertinent daily patient assessments and observations specific to each patient's diagnosis and treatment plan. Nurse documentation was thorough and included general physical assessments, wound characteristics, the appearance of intravenous (IV) catheter insertions sites, progress with ambulation, and patients' abilities to perform self-care tasks.

Nursing documentation also included subjective information from the patient, changes in patient status, medication compliance, and provider contacts. Nurses made regular patient rounds to assess

patients and to ascertain patient needs. There were three minor nursing documentation deficiencies, in cases 29 (twice) and 51.

**Pharmacy and Medication Management**

The OHU pharmacy and nursing staff sometimes had difficulty ensuring that essential medications, such as antibiotics, and seizure and blood pressure medications were available and given as prescribed. There were two deficiencies, both of which were significant:

- In case 50, a provider prescribed an important blood thinner to prevent blood clots after the patient sustained a leg fracture. The blood thinner was not available for two days.

- In case 52, the patient had a jaw infection and was receiving intravenous antibiotics. The patient did not receive the intravenous antibiotic for one day because it was not available, placing the patient at risk for undertreated infection.

**Clinical Onsite Inspection**

In the OHU, registered nurses (RNs) were on duty during the day shifts. ASP staffed the evening and night shifts with licensed vocational nurses (LVNs). Certified nursing assistants assisted the RN on the day shift and the LVN on the afternoon shift. RN supervisors were available for all shifts 24 hours per day.

ASP staffed the OHU with experienced nurses and sufficient custody staff to support patient care. Administrative staff reported that patient names and diagnoses were available in the EHRS. Medical staff admitted patients who were scheduled for offsite procedures that required no food or drink after midnight to the OHU, where the nurses monitored and educated the patients the day before their procedures.

**Case Review Conclusion**

ASP providers appropriately admitted patients needing a higher level of care to the OHU and provided appropriate care to those patients after admission. Provider and nursing care in the OHU were excellent. However, critical medications were not consistently available when needed. We therefore rated ASP's S*pecialized Medical Housing* indicator *adequate.*

## *Compliance Testing Results*

The institution earned a *proficient* compliance score of 100.0 percent. All three tests in this indicator were *proficient*:

- For all ten patients sampled, nursing staff timely completed an initial assessment on the day of their admission to the OHU (MIT 13.001).

- ASP's providers timely completed subjective, objective, assessment, plan, and education (SOAPE) notes at required intervals for all ten applicable OHU patients sampled (MIT 13.003).

- When we observed the working order of sampled call buttons in OHU patient rooms, they found all working properly. In addition, according to staff members interviewed, custody officers and clinicians were able to expeditiously access patients' locked rooms when emergent events occurred (MIT 13.101).

This indicator focuses on specialist care from the time a provider requests or orders a specialty service until that care is completed and that provider reviews and implements the specialist's recommendations. If the ASP provider chooses not to implement the specialist's recommendations then OIG clinicians evaluate documentation of the reason. OIG clinicians also review whether ASP providers communicate specialist's findings and recommendations to the patients. For specialty services denied by the institution, the OIG determines whether the denials are timely and appropriate, and whether providers update the patient on the consequent plan of care.

> **Case Review Rating:**
> *Proficient*
> **Compliance Score:**
> *Adequate*
> *(82.4%)*
>
> **Overall Rating:**
> *Proficient*

For this indicator, the case review and compliance review processes yielded different results, with the case reviewers assigning a *proficient* rating and the compliance testing resulting in an *adequate* score. The main reason the compliance score was not *proficient* was that ASP had intermittent difficulty providing specialty services to patients who had transferred into ASP with pre-approved specialty referrals. Also, when ASP denied a specialty service, the staff did not timely communicate the denial to the patient. However, these errors did not significantly result in a risk of patient harm and we determined the rating for this indicator was *proficient*.

## Case Review Results

We reviewed 69 events related to the S*pecialty Services* indicator, which included 49 specialty consultations and procedures and 20 nursing encounters. There were four deficiencies, two of which were significant. The case review rating for this indicator was *proficient.*

**Access to Specialty Services**

Specialty appointments are integral to specialty services, and we found that most specialty appointments occurred within the requested time frame. Delays in specialty access occurred in only 2 of the 23 applicable cases. One of those delays was significant:

- In case 48, a provider requested a lung specialist follow-up within two weeks; however, the appointment did not occur until one month later.

**Nursing Performance**

We reviewed 20 nursing encounters when patients returned from their specialty appointments. The nurses performed good patient assessments, obtained the specialist's initial findings and recommendations, and communicated them to the provider. Nurses provided education to the patients as needed. We did not find any nursing performance deficiencies in specialty services.

**Provider Performance**

We found that providers referred patients to specialists appropriately and addressed specialists' recommendations after specialty appointments. There was one significant exception:

- In case 48, the patient had severe chronic lung disease. The pulmonologist recommended pulmonary function testing and a follow-up in six to eight weeks. The provider reviewed the consultation report but did not address the recommendations. This error resulted in a lapse in care.

**Health Information Management**

ASP performed well in this area. The institution retrieved and scanned all specialty reports into the medical record timely.

**Case Review Conclusion**

The *Specialty Services* indicator was *proficient* because ASP staff completed most specialty appointments timely, retrieved and scanned specialty reports, properly reviewed the recommendations, and acted on them appropriately.

## *Compliance Testing Results*

The institution received an *adequate* compliance score of 82.4 percent in the *Specialty Services* indicator. Five tests earned *proficient* scores, as follows:

- For all 15 patients sampled, high-priority specialty services appointments occurred within 14 calendar days of the provider's order (MIT 14.001).

- Providers timely received and reviewed high-priority specialists' reports for 14 of 15 patients sampled (93.3 percent). For one patient, ASP did not scan the report into the patient's electronic medical record (MIT 14.002).

- For all 15 patients sampled, routine priority specialty service appointments occurred within 90 calendar days of the provider's order (MIT 14.003).

- Providers timely received and reviewed routine priority specialists' reports for 14 of 15 patients sampled (93.3 percent). For one patient, the provider reviewed the report seven days late (MIT 14.004).

- ASP's health care management timely denied providers' specialty services requests for 19 of 20 sampled patients (95.0 percent). Management denied one specialty services request three days late (MIT 14.006).

Two tests resulted in *inadequate* scores at the institution:

- Only 9 of 20 patients who transferred into ASP with an approved specialty service (45.0 percent) received it within the required time frame. The remaining 11 patients sampled received their services late or did not receive them at all: one patient received his service one day late; three patients received their services from 12 to 20 days late; six patients never received their services; for one final patient, the provider cancelled his service, but the cancellation was out of compliance by four days (MIT 14.005).

- For 10 of 20 patients sampled (50.0 percent), providers timely communicated the denial status of specialty services. For three patients, providers did not communicate the denial status at all. For six other patients, the provider communicated the denial status from 2 to 17 days late. For one remaining patient, the provider communicated the denial status 40 days late (MIT 14.007).

# 15 — ADMINISTRATIVE OPERATIONS (SECONDARY)

This indicator focuses on the institution's administrative health care oversight functions. The OIG evaluates whether the institution promptly processes patient medical appeals and addresses all appealed issues. Inspectors also verify that the institution follows reporting requirements for adverse/sentinel events and patient deaths. 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. In addition, the OIG examines whether the institution adequately manages its health care staffing resources by evaluating whether job performance reviews are completed as required; specified staff possess current, valid credentials and professional licenses or certifications; nursing staff receive new employee orientation training and annual competency testing; and clinical and custody staff have current emergency medical response certifications. The *Administrative Operations* indicator is a secondary indicator; therefore, it was not relied on for the institution's overall score.

> *Case Review Rating:*
> *Not Applicable*
> *Compliance Score:*
> *Proficient*
> *(94.4%)*
>
> *Overall Rating:*
> *Proficient*

## Compliance Testing Results

The institution received a *proficient* score of 94.4 percent in this indicator with several tests scoring 100.0 percent:

- We reviewed data received from the institution to determine if ASP timely processed at least 95 percent of its monthly patient medical appeals during the most recent 12-month period. ASP timely processed all 12 months' appeals reviewed (MIT 15.001).

- ASP's Quality Management Committee (QMC) met monthly, evaluated program performance, and acted when management identified areas for improvement opportunities (MIT 15.003).

- ASP took adequate steps to ensure the accuracy of its Dashboard data reporting (MIT 15.004).

- We reviewed drill packages for three medical emergency response drills conducted in the prior quarter; each drill package contained all required summary reports and related documentation. In addition, the drills included participation by both health care and custody staff (MIT 15.101).

- Based on a sample of ten second-level medical appeals, the institution's responses addressed all the patients' appealed issues (MIT 15.102).

- All ten nurses sampled were current with their clinical competency validations (MIT 15.105).

- We reviewed performance evaluation packets for ASP's nine providers; ASP met all performance review requirements for its providers (MIT 15.106).

- All providers at the institution were current with their professional licenses. Similarly, all nursing staff and the pharmacist in charge were current with their professional licenses and certification requirements (MIT 15.107, 15.109).

- All active-duty providers and nurses were current with their emergency response certifications (MIT 15.108).

- All pharmacy staff and providers who prescribed controlled substances had current Drug Enforcement Agency registrations (MIT 15.110).

- Nursing staff hired within the last year timely received new employee orientation training (MIT 15.111).

One test earned an *adequate* score:

- When we examined records to determine if nursing supervisors were completing the required number of monthly case reviews for subordinate nurses as well as discussing the results of those reviews, four of five sampled nurse supervisors properly completed their reviews (80.0 percent). One of the reviewing nurses did not discuss the review results with the subordinate nurse (MIT 15.104).

One test earned an *inadequate* score:

- Of the 12 sampled incident packages for emergency medical responses reviewed by the institution's Emergency Medical Response Review Committee (EMRRC) during the prior 12-month period, 5 (41.7 percent) complied with policy. Seven incident packages did not include the required EMRRC checklist (MIT 15.005).

**Non-Scored Results**

- We gathered non-scored data regarding the CCHCS Death Review Committee (DRC) completing its death review reports. There were no applicable deaths that occurred at ASP in the prior 12-month period (MIT 15.998).

- We discuss the institution's health care staffing resources in the *About the Institution* section of this report (MIT 15.999).

# RECOMMENDATION

- ASP's pharmacist in charge (PIC) and chief nurse executive (CNE) should implement quality improvement measures to adjust pharmacy and nursing administration processes and ensure medications are available when patients need them. In this inspection, the institution did not reliably give needed medications to patients who transferred from other institutions, returned from the hospital, or needed intravenous antibiotics.

# POPULATION-BASED METRICS

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

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

**Methodology**

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

**Comparison of Population-Based Metrics**

For the Avenal State Prison, we selected seven HEDIS measures and listed them in the following *ASP Results Compared to State and National HEDIS Scores* table. Multiple health plans publish their HEDIS performance measures at the State and national levels. We provide selected results for several health plans in both categories for comparative purposes.

**Results of Population-Based Metric Comparison**

For chronic care management, we 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 to produce optimal results.

When compared statewide, ASP outperformed all plans by scoring higher in all five diabetic measures tested. When compared nationally, ASP outperformed Medicaid, Medicare, and commercial plans in all five diabetic measures. ASP outperformed the United States Department of Veterans Affairs (VA) in three of the four applicable measures but scored one percentage point lower for eye exams.

Comparative data for immunizations was only fully available for the VA and partially available for Kaiser, commercial plans, Medicaid and Medicare. Additionally, ASP's population did not contain inmate-patients over the age of 65; therefore, we omitted influenza shots for patients 65 and older and pneumococcal immunizations from the comparative analysis. With respect to administering influenza vaccinations to younger adults, ASP scored higher than all State and national health plans.

With respect to colorectal cancer screening, ASP scored much lower than all State and national health plans. However, over half of the sampled patients refused the cancer screening, which negatively affected the institution's score.

**Summary**

ASP performed favorably with regard to population-based metrics in comparison to the other health care plans reviewed. The institution may improve its scores for cancer screenings by reducing patient refusals through patient education.

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# Avenal State Prison Results Compared to State and National HEDIS Score

| Clinical Measures | California | | | | National | | | |
|---|---|---|---|---|---|---|---|---|
| | ASP Cycle 5 Results[1] | HEDIS Medi-Cal 2017[2] | HEDIS Kaiser (No. CA) 2016[3] | HEDIS Kaiser (So.CA) 2016[3] | HEDIS Medicaid 2017[4] | HEDIS Commercial 2017[4] | HEDIS Medicare 2017[4] | VA Average 2016[5] |
| **Comprehensive Diabetes Care** | | | | | | | | |
| HbA1c Testing (Monitoring) | **100%** | 87% | 94% | 94% | 87% | 91% | 94% | 99% |
| Poor HbA1c Control (>9.0%)[6, 7] | **2%** | 38% | 20% | 23% | 43% | 33% | 26% | 18% |
| HbA1c Control (<8.0%)[6] | **95%** | 52% | 70% | 63% | 47% | 56% | 63% | - |
| Blood Pressure Control (<140/90)[6] | **92%** | 63% | 83% | 83% | 60% | 62% | 64% | 76% |
| Eye Exams | **88%** | 57% | 68% | 81% | 55% | 54% | 70% | 89% |
| **Immunizations** | | | | | | | | |
| Influenza Shots - Adults (18–64) | **70%** | - | 56% | 57% | 39% | 48% | - | 52% |
| Influenza Shots - Adults (65+)[8] | **N/a** | - | - | - | - | - | 71% | 72% |
| Immunizations: Pneumococcal[8] | **N/a** | - | - | - | - | - | 74% | 93% |
| **Cancer Screening** | | | | | | | | |
| Colorectal Cancer Screening | **44%** | - | 79% | 82% | - | 62% | 67% | 82% |
| | | | | | | | | |

1. Unless otherwise stated, data was collected in August 2017 by reviewing medical records from a sample of ASP'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 *Medi-Cal Managed Care External Quality Review Technical Report (July 1, 2016 - June 30, 2017)*.

3. Data was obtained from Kaiser Permanente November 2016 reports for the Northern and Southern California regions.

4. National HEDIS data for Medicaid, commercial plans, and Medicare was obtained from the 2017 *State of Health Care Quality Report*, available on the NCQA website: www.ncqa.org. The results for commercial plans were based on data received from various health maintenance organizations.

5. The Department of Veterans Affairs (VA) data was obtained from the VA's website, www.va.gov.
For the Immunizations: Pneumococcal measure only, the data was obtained from the *VHA Facility Quality and Safety Report - Fiscal Year 2012 Data*.

6. For this indicator, the entire applicable ASP 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. Population did not contain inmate-patients over the age of 65; therefore, sample omitted from the comparative analysis.

# APPENDIX A—COMPLIANCE TEST RESULTS

| Avenal State Prison<br>Range of Summary Scores: 52.3% - 100.0% | |
|---|---|
| **Indicator** | **Compliance Score (Yes %)** |
| **1–*Access to Care*** | 90.4% |
| **2–*Diagnostic Services*** | 75.4% |
| **3–*Emergency Services*** | Not Applicable |
| **4–*Health Information Management (Medical Records)*** | 72.9% |
| **5–*Health Care Environment*** | 52.3% |
| **6–*Inter- and Intra-System Transfers*** | 91.4% |
| **7–*Pharmacy and Medication Management*** | 65.5% |
| **8–*Prenatal and Post-Delivery Services*** | Not Applicable |
| **9–*Preventive Services*** | 93.8% |
| **10–*Quality of Nursing Performance*** | Not Applicable |
| **11–*Quality of Provider Performance*** | Not Applicable |
| **12–*Reception Center Arrivals*** | Not Applicable |
| **13–*Specialized Medical Housing (OHU, CTC, SNF, Hospice)*** | 100.0% |
| **14–*Specialty Services*** | 82.4% |
| **15–*Administrative Operations*** | 94.4% |
| | |

| Reference Number | 1–Access to Care | Scored Answers | | | | | N/A |
|---|---|---|---|---|---|---|---|
| | | Yes | No | Yes + No | Yes % | | |
| 1.001 | Chronic care follow-up appointments: Was the patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter? | 22 | 3 | 25 | 88.0% | | 0 |
| 1.002 | For endorsed patients received from another CDCR institution: If the nurse referred the patient to a provider during the initial health screening, was the patient seen within the required time frame? | 19 | 6 | 25 | 76.0% | | 0 |
| 1.003 | Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? | 30 | 0 | 30 | 100.0% | | 0 |
| 1.004 | Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed? | 30 | 0 | 30 | 100.0% | | 0 |
| 1.005 | Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter? | 11 | 1 | 12 | 91.7% | | 18 |
| 1.006 | Sick call follow-up appointments: If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified? | 3 | 0 | 3 | 100.0% | | 27 |
| 1.007 | Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame? | 14 | 3 | 17 | 82.4% | | 0 |
| 1.008 | Specialty service follow-up appointments: Do specialty service primary care physician follow-up visits occur within required time frames? | 22 | 7 | 29 | 75.9% | | 1 |
| 1.101 | Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? | 6 | 0 | 6 | 100.0% | | 0 |
| **Overall percentage:** | | | | | **90.4%** | | |

| Reference Number | 2–Diagnostic Services | Scored Answers | | | | N/A |
|---|---|---|---|---|---|---|
| | | Yes | No | Yes + No | Yes % | |
| 2.001 | Radiology: Was the radiology service provided within the time frame specified in the provider's order? | 10 | 0 | 10 | 100.0% | 0 |
| 2.002 | Radiology: Did the primary care provider review and initial the diagnostic report within specified time frames? | 6 | 4 | 10 | 60.0% | 0 |
| 2.003 | Radiology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames? | 8 | 1 | 9 | 88.9% | 1 |
| 2.004 | Laboratory: Was the laboratory service provided within the time frame specified in the provider's order? | 10 | 0 | 10 | 100.0% | 0 |
| 2.005 | Laboratory: Did the primary care provider review and initial the diagnostic report within specified time frames? | 10 | 0 | 10 | 100.0% | 0 |
| 2.006 | Laboratory: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames? | 1 | 9 | 10 | 10.0% | 0 |
| 2.007 | Pathology: Did the institution receive the final diagnostic report within the required time frames? | 9 | 1 | 10 | 90.0% | 0 |
| 2.008 | Pathology: Did the primary care provider review and initial the diagnostic report within specified time frames? | 9 | 1 | 10 | 90.0% | 0 |
| 2.009 | Pathology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames? | 4 | 6 | 10 | 40.0% | 0 |
| **Overall percentage:** | | | | | **75.4%** | |

## 3–Emergency Services

This indicator is evaluated only by case review clinicians. There is no compliance testing component.

| Reference Number | 4–Health Information Management | Scored Answers | | | | N/A |
|---|---|---|---|---|---|---|
| | | Yes | No | Yes + No | Yes % | |
| 4.001 | Are non-dictated health care documents (provider progress notes) scanned within 3 calendar days of the patient encounter date? | 9 | 1 | 10 | 90.0% | 0 |
| 4.002 | Are dictated/transcribed documents scanned into the patient's electronic health record within five calendar days of the encounter date? | 1 | 0 | 1 | 100.0% | 0 |
| 4.003 | Are High-Priority specialty notes (either a Form 7243 or other scanned consulting report) scanned within the required time frame? | 16 | 4 | 20 | 80.0% | 0 |
| 4.004 | Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? | 13 | 3 | 16 | 81.3% | 0 |
| 4.005 | Are medication administration records (MARs) scanned into the patient's electronic health record within the required time frames? | 0 | 0 | 0 | NA | 0 |
| 4.006 | During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? | 8 | 16 | 24 | 33.3% | 0 |
| 4.007 | For patients discharged from a community hospital: Did the preliminary hospital discharge report include key elements and did a primary care provider review the report within three calendar days of discharge? | 9 | 8 | 17 | 52.9% | 0 |
| Overall percentage: | | | | | 72.9% | |

| Reference Number | 5–Health Care Environment | Scored Answers | | | | N/A |
|---|---|---|---|---|---|---|
| | | Yes | No | Yes + No | Yes % | |
| 5.101 | Are clinical health care areas appropriately disinfected, cleaned and sanitary? | 8 | 2 | 10 | 80.0% | 0 |
| 5.102 | Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted? | 8 | 1 | 9 | 88.9% | 1 |
| 5.103 | Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? | 10 | 0 | 10 | 100.0% | 0 |
| 5.104 | Does clinical health care staff adhere to universal hand hygiene precautions? | 2 | 7 | 9 | 22.2% | 1 |
| 5.105 | Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? | 9 | 1 | 10 | 90.0% | 0 |
| 5.106 | Warehouse, Conex and other non-clinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program? | 0 | 1 | 1 | 0.0% | 0 |
| 5.107 | Does each clinic follow adequate protocols for managing and storing bulk medical supplies? | 2 | 8 | 10 | 20.0% | 0 |
| 5.108 | Do clinic common areas and exam rooms have essential core medical equipment and supplies? | 4 | 6 | 10 | 40.0% | 0 |
| 5.109 | Do clinic common areas have an adequate environment conducive to providing medical services? | 10 | 0 | 10 | 100.0% | 0 |
| 5.110 | Do clinic exam rooms have an adequate environment conducive to providing medical services? | 2 | 7 | 9 | 22.2% | 1 |
| 5.111 | Emergency response bags: Are TTA and clinic emergency medical response bags inspected daily and inventoried monthly, and do they contain essential items? | 1 | 7 | 8 | 12.5% | 2 |
| | **Overall percentage:** | | | | **52.3%** | |

| Reference Number | 6–Inter- and Intra-System Transfers | Scored Answers | | | | N/A |
|---|---|---|---|---|---|---|
| | | Yes | No | Yes + No | Yes % | |
| 6.001 | For endorsed patients received from another CDCR institution or COCF: Did nursing staff complete the initial health screening and answer all screening questions on the same day the patient arrived at the institution? | 22 | 3 | 25 | 88.0% | 0 |
| 6.002 | For endorsed patients received from another CDCR institution or COCF: When required, did the RN complete the assessment and disposition section of the health screening form; refer the 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? | 25 | 0 | 25 | 100.0% | 0 |
| 6.003 | For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? | 10 | 2 | 12 | 83.3% | 13 |
| 6.004 | For patients transferred out of the facility: Were scheduled specialty service appointments identified on the patient's health care transfer information form? | 6 | 1 | 7 | 85.7% | 0 |
| 6.101 | For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? | 1 | 0 | 1 | 100.0% | 5 |
| **Overall percentage:** | | | | | **91.4%** | |

| Reference Number | 7–Pharmacy and Medication Management | Scored Answers | | | | N/A |
| | | Yes | No | Yes + No | Yes % | |
|---|---|---|---|---|---|---|
| 7.001 | Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows? | 14 | 3 | 17 | 82.4% | 8 |
| 7.002 | Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? | 23 | 2 | 25 | 92.0% | 0 |
| 7.003 | Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? | 13 | 4 | 17 | 76.5% | 0 |
| 7.004 | For patients received from a county jail: Were all medications ordered by the institution's reception center provider administered, made available, or delivered to the patient within the required time frames? | 0 | 0 | 0 | NA | 0 |
| 7.005 | Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? | 25 | 0 | 25 | 100.0% | 0 |
| 7.006 | For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? | 0 | 0 | 0 | NA | 0 |
| 7.101 | All clinical and medication line storage areas for narcotic medications: Does the Institution employ strong medication security over narcotic medications assigned to its clinical areas? | 6 | 3 | 9 | 66.7% | 1 |
| 7.102 | All clinical and medication line storage areas for non-narcotic medications: Does the Institution properly store non-narcotic medications that do not require refrigeration in assigned clinical areas? | 2 | 8 | 10 | 20.0% | 0 |
| 7.103 | All clinical and medication line storage areas for non-narcotic medications: Does the institution properly store non-narcotic medications that require refrigeration in assigned clinical areas? | 2 | 6 | 8 | 25.0% | 2 |
| 7.104 | Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes? | 5 | 1 | 6 | 83.3% | 4 |
| 7.105 | Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients? | 6 | 0 | 6 | 100.0% | 4 |
| 7.106 | Medication preparation and administration areas: Does the Institution employ appropriate administrative controls and protocols when distributing medications to patients? | 6 | 0 | 6 | 100.0% | 4 |
| 7.107 | Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and satellite pharmacies? | 1 | 0 | 1 | 100.0% | 0 |

| Reference Number | 7–Pharmacy and Medication Management | Scored Answers | | | | | N/A |
|---|---|---|---|---|---|---|---|
| | | Yes | No | Yes + No | Yes % | | |
| 7.108 | Pharmacy: Does the institution's pharmacy properly store non-refrigerated medications? | 0 | 1 | 1 | 0.0% | | 0 |
| 7.109 | Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? | 1 | 0 | 1 | 100.0% | | 0 |
| 7.110 | Pharmacy: Does the institution's pharmacy properly account for narcotic medications? | 0 | 1 | 1 | 0.0% | | 0 |
| 7.111 | Does the institution follow key medication error reporting protocols? | 9 | 16 | 25 | 36.0% | | 0 |
| **Overall percentage:** | | | | | **65.5%** | | |

## 8–Prenatal and Post-Delivery Services

The institution has no female patients, so this indicator is not applicable.

| Reference Number | 9–Preventive Services | Scored Answers | | | | N/A |
|---|---|---|---|---|---|---|
| | | Yes | No | Yes + No | Yes % | |
| 9.001 | Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? | 12 | 0 | 12 | 100.0% | 0 |
| 9.002 | Patients prescribed TB medication: Did the institution monitor the patient monthly for the most recent three months he or she was on the medication? | 12 | 0 | 12 | 100.0% | 0 |
| 9.003 | Annual TB Screening: Was the patient screened for TB within the last year? | 20 | 10 | 30 | 66.7% | 0 |
| 9.004 | Were all patients offered an influenza vaccination for the most recent influenza season? | 25 | 0 | 25 | 100.0% | 0 |
| 9.005 | All patients from the age of 50 - 75: Was the patient offered colorectal cancer screening? | 25 | 0 | 25 | 100.0% | 0 |
| 9.006 | Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy? | 0 | 0 | 0 | NA | 0 |
| 9.007 | Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy? | 0 | 0 | 0 | NA | 0 |
| 9.008 | Are required immunizations being offered for chronic care patients? | 10 | 0 | 10 | 100.0% | 15 |
| 9.009 | Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner? | 18 | 2 | 20 | 90.0% | 0 |
| Overall percentage: | | | | | 93.8% | |

# 10–Quality of Nursing Performance

This indicator is evaluated only by case review clinicians. There is no compliance testing component.

# 11–Quality of Provider Performance

This indicator is evaluated only by case review clinicians. There is no compliance testing component.

## 12–*Reception Center Arrivals*

The institution has no reception center, so this indicator is not applicable.

| Reference Number | 13–*Specialized Medical Housing* | Scored Answers | | | | N/A |
|---|---|---|---|---|---|---|
| | | Yes | No | Yes + No | Yes % | |
| 13.001 | For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient on the day of admission, or within eight hours of admission to CMF's Hospice? | 10 | 0 | 10 | 100.0% | 0 |
| 13.002 | For CTC and SNF only: Was a written history and physical examination completed within the required time frame? | 0 | 0 | 0 | NA | 0 |
| 13.003 | For OHU, CTC, SNF, and Hospice: Did the primary care provider complete the Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes on the patient at the minimum intervals required for the type of facility where the patient was treated? | 10 | 0 | 10 | 100.0% | 0 |
| 13.101 | For OHU and CTC Only: Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter patient's cells? | 1 | 0 | 1 | 100.0% | 0 |
| | **Overall percentage:** | | | | **100.0%** | |

| Reference Number | 14–*Specialty Services* | Scored Answers | | | | N/A |
|---|---|---|---|---|---|---|
| | | Yes | No | Yes + No | Yes % | |
| 14.001 | Did the patient receive the high priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? | 15 | 0 | 15 | 100.0% | 0 |
| 14.002 | Did the primary care provider review the high priority specialty service consultant report within the required time frame? | 14 | 1 | 15 | 93.3% | 0 |
| 14.003 | Did the patient receive the routine specialty service within 90 calendar days of the primary care provider order or Physician Request for Service? | 15 | 0 | 15 | 100.0% | 0 |
| 14.004 | Did the primary care provider review the routine specialty service consultant report within the required time frame? | 14 | 1 | 15 | 93.3% | 0 |
| 14.005 | For endorsed patients received from another CDCR institution: If the 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? | 9 | 11 | 20 | 45.0% | 0 |
| 14.006 | Did the institution deny the primary care provider request for specialty services within required time frames? | 19 | 1 | 20 | 95.0% | 0 |
| 14.007 | Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? | 10 | 10 | 20 | 50.0% | 0 |
| **Overall percentage:** | | | | | **82.4%** | |

| Reference Number | 15–*Administrative Operations* | Scored Answers | | | | N/A |
|---|---|---|---|---|---|---|
| | | Yes | No | Yes + No | Yes % | |
| 15.001 | Did the institution promptly process inmate medical appeals during the most recent 12 months? | 12 | 0 | 12 | 100.0% | 0 |
| 15.002 | Does the institution follow adverse / sentinel event reporting requirements? | 0 | 0 | 0 | NA | 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? | 6 | 0 | 6 | 100.0% | 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% | 0 |
| 15.005 | Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents? | 5 | 7 | 12 | 41.7% | 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? | 0 | 0 | 0 | NA | 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? | 3 | 0 | 3 | 100.0% | 0 |
| 15.102 | Did the institution's second level medical appeal response address all of the patient's appealed issues? | 10 | 0 | 10 | 100.0% | 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? | 0 | 0 | 0 | NA | 0 |
| 15.104 | Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff? | 4 | 1 | 5 | 80.0% | 0 |
| 15.105 | Are nursing staff who administer medications current on their clinical competency validation? | 10 | 0 | 10 | 100.0% | 10 |
| 15.106 | Are structured clinical performance appraisals completed timely? | 9 | 0 | 9 | 100.0% | 0 |
| 15.107 | Do all providers maintain a current medical license? | 12 | 0 | 12 | 100.0% | 0 |
| 15.108 | Are staff current with required medical emergency response certifications? | 2 | 0 | 2 | 100.0% | 0 |
| 15.109 | Are nursing staff and the Pharmacist-in-Charge current with their professional licenses and certifications, and is the pharmacy licensed as a correctional pharmacy by the California State Board of Pharmacy? | 5 | 0 | 5 | 100.0% | 0 |

| Reference Number | 15–*Administrative Operations* | Scored Answers | | | | N/A |
|---|---|---|---|---|---|---|
| | | Yes | No | Yes + No | Yes % | |
| 15.110 | Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations? | 1 | 0 | 1 | 100.0% | 0 |
| 15.111 | Are nursing staff current with required new employee orientation? | 1 | 0 | 1 | 100.0% | 0 |
| **Overall percentage:** | | | | | **94.4%** | |

# APPENDIX B — CLINICAL DATA

## Table B-1: ASP Sample Sets

| Sample Set | Total |
|---|---|
| CTC/OHU | 3 |
| Death Review/Sentinel Events | 1 |
| Diabetes | 4 |
| Emergency Services - CPR | 3 |
| Emergency Services - Non-CPR | 2 |
| High Risk | 5 |
| Hospitalization | 5 |
| Intra-system Transfers-In | 3 |
| Intra-system Transfers-Out | 3 |
| RN Sick Call | 18 |
| Specialty Services | 3 |
| | **50** |
| | |

## Table B-2: ASP Chronic Care Diagnoses

| Diagnosis | Total |
|---|---|
| Anemia | 1 |
| Arthritis/Degenerative Joint Disease | 5 |
| Asthma | 5 |
| COPD | 2 |
| Cancer | 6 |
| Cardiovascular Disease | 3 |
| Chronic Pain | 14 |
| Cirrhosis/End Stage Liver Disease | 1 |
| Coccidioidomycosis | 5 |
| Diabetes | 5 |
| Gastroesophageal Reflux Disease | 8 |
| Hepatitis C | 11 |
| Hyperlipidemia | 15 |
| Hypertension | 18 |
| Mental Health | 15 |
| Migraine Headaches | 2 |
| Seizure Disorder | 3 |
| Sleep Apnea | 1 |
| Thyroid Disease | 1 |
| | **121** |

## Table B-3: ASP Event – Program

| Diagnosis | Total |
|---|---|
| Diagnostic Services | 60 |
| Emergency Care | 26 |
| Hospitalization | 33 |
| Intra-system Transfers-In | 9 |
| Intra-system Transfers-Out | 10 |
| Outpatient Care | 295 |
| Specialized Medical Housing | 64 |
| Specialty Services | 83 |
| | **580** |
| | |

# Table B-4: ASP Review Sample Summary

| | Total |
|---|---|
| MD Reviews Detailed | 20 |
| MD Reviews Focused | 1 |
| RN Reviews Detailed | 13 |
| RN Reviews Focused | 27 |
| Total Reviews | 61 |
| Total Unique Cases | 50 |
| Overlapping Reviews (MD & RN) | 11 |

# APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

## Avenal State Prison (ASP)

| Quality Indicator | Sample Category (number of samples) | Data Source | Filters |
|---|---|---|---|
| **Access to Care** | | | |
| MIT 1.001 | Chronic Care Patients (25) | Master Registry | • Chronic care conditions (at least one condition per patient—any risk level)<br>• **Randomize** |
| MIT 1.002 | Nursing Referrals (25) | OIG Q: 6.001 | • See *Intra-system Transfers* |
| MITs 1.003-006 | Nursing Sick Call (5 per clinic) (30) | MedSATS | • Clinic (each clinic tested)<br>• Appointment date (2–9 months)<br>• **Randomize** |
| MIT 1.007 | Returns from Community Hospital (17) | OIG Q: 4.007 | • See *Health Information Management (Medical Records)* (returns from community hospital) |
| MIT 1.008 | Specialty Services Follow-up (30) | OIG Q: 14.001 & 14.003 | • See *Specialty Services* |
| MIT 1.101 | Availability of Health Care Services Request Forms (6) | OIG onsite review | • Randomly select one housing unit from each yard |
| **Diagnostic Services** | | | |
| MITs 2.001–003 | Radiology (10) | Radiology Logs | • Appointment date (90 days–9 months)<br>• **Randomize**<br>• Abnormal |
| MITs 2.004–006 | Laboratory (10) | Quest | • Appt. date (90 days–9 months)<br>• Order name (CBC or CMPs only)<br>• **Randomize**<br>• Abnormal |
| MITs 2.007–009 | Pathology (10) | InterQual | • Appt. date (90 days–9 months)<br>• Service (pathology related)<br>• **Randomize** |

| Quality Indicator | Sample Category (number of samples) | Data Source | Filters |
|---|---|---|---|
| **Health Information Management (Medical Records)** | | | |
| MIT 4.001 | Timely Scanning (10) | OIG Qs: 1.001, 1.002, & 1.004 | • Non-dictated documents<br>• 1st 10 IPs MIT 1.001, 1st 5 IPs MITs 1.002, 1.004 |
| MIT 4.002 | (1) | OIG Q: 1.001 | • Dictated documents<br>• First 20 IPs selected |
| MIT 4.003 | (20) | OIG Qs: 14.002 & 14.004 | • Specialty documents<br>• First 10 IPs for each question |
| MIT 4.004 | (16) | OIG Q: 4.007 | • Community hospital discharge documents<br>• First 20 IPs selected |
| MIT 4.005 | (0) | OIG Q: 7.001 | • MARs<br>• First 20 IPs selected |
| MIT 4.006 | (16) | Documents for any tested inmate | • Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No) |
| MIT 4.007 | Returns From Community Hospital<br><br><br><br><br><br>(17) | Inpatient claims data | • Date (2–8 months)<br>• Most recent 6 months provided (within date range)<br>• Rx count<br>• Discharge date<br>• **Randomize** (each month individually)<br>• First 5 patients from each of the 6 months (if not 5 in a month, supplement from another, as needed) |
| **Health Care Environment** | | | |
| MIT 5.101-105<br>MIT 5.107–111 | Clinical Areas (10) | OIG inspector onsite review | • Identify and inspect all onsite clinical areas. |
| **Inter- and Intra-System Transfers** | | | |
| MIT 6.001-003 | Intra-System Transfers<br><br><br>(25) | SOMS | • Arrival date (3–9 months)<br>• Arrived from (another CDCR facility)<br>• Rx count<br>• **Randomize** |
| MIT 6.004 | Specialty Services Send-Outs (7) | MedSATS | • Date of transfer (3–9 months)<br>• **Randomize** |
| MIT 6.101 | Transfers Out (6) | OIG inspector onsite review | • R&R IP transfers with medication |

| Quality Indicator | Sample Category (number of samples) | Data Source | Filters |
|---|---|---|---|
| **Pharmacy and Medication Management** | | | |
| MIT 7.001 | Chronic Care Medication (25) | OIG Q: 1.001 | *See **Access to Care*** <br>• At least one condition per patient—any risk level <br>• **Randomize** |
| MIT 7.002 | New Medication Orders (25) | Master Registry | • Rx count <br>• **Randomize** <br>• Ensure no duplication of IPs tested in MIT 7.001 |
| MIT 7.003 | Returns from Community Hospital (17) | OIG Q: 4.007 | • See ***Health Information Management (Medical Records)*** *(returns from community hospital)* |
| MIT 7.004 | RC Arrivals – Medication Orders *(N/A at this institution)* | OIG Q: 12.001 | • See ***Reception Center Arrivals*** |
| MIT 7.005 | Intra-Facility Moves (25) | MAPIP transfer data | • Date of transfer (2–8 months) <br>• To location/from location (yard to yard and to/from ASU) <br>• Remove any to/from MHCB <br>• NA/DOT meds (and risk level) <br>• **Randomize** |
| MIT 7.006 | En Route (0) | SOMS | • Date of transfer (2–8 months) <br>• Sending institution (another CDCR facility) <br>• **Randomize** <br>• NA/DOT meds |
| MITs 7.101-103 | Medication Storage Areas (varies by test) | OIG inspector onsite review | • Identify and inspect clinical & med line areas that store medications |
| MITs 7.104–106 | Medication Preparation and Administration Areas (varies by test) | OIG inspector onsite review | • Identify and inspect onsite clinical areas that prepare and administer medications |
| MITs 7.107-110 | Pharmacy (1) | OIG inspector onsite review | • Identify & inspect all onsite pharmacies |
| MIT 7.111 | Medication Error Reporting (25) | Monthly medication error reports | • All monthly statistic reports with Level 4 or higher <br>• Select a total of 5 months |
| MIT 7.999 | Isolation Unit KOP Medications (0) | Onsite active medication listing | • KOP rescue inhalers & nitroglycerin medications for IPs housed in isolation units |
| **Prenatal and Post-Delivery Services** | | | |
| MIT 8.001-007 | Recent Deliveries *(N/A at this institution)* | OB Roster | • Delivery date (2–12 months) <br>• **Most recent** deliveries (within date range) |
| | Pregnant Arrivals *(N/A at this institution)* | OB Roster | • Arrival date (2–12 months) <br>• **Earliest** arrivals (within date range) |

| Quality Indicator | Sample Category (number of samples) | Data Source | Filters |
|---|---|---|---|
| **Preventive Services** | | | |
| MITs 9.001–002 | TB Medications (12) | Maxor | • Dispense date (past 9 months)<br>• Time period on TB meds (3 months or 12 weeks)<br>• **Randomize** |
| MIT 9.003 | TB Evaluation, Annual Screening (30) | SOMS | • Arrival date (at least 1 year prior to inspection)<br>• Birth Month<br>• **Randomize** |
| MIT 9.004 | Influenza Vaccinations (25) | SOMS | • Arrival date (at least 1 year prior to inspection)<br>• **Randomize**<br>• Filter out IPs tested in MIT 9.008 |
| MIT 9.005 | Colorectal Cancer Screening (25) | SOMS | • Arrival date (at least 1 year prior to inspection)<br>• Date of birth (51 or older)<br>• **Randomize** |
| MIT 9.006 | Mammogram *(N/A at this institution)* | SOMS | • Arrival date (at least 2 yrs prior to inspection)<br>• Date of birth (age 52–74)<br>• **Randomize** |
| MIT 9.007 | Pap Smear *(N/A at this institution)* | SOMS | • Arrival date (at least three yrs prior to inspection)<br>• Date of birth (age 24–53)<br>• **Randomize** |
| MIT 9.008 | Chronic Care Vaccinations (25) | OIG Q: 1.001 | • Chronic care conditions (at least 1 condition per IP—any risk level)<br>• **Randomize**<br>• Condition must require vaccination(s) |
| MIT 9.009 | Valley Fever (number will vary) (20) | Cocci transfer status report | • Reports from past 2–8 months<br>• Institution<br>• Ineligibility date (60 days prior to inspection date)<br>• **All** |

| Quality Indicator | Sample Category (number of samples) | Data Source | Filters |
|---|---|---|---|
| **Reception Center Arrivals** | | | |
| MITs 12.001–008 | RC *(N/A at this institution)* | SOMS | • Arrival date (2–8 months)<br>• Arrived from (county jail, return from parole, etc.)<br>• **Randomize** |
| **Specialized Medical Housing** | | | |
| MITs 13.001–003 | OHU<br><br><br>(10) | CADDIS | • Admit date (1–6 months)<br>• Type of stay (no MH beds)<br>• Length of stay (minimum of 5 days)<br>• **Randomize** |
| MIT 13.101 | Call Buttons OHU (all) | OIG inspector onsite review | • Review by location |
| **Specialty Services** | | | |
| MITs 14.001–002 | High-Priority (15) | MedSATS | • Approval date (3–9 months)<br>• **Randomize** |
| MITs 14.003–004 | Routine<br><br>(15) | MedSATS | • Approval date (3–9 months)<br>• Remove optometry, physical therapy or podiatry<br>• **Randomize** |
| MIT 14.005 | Specialty Services Arrivals (20) | MedSATS | • Arrived from (other CDCR institution)<br>• Date of transfer (3–9 months)<br>• **Randomize** |
| MIT 14.006-007 | Denials (7) | InterQual | • Review date (3–9 months)<br>• **Randomize** |
| | (13) | IUMC/MAR Meeting Minutes | • Meeting date (9 months)<br>• Denial upheld<br>• **Randomize** |

| Quality Indicator | Sample Category (number of samples) | Data Source | Filters |
|---|---|---|---|
| **Administrative Operations** | | | |
| MIT 15.001 | Medical Appeals (all) | Monthly medical appeals reports | • Medical appeals (12 months) |
| MIT 15.002 | Adverse/Sentinel Events (0) | Adverse/sentinel events report | • Adverse/sentinel events (2–8 months) |
| MITs 15.003–004 | QMC Meetings (6) | Quality Management Committee meeting minutes | • Meeting minutes (12 months) |
| MIT 15.005 | EMRRC (12) | EMRRC meeting minutes | • Monthly meeting minutes (6 months) |
| MIT 15.006 | LGB (0) | LGB meeting minutes | • Quarterly meeting minutes (12 months) |
| MIT 15.101 | Medical Emergency Response Drills (3) | Onsite summary reports & documentation for ER drills | • Most recent full quarter<br>• Each watch |
| MIT 15.102 | 2nd Level Medical Appeals (10) | Onsite list of appeals/closed appeals files | • Medical appeals denied (6 months) |
| MIT 15.103 | Death Reports (0) | Institution-list of deaths in prior 12 months | • Most recent 10 deaths<br>• Initial death reports |
| MIT 15.104 | RN Review Evaluations (5) | Onsite supervisor periodic RN reviews | • RNs who worked in clinic or emergency setting six or more days in sampled month<br>• **Randomize** |
| MIT 15.105 | Nursing Staff Validations (10) | Onsite nursing education files | • On duty one or more years<br>• Nurse administers medications<br>• **Randomize** |
| MIT 15.106 | Provider Annual Evaluation Packets (9) | Onsite provider evaluation files | • All required performance evaluation documents |
| MIT 15.107 | Provider licenses (12) | Current provider listing (at start of inspection) | • Review all |
| MIT 15.108 | Medical Emergency Response Certifications (all) | Onsite certification tracking logs | • All staff<br>  o Providers (ACLS)<br>  o Nursing (BLS/CPR)<br>• Custody (CPR/BLS) |
| MIT 15.109 | Nursing staff and Pharmacist in Charge Professional Licenses and Certifications (all) | Onsite tracking system, logs, or employee files | • All required licenses and certifications |

| Quality Indicator | Sample Category (number of samples) | Data Source | Filters |
|---|---|---|---|
| **Administrative Operations** | | | |
| MIT 15.110 | Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations (all) | Onsite listing of provider DEA registration #s & pharmacy registration document | • All DEA registrations |
| MIT 15.111 | Nursing Staff New Employee Orientations (all) | Nursing staff training logs | • New employees (hired within last 12 months) <br> • |
| MIT 15.998 | Death Review Committee (0) | OIG summary log - deaths | • Between 35 business days & 12 months prior <br> • CCHCS death reviews |
| | | | |

# CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

August 6, 2018

Roy Wesley, Inspector General
Office of the Inspector General
10111 Old Placerville Road, Suite 110
Sacramento, CA 95827

Dear Mr. Wesley:

The Office of the Receiver has reviewed the draft report of the Office of the Inspector General (OIG) Medical Inspection Results for Avenal State Prison (ASP) conducted from August 2017 to January 2018. California Correctional Health Care Services (CCHCS) acknowledges the OIG findings.

Thank you for preparing the report. Your efforts have advanced our mutual objective of ensuring transparency and accountability in CCHCS operations. If you have any questions or concerns, please contact me at (916) 691-3747.

Sincerely,
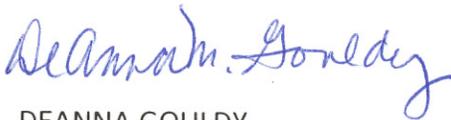
DEANNA GOULDY
Associate Director
Risk Management Branch
California Correctional Health Care Services

cc:  Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
     Clark Kelso, Receiver
     Richard Kirkland, Chief Deputy Receiver
     Stephen Tseng, M.D., Chief of Medical Inspections, OIG
     Penny Horper, R.N., MSN, CPHQ, Nurse Consultant Program Review, OIG
     Yulanda Mynhier, Director, Health Care Policy and Administration, CCHCS
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     Renee Kanan, M.D., Deputy Director, Medical Services, CCHCS
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