Robert A. Barton
Inspector General

Office of the Inspector General

Deuel Vocational Institution
Medical Inspection Results
Cycle 4

January 2017

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

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Robert A. Barton
Inspector General

Roy W. Wesley
Chief Deputy Inspector General

Shaun R. Spillane
Public Information Officer

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EXECUTIVE SUMMARY

Pursuant to California Penal Code Section 6126, which assigns the Office of the Inspector General (OIG) responsibility for oversight of the California Department of Corrections and Rehabilitation (CDCR), the OIG conducts a comprehensive inspection program to evaluate the delivery of medical care at each of CDCR's 35 adult prisons. The OIG **explicitly** makes no determination regarding the constitutionality of care in the prison setting. That determination is left to the Receiver and the federal court. The assessment of care by the OIG is just one factor in the court's determination whether care in the prisons meets constitutional standards. The court may find that an institution the OIG found to be providing adequate care still did not meet constitutional standards, depending on the analysis of the underlying data provided by the OIG. Likewise, an institution that has been rated *inadequate* by the OIG could still be found to pass constitutional muster with the implementation of remedial measures if the underlying data were to reveal easily mitigated deficiencies.

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

For this fourth cycle of inspections, the OIG added a clinical case review component and significantly enhanced the compliance portion of the inspection process from that used in prior cycles. In addition, the OIG added a population-based metric comparison of selected Healthcare Effectiveness Data Information Set (HEDIS) measures from other State and national health care organizations and compared that data to similar results for Deuel Vocational Institution (DVI).

The OIG performed its Cycle 4 medical inspection at DVI from May to August 2016. The inspection included in-depth reviews of 58 inmate-patient files conducted by clinicians, as well as reviews of documents from 423 inmate-patient files, covering 100 objectively scored tests of compliance with policies and procedures applicable to the delivery of medical care. The OIG assessed the case review and compliance results at DVI using 15 health care quality indicators applicable to the institution, made up of 13 primary clinical indicators and two secondary administrative indicators. To conduct clinical case reviews, the OIG employs a clinician team consisting of a physician and a registered nurse consultant, while compliance testing is done by a team of deputy inspectors general and registered nurses trained in monitoring medical policy compliance. Of the 13 primary indicators, 8 were rated by both case review clinicians and compliance inspectors, 3 were rated by case review clinicians only, and 2 were rated by compliance inspectors only; both secondary indicators were rated by compliance inspectors only. See the *Health Care Quality Indicators* table on page *ii*. Based on that analysis, OIG experts made a considered and measured overall opinion that the quality of health care at DVI was ***adequate***.

Health Care Quality Indicators

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

Overall Assessment: Adequate

Overall Assessment Rating:

Adequate

Based on the clinical case reviews and compliance testing, the OIG's overall assessment rating for DVI was *adequate*. Of the 13 primary (clinical) quality indicators applicable to DVI, the OIG found one *proficient*, nine *adequate*, and three *inadequate*. Of the two secondary (administrative) quality indicators, the OIG found one *proficient* and one *inadequate*. To determine the overall assessment for DVI, the OIG considered individual clinical ratings and individual compliance question scores within each of the indicator categories, putting emphasis on the primary indicators. Based on that analysis, OIG experts made a considered and measured overall opinion about the quality of health care observed at DVI.

Clinical Case Review and OIG Clinician Inspection Results

The clinicians' case reviews sampled patients with high medical needs and included a review of 1,561 patient care events.[1] Of the 13 primary indicators applicable to DVI, 11 were evaluated by clinician case review; 10 were *adequate*, and one was *inadequate.* When determining the overall adequacy of care, the OIG paid particular attention to the clinical nursing and provider quality indicators, as adequate health care staff can sometimes overcome suboptimal processes and programs. However, the opposite is not true; inadequate health care staff cannot provide adequate care, even though the established processes and programs onsite may be adequate. The OIG clinicians identify inadequate medical care based on the risk of significant harm to the patient, not the actual outcome.

Program Strengths — Clinical

- Clinicians at DVI used several types of morning huddles, which were scheduled and staggered at different times in the morning. This process allowed excellent transmission of clinical information between different departments and various medical staff as well as within the provider group itself.

- The institution had fully committed to a primary care home model, providing good provider continuity. Nursing staff were equally committed to this model. At the onsite inspection, the OIG clinicians found well-functioning care teams with open lines of communication between providers and nurses.

- Health care leadership at DVI was excellent and provided good support to medical staff. This allowed each primary care team to deliver effective health care to patients. Nursing staff at DVI felt supported by their supervisors and the chief nurse executive (CNE).

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

- The majority of nurses interviewed were enthusiastic about their positions at DVI. This too was largely due to the excellent leadership at DVI.

- During the onsite interviews, all of the DVI providers expressed excellent job satisfaction and morale. A few of the providers reported a long history of poor morale that had improved after the current chief medical executive (CME) started in the position.

- Several providers have worked at DVI for more than ten years, often in the same clinic. This provided patients not only with good continuity of care, but also with providers highly experienced in managing their patient population.

Program Weaknesses — Clinical

- DVI performed poorly in most aspects of diagnostic services involving laboratory services. There was a high, recurring rate of laboratory requests that were not completed. The retrieval of diagnostic test results was sometimes problematic with intermittent failures to scan radiology reports into the eUHR. The failure to include radiology reports in the primary medical record represented a significant and ongoing lapse in patient care.

- Provider documentation was scant at times, with providers failing to document their thought processes and reasoning in their progress notes. This sometimes resulted in inadequate care management. Provider progress notes were also sometimes illegible when providers did not use dictation.

- There were delays in specialist follow-up appointments that could have affected patient care. There were also some delays in the retrieval of specialty reports.

Compliance Testing Results

Of the 15 health care indicators applicable to DVI, 12 were evaluated by compliance inspectors.[2] There were 100 individual compliance questions within those 12 indicators, generating 1,421 data points that tested DVI's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[3] Those 100 questions are detailed in *Appendix A — Compliance Test Results*. The institution's inspection scores in the 12 applicable indicators ranged from 55.0 percent to 90.8 percent, with the primary indicator *Pharmacy and Medication Management* receiving the lowest score, and the primary indicator *Preventive Services* receiving the highest. Of the ten primary indicators applicable to compliance testing, the OIG rated one *proficient*, six *adequate*, and

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

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

three *inadequate.* Of the two secondary indicators, which involve administrative health care functions, one was rated *proficient* and one, *inadequate*.

Program Strengths — Compliance

As the *DVI Executive Summary Table* on page *viii* indicates, the institution's compliance rating was *proficient*, scoring above 85 percent, in the primary indicator *Preventive Services*. The institution also received a *proficient* score in the secondary indicator *Internal Monitoring, Quality Improvement, and Administrative Operations*. The following are some of DVI's strengths based on its compliance scores on individual questions in all the primary health care indicators:

- Patients with chronic care conditions receive a chronic care provider follow-up appointment within required time frames.
- Patients returning from a community hospital received timely provider follow-up visits.
- The institution's medical records staff timely scanned all miscellaneous non-dictated documents, dictated provider notes, and specialty service reports within required time frames.
- DVI nursing staff timely completed assessments and dispositions for patients transferring into the institution. Nursing staff also generally completed an Initial Health Screening form (CDCR Form 7277) on the same day the patient arrived.
- Nursing staff dispensed new medication orders to patients within required time frames.
- Nursing staff at all medication and preparation administration locations employed appropriate administrative controls and protocols during medication preparation.
- DVI staff properly monitored patients taking tuberculosis (TB) medication on a weekly or monthly basis.
- The institution timely offered all sampled patients an influenza vaccination.
- The institution provided colorectal cancer screenings to patients subject to the annual screening requirement within required time frames.
- Providers completed a written history and physical examination for all reception center patients within required time frames.
- For patients entering the outpatient housing unit, nursing staff timely completed an initial assessment on the day of the patient's admission.
- The institution provided routine specialty service appointments timely, and providers received and reviewed routine specialty service reports within required time frames.

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

- The documentation for DVI's medical emergency response drills contained the required summary reports and related records. Both health care and custody staff participated in the drills.

- All DVI providers had an appropriate clinical performance appraisal within the required time frame.

Program Weaknesses — Compliance

The institution received ratings of *inadequate*, scoring below 75 percent, in the following three primary indicators: *Health Care Environment*, *Pharmacy and Medication Management*, and *Reception Center Arrivals*. The institution also received an *inadequate* score in the secondary indicator *Job Performance, Training, Licensing, and Certifications*. The following are some of the weaknesses identified by DVI's compliance scores for individual questions in all the primary health care indicators:

- Patients who transferred into DVI and received a nurse referral to a provider did not always receive their provider visit within the required time frame.

- Providers did not always review patient hospital discharge reports within the required time frame.

- Clinicians did not always wash or sanitize their hands before putting on gloves and before or after patient contact.

- Clinic exam rooms did not always have an adequate environment to allow clinicians to perform proper clinical exams, and several clinic common areas and exam rooms were lacking core medical equipment and supplies, such as a Snellen eye chart, exam table, and a medication refrigerator.

- Patients in transit to other institutions who were temporarily laid over at DVI did not always receive their medications without interruption.

- Clinic and medication line locations did not properly store medications at any of the locations observed by inspectors.

- Nursing staff did not properly read TB tests for reception center patients; specifically, licensed vocation nurses read several TB tests, but policy requires a registered nurse, public health nurse, or a provider to read the TB test.

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

- Supervising nurses did not properly complete periodic reviews of nursing staff, and failed to summarize aspects of the subordinates' work that was well done or needed improvement.

- DVI did not timely provide new employee orientation to all nurses hired in the most recent 12 months as required.

The *DVI Executive Summary Table* on the following page lists the quality indicators the OIG inspected and assessed during the clinical case reviews and objective compliance tests, and provides the institution's rating in each area. The overall indicator ratings were based on a consensus decision by the OIG's clinicians and non-clinical inspectors.

DVI Executive Summary Table

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

The *Prenatal and Post-Delivery Services* indicator did not apply to this institution.

Secondary Indicators (Administrative)	Case Review Rating	Compliance Rating	Overall Indicator Rating
Internal Monitoring, Quality Improvement, and Administrative Operations	Not Applicable	*Proficient*	*Proficient*
Job Performance, Training, Licensing, and Certifications	Not Applicable	*Inadequate*	*Inadequate*

Compliance results for quality indicators are *proficient* (greater than 85.0 percent), *adequate* (75.0 percent to 85.0 percent), or *inadequate* (below 75.0 percent).

Population-Based Metrics

Overall, population-based metrics showed that DVI's statewide and national comparative performance was generally adequate for diabetic care, influenza vaccinations for older adults, and pneumococcal immunization, but has room for improvement for influenza immunizations for younger adults and colorectal cancer screening measures. Statewide, DVI scored higher than Medi-Cal in all five diabetic measures, and scored higher than Kaiser did in all diabetic measures, with the exception of diabetic patients under good control, in which Kaiser North scored higher. Nationally, the institution outperformed Medicaid, Medicare, and commercial health plans, in all diabetic measures; and performed better in comparison to the United States Department of Veterans Affairs (VA) in three of the four diabetic measures, with VA scoring higher than DVI for eye exams.

With regard to immunizations, the institution scored significantly lower than all applicable State and national health organizations for influenza immunizations for young adults. Patient refusals negatively affected the institution's score for this measure. However, the institution outperformed both Medicare and the VA for administering influenza immunizations for older adults. In addition, DVI scored higher than Medicare for administering pneumococcal immunizations, and matched the VA for the same measure. Finally, the institution scored lower than Kaiser and the VA for colorectal cancer screenings, but higher than commercial plans and Medicare.

Overall, DVI's performance demonstrated by population-based metrics indicated that the comprehensive diabetes care, influenza immunizations for older adults, and pneumococcal immunizations were average in comparison to statewide and national health care organizations. The institution could improve their score for influenza immunizations for younger adults and colorectal cancer screenings by making interventions to educate patients on the benefits of these services to reduce the number of refusals.

INTRODUCTION

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

Deuel Vocational Institution (DVI) was the 31st medical inspection of Cycle 4. During the inspection process, the OIG assessed the delivery of medical care to patients for 13 primary clinical health care indicators and two secondary administrative health care indicators applicable to the institution. It is important to note that while the primary quality indicators represent the clinical care being provided by the institution at the time of the inspection, the secondary quality indicators are purely administrative and are not reflective of the actual clinical care provided.

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

ABOUT THE INSTITUTION

The mission at DVI is two-fold; the primary function is as a reception center that receives inmates from 29 Northern California counties; secondarily, the institution provides housing for custody levels I and II general population inmates serving their terms of incarceration. The institution runs multiple medical clinics where staff members handle non-urgent requests for medical services, and it treats inmates needing urgent or emergency care in its triage and treatment area (TTA). The institution also treats patients who require assistance with the activities of daily living but who do not require a higher level of inpatient care in the institution's outpatient housing unit (OHU). DVI has been designated as a "basic" care institution, located in a rural area away from tertiary care centers and specialty care providers whose services would likely be used frequently by higher-risk patients.

At the time of the medical inspection, DVI was scheduled for a review from the Commission on Accreditation for Corrections, a professional peer review process based on national standards set by the American Correctional Association. The inspection is scheduled to take place in April of 2017.

Based on staffing data the OIG obtained from the institution, DVI's vacancy rate among medical managers, primary care providers, supervisors, and non-supervisory nurses was 11 percent in May 2016, with the highest vacancy percentages among medical managers at 25 percent, and nursing supervisors at 19 percent. The institution also utilized one primary care provider and 11 nursing staff from the registry. DVI had three staff members that were on long-term medical leave.

DVI Health Care Staffing Resources as of May 2016

	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff		Totals	
Description	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Authorized Positions	4	4%	6	7%	10.5	12%	69.8	77%	90.3	100%
Filled Positions	3	75%	6	100%	8.5	81%	62.8	90%	80.3	89%
Vacancies	1	25%	0	0%	2	19%	7	10%	10	11%
Recent Hires (within 12 months)	2	67%	0	0%	3	35%	14	22%	19	24%
Staff Utilized from Registry	0	0%	1	17%	0	0%	11	18%	12	15%
Redirected Staff (to Non-Patient Care Areas)	0	0%	0	0%	0	0%	0	0%	0	0%
Staff on Long-term Medical Leave	0	0%	0	0%	1	12%	2	3%	3	4%

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

As of May 16, 2016, the Master Registry for DVI showed that the institution had a total population of 2,255 inmates. Within that total population, 1.5 percent were designated as high medical risk, Priority 1 (High 1), and 4.7 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 labs 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.

DVI Master Registry Data as of May 16, 2016

Medical Risk Level	# of Inmate-Patients	Percentage
High 1	34	1.5%
High 2	106	4.7%
Medium	761	33.8%
Low	1,354	60.0 %
Total	**2,255**	**100.0%**

Commonly Used Abbreviations

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

OBJECTIVES, SCOPE, AND METHODOLOGY

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

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

The OIG rates each of the quality indicators applicable to the institution under inspection based on case reviews conducted by OIG clinicians and compliance tests conducted by OIG deputy inspectors general and registered nurses. The ratings may be derived from the case review results alone, the compliance test results alone, or a combination of both these information sources. For example, the ratings for the primary quality indicators *Quality of Nursing Performance* and *Quality of Provider Performance* are derived entirely from the case review results, while the ratings for the primary quality indicators *Health Care Environment* and *Preventive Services* are derived entirely from compliance test results. As another example, primary quality indicators such as *Diagnostic Services* and *Specialty Services* receive ratings derived from both sources. At DVI, 15 of the quality indicators were applicable, consisting of 13 primary clinical indicators and 2 secondary administrative indicators. Of the 13 primary indicators, 8 were rated by both case review clinicians and compliance inspectors, 3 were rated by case review clinicians only, and 2 were rated by compliance inspectors only; both secondary indicators were rated by compliance inspectors only.

Consistent with the OIG's agreement with the Receiver, this report only addresses the conditions found related to medical care criteria. The OIG does not review for efficiency and economy of

operations. Moreover, if the OIG learns of an inmate-patient needing immediate care, the OIG notifies the chief executive officer of health care services and requests a status report. Additionally, if the OIG learns of significant departures from community standards, it may report such departures to the institution's chief executive officer or to CCHCS. Because these matters involve confidential medical information protected by State and federal privacy laws, specific identifying details related to any such cases are not included in the OIG's public report.

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

CASE REVIEWS

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

PATIENT SELECTION FOR RETROSPECTIVE CASE REVIEWS

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

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

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

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

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

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

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

BENEFITS AND LIMITATIONS OF TARGETED SUBPOPULATION REVIEW

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

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

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

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

CASE REVIEWS SAMPLED

As indicated in *Appendix B, Table B–1: DVI Sample Sets*, the OIG clinicians evaluated medical charts for 58 unique inmate-patients. *Appendix B, Table B–4: DVI Case Review Sample Summary*, clarifies that both nurses and physicians reviewed charts for 17 of those patients, for 75 reviews in total. Physicians performed detailed reviews of 30 charts, and nurses performed detailed reviews of 20 charts, totaling 50 detailed reviews. For detailed case reviews, physicians or nurses looked at all encounters occurring in approximately six months of medical care. Nurses also performed a limited or focused review of medical records for an additional 25 inmate-patients. These generated 1,561 clinical events for review (*Appendix B, Table B–3: DVI Event—Program*). The inspection tool provides details on whether the encounter was adequate or had significant deficiencies, and identifies deficiencies by programs and processes to help the institution focus on improvement areas.

While the sample method specifically pulled only 6 chronic care patient records, i.e., 3 diabetes patients and 3 anticoagulation patients (*Appendix B, Table B–1: DVI Sample Sets*), the 58 unique inmate-patients sampled included patients with 153 chronic care diagnoses, including 13 additional patients with diabetes (for a total of 16) (*Appendix B, Table B–2: DVI Chronic Care Diagnoses*). The OIG's sample selection tool allowed evaluation of many chronic care programs because the complex and high-risk patients selected from the different categories often had multiple medical problems. While the OIG did not evaluate every chronic disease or health care staff member, the overall operation of the institution's system and staff were assessed for adequacy. The OIG's case review methodology and sample size matched other qualitative research. The empirical findings, supported by expert statistical consultants, showed adequate conclusions after 10 to 15 charts had undergone full clinician review. In qualitative statistics, this phenomenon is known as "saturation." The OIG asserts that the physician sample size of over 30 detailed reviews certainly far exceeds the saturation point necessary for an adequate qualitative review. With regard to reviewing charts from different providers, the case review is not intended to be a focused search for poorly performing providers; rather, it is focused on how the system cares for those patients who need care the most. Nonetheless, while not sampling cases by each provider at the institution, the OIG inspections adequately review most providers. Providers would only escape OIG case review if institutional management successfully mitigated patient risk by having the more poorly performing providers care for the less complicated, low-utilizing, and lower-risk patients. The OIG's clinicians concluded that the case review sample size was more than adequate to assess the quality of services provided.

Based on the collective results of clinicians' case reviews, the OIG rated each quality indicator as either *proficient* (excellent), *adequate* (passing), *inadequate* (failing), or *not applicable*. A separate confidential *DVI Supplemental Medical Inspection Results: Individual Case Review Summaries* report details the case reviews OIG clinicians conducted and is available to specific stakeholders. For further details regarding the sampling methodologies and counts, see *Appendix B — Clinical Data, Table B–1; Table B–2; Table B–3;* and *Table B–4*.

COMPLIANCE TESTING

SAMPLING METHODS FOR CONDUCTING COMPLIANCE TESTING

From May to August 2016, deputy inspectors general and registered nurses attained answers to 100 objective medical inspection test (MIT) questions designed to assess the institution's compliance with critical policies and procedures applicable to the delivery of medical care. To conduct most tests, inspectors randomly selected samples of inmate-patients for whom the testing objectives were applicable and reviewed their electronic unit health records. In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed health records for 423 individual inmate-patients and analyzed specific transactions within their records for evidence that critical events occurred. Inspectors also reviewed management reports and meeting minutes to assess certain administrative operations. In addition, during the week of May 31, 2016, field inspectors conducted a detailed onsite inspection of DVI's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,421 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 DVI's plant infrastructure, protocols for tracking medical appeals and local operating procedures, and staffing resources.

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

SCORING OF COMPLIANCE TESTING RESULTS

The OIG rated the institution in the following 10 primary (clinical) and 2 secondary (administrative) quality indicators applicable to the institution for compliance testing:

- Primary indicators: *Access to Care*; *Diagnostic Services*; *Health Information Management (Medical Records)*; *Health Care Environment*; *Inter- and Intra-System Transfers*; *Pharmacy and Medication Management*; *Preventive Services*; *Reception Center Arrivals*; *Specialized Medical Housing*; and *Specialty Services.*

- Secondary indicators: *Internal Monitoring, Quality Improvement, and Administrative Operations*; and *Job Performance, Training, Licensing, and Certifications*.

After compiling the answers to the 100 questions, the OIG derived a score for each primary and secondary quality indicator identified above by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Based on those results, the OIG assigned a rating to each quality indicator of *proficient* (greater than 85 percent), *adequate* (between 75 percent and 85 percent), or *inadequate* (less than 75 percent).

DASHBOARD COMPARISONS

In the first ten medical inspection reports of Cycle 4, the OIG identified where similar metrics for some of the individual compliance questions were available within the CCHCS Dashboard, which is a monthly report that consolidates key health care performance measures statewide and by institution. However, there was not complete parity between the metrics due to differing time frames for data collecting and differences in sampling methods, rendering the metrics incomparable. The OIG has removed the Dashboard comparisons to eliminate confusion. Dashboard data is available on CCHCS's website, www.cphcs.ca.gov.

OVERALL QUALITY INDICATOR RATING FOR CASE REVIEWS AND COMPLIANCE TESTING

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

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

POPULATION-BASED METRICS

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

MEDICAL INSPECTION RESULTS

PRIMARY (CLINICAL) QUALITY INDICATORS OF HEALTH CARE

The primary quality indicators assess the clinical aspects of health care. As shown on the *Health Care Quality Indicators* table on page *ii* of this report, 13 of the OIG's primary indicators were applicable to DVI. Of those 13 indicators, 8 were rated by both the case review and compliance components of the inspection, 3 were rated by the case review component alone, and 4 were rated by the compliance component alone.

The *DVI Executive Summary Table* on page *viii* shows the case review and compliance ratings for each applicable indicator.

Summary of Case Review Results: The clinical case review component assessed 11 of the 13 primary (clinical) indicators applicable to DVI. Of these 11 indicators, OIG clinicians rated zero *proficient*, ten *adequate*, and one *inadequate*.

The OIG physicians rated the adequacy of care for each of the 30 detailed case reviews they conducted. Of these 30 cases, none was *proficient*, four were *inadequate*, and 26 were *adequate*. In the 1,561 events reviewed, there were 534 deficiencies, 74 of which were considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

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

- In case 38, the patient had a recent revision of his orbital eye fracture. A provider saw the patient in the TTA for eye pain, redness, and the sensation of having a foreign body in his eye. While the provider referred the patient for a next-day evaluation with the optometrist, this follow-up never actually occurred. The patient's eye problem remained undiagnosed and he was at risk of developing permanent eye damage.

Summary of Compliance Results: The compliance component assessed 10 of the 13 primary (clinical) indicators applicable to DVI. Of these ten indicators, OIG inspectors rated one *proficient*, six *adequate*, and three *inadequate*. The results of those assessments are summarized within this section of the report. The test questions used to assess compliance for each indicator are detailed in *Appendix A*.

ACCESS TO CARE

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

Case Review Rating:
Adequate
Compliance Score:
Adequate
(79.4%)

Overall Rating:
Adequate

Case Review Results

The OIG clinicians reviewed 941 provider, nursing, specialty, and outside hospital encounters and identified 100 deficiencies relating to access to care, of which 29 were significant and placed the patient at risk of harm. Due to the low number of severe deficiencies identified, the OIG rated the *Access to Care* indicator *adequate.*

Provider-to-Provider Follow-up Appointments

DVI performed adequately with provider-ordered follow-up appointments. These are among the most important aspects of the *Access to Care* indicator. Failure to accommodate provider-ordered appointments can often result in lapses in care or can even result in patients being lost to follow-up. This problem was infrequent at DVI. While follow-up appointments were sometimes late, they were held. This deficiency was identified in cases 1, 20, 25, 33, 42, 44, and the following case:

- In case 38, the provider ordered a two- to three-day follow-up for the patient, but it was over two weeks before the provider followed up with the patient.

Nursing Sick Call Access

The institution performed adequately with nursing sick call access. This is a critical component of the *Access to Care* indicator because nursing sick call requests are the primary method patients use to access health care initially. DVI nurses appropriately identified which symptoms required same-day intervention. Most of the sick call requests reviewed were processed in a timely manner. Exceptions were found in cases 5, 20, 21, 27, 47, 50, and 53, in which nurse assessments were delayed because the requests were received on a weekend or a holiday.

Nurse-to-Provider Referrals

Nursing staff at the institution made appropriate referrals to providers, and provider visits usually occurred within the requested time frame. The nursing staff at the institution made appropriate referrals to the providers, and the provider visits usually occurred within the requested time interval. However, provider visits were delayed twice in case 22 and once in case 29.

Provider Follow-up After Specialty Service

DVI providers consistently followed up with patients after specialty services. The OIG clinicians reviewed 127 diagnostic and consultative specialty service appointments; in only a few instances were provider follow-ups delayed. These usually occurred after patients returned to the triage and treatment area (TTA) from offsite specialty visits. However, delays such as these increased the risk of lapses or delays in patient care. These deficiencies occurred in cases 25, 36, 38, 39, and the following case:

- In case 27, the patient returned from the hospital after having a coronary angiogram (scan to evaluate blood flow to the heart). The TTA nurse requested a one-day follow-up for the patient with his provider, but this did not occur within the requested time frame. This failure was significant because short-interval follow-ups either from the TTA or from an outside hospital usually involve patients with an acute medical issue that should be closely monitored by a provider.

Intra-System Transfers

Nurses assessed newly transferred patients and always referred them to a provider. The OIG clinicians reviewed eight transfer-in patients and found three instances in which there was a short delay before the provider saw a newly transferred patient (cases 6, 7, and 8).

Follow-up After Hospitalization

The institution adequately ensured that providers saw their patients after they returned from an outside hospital or an emergency department. The OIG clinicians reviewed 37 hospitalization and outside emergency events. The five deficiencies with access to care in this area occurred in cases 2, 26, 28, 39, and the following:

- In case 21, the provider failed to follow-up with the patient after the patient was discharged from the hospital following foot surgery.

Urgent/Emergent Care

DVI had no difficulty ensuring that the primary care provider or the clinic nurse evaluated patients in the TTA. The OIG clinicians reviewed 53 urgent or emergent encounters, of which 40 required a provider or nurse follow-up. Provider follow-ups were slightly delayed in cases 1, 25, and 38.

Specialized Medical Housing

The institution's medical staff performed adequately with provider access during and after patients were admitted to the outpatient housing unit (OHU). A provider usually saw OHU patients at appropriate time intervals. The OIG clinicians reviewed 12 OHU admissions with 127 provider encounters. There were ten instances in which a provider did not timely perform OHU follow-ups as ordered by the provider or per the every-two-week follow-up policy requirement. The ten deficiencies that occurred were in cases 25, 26, 38, 39, and 42.

Reception Center

DVI performed adequately in providing initial provider visits for history and physical examinations. The majority of these visits were completed timely. Of the 15 patients reviewed, 13 had a provider visit within seven days as required by CCHCS policy. Mild delays that occurred outside the required seven days were identified in cases 12 and 18.

Nursing Case Management

The OIG clinicians reviewed 18 case management nurse encounters with nine patients. Most case management nurses met quarterly with their assigned patients. While there was one encounter that occurred beyond the requested time frame (case 24), this delay did not affect patient care.

Clinician Onsite Inspection

DVI had approximately 800 general population patients and 160 reception center patients with no provider backlog in either clinic. This lack of backlogs was due to DVI being fully staffed as well as having a number of highly experienced providers. There were at least seven full-time providers working in either clinic, with the providers averaging 12 to 14 patients per day. Furthermore, some of these providers had worked at DVI for more than ten years, often in the same clinic. This consistency provided patients with not only continuity of care, but also with providers highly experienced in managing their patient population.

During the meeting with the chief medical executive (CME) and the chief physician and surgeon (CP&S), the OIG clinicians also learned that DVI used registry physicians to further strengthen access to care at DVI.

Clinician Summary

The institution demonstrated adequate ability to provide patients with access to care. The OIG clinicians found adequate performance in almost all areas, except for timely follow-ups with specialty services. Despite this issue, the OIG clinicians rated this indicator *adequate*.

Compliance Testing Results

The institution received an *adequate* compliance score of 79.4 percent in the *Access to Care* indicator, scoring within the *proficient* range in the following five tests:

- Inmates had access to Health Care Services Request forms (CDCR Form 7362) at all six housing units inspected (MIT 1.101).

- Inspectors sampled 30 health care service requests submitted by patients across all facility clinics. As documented on the requests, for all samples, nursing staff reviewed the request form on the same day it was received (MIT 1.003).

- The OIG tested 30 patients discharged from a community hospital to determine if they received a provider follow-up appointment within five calendar days of their return to DVI, and all 30 patients received a timely provider follow-up appointment (MIT 1.007).

- Inspectors reviewed recent appointments for 30 patients who suffered with one or more chronic care conditions and 29 of the patients (97 percent) had timely follow-up appointments. One patient received a follow-up appointment nearly four months late (MIT 1.001).

- OIG inspectors sampled 30 patients who submitted a health care services request, of whom 10 received a nurse referral to a provider. Of those ten patients, nine (90 percent) received a timely appointment. One patient did not receive his appointment at all (MIT 1.005).

- Inspectors sampled 28 patients who had received a specialty service; 24 of them (86 percent) received a timely follow-up appointment with a provider. Four patients received a follow-up appointment from one to 12 days late (MIT 1.008).

The institution scored in the *inadequate* range and showed room for improvement in the following areas:

- Of the four patients whom nursing staff referred to a provider from a sick call encounter and for whom the provider subsequently ordered a follow-up appointment, only one (25 percent) received a timely follow-up appointment. The remaining three patients each received a follow-up appointment one day late (MIT 1.006).

- Only 9 of the 19 patients sampled who transferred into DVI from other institutions and were referred to a provider for a routine appointment based on nursing staff's initial health care screening of the patient were seen timely (47 percent). Among the other ten patients, seven received appointments between one and 19 days late, and two received appointments 63 and 85 days late. There was no evidence found in the eUHR that one other patient received an appointment at all (MIT 1.002).

- Nursing staff completed a face-to-face encounter with the patient within one business day of reviewing the service request form for 21 of the 30 patients sampled (70 percent). For nine patients, the nurse conducted the visit from one to three days late (MIT 1.004).

Recommendations

No specific recommendations.

DIAGNOSTIC SERVICES

Case Review Rating:
Inadequate
Compliance Score:
Adequate
(83.7%)

Overall Rating:
Inadequate

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

For this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *inadequate* rating and the compliance testing resulting in an *adequate* rating. Case review revealed that diagnostic tests were frequently not completed as ordered, which is a serious deficiency that can potentially lead to significant delays or even lapses in medical care. The institution also had problems retrieving diagnostic reports. The OIG's internal review process considered those factors that led to both scores and ultimately rated this indicator *inadequate*.

Case Review Results

The OIG clinicians reviewed 228 diagnostic events and found 55 deficiencies, 19 of which were significant. Of the 55 deficiencies, 25 were related to health information management and 30 to diagnostic test orders that were not completed. Test reports that were never retrieved or reviewed were considered just as severe a problem as tests that were not completed as ordered.

Laboratory tests that were ordered by the provider but never processed by the laboratory were found in cases 2, 5, 19, 21, 25, 29, 30, 31, 35, 38, 39, 42, and the following:

- In case 3, the patient was seen in the TTA for lightheadedness. The provider ordered a laboratory test to determine if anemia was the cause of his symptoms. This test was never completed, which increased the patient's risk of having undiagnosed anemia.

- In case 20, the provider saw the patient in follow-up after a hospital discharge for heart failure and atrial fibrillation (irregular heartbeat). Laboratory tests ordered by the provider were never completed. These tests had to be reordered by the provider at a subsequent follow-up. This failure not only delayed the patient's medical care, but also generated an unnecessary extra provider follow-up.

- In case 22, the patient had bloody stools after taking ibuprofen. The provider ordered a laboratory test to determine if the patient had anemia. This test was never completed, which increased the patient's risk of having undiagnosed anemia.

Mild to moderate delays in the collection of labs were found in cases 12 and 24. Diagnostic scans that were ordered by the provider but not performed were found in cases 3, 4, and the following:

- In case 5, the patient was seen in the TTA after having fallen off the top bunk. He was evaluated by the provider, who ordered mid- and lower-spine x-rays. The mid-spine x-ray was never completed, which placed the patient at an increased risk of having an undiagnosed spinal fracture.

Laboratory and diagnostic reports were not retrieved and scanned into the eUHR in cases 20, 25, 31, 32, 36, and 38. DVI also demonstrated poor performance in the retrieval and scanning of radiology reports into the eUHR. This type of failure increases the risk of patient harm or lapse in care because the ordering provider or subsequent providers may not be aware of this pertinent information being available to them.

Delayed scans of laboratory reports into the eUHR were found in cases 2, 3, 20, 25, 27, 34, and the examples below. These delays were moderate to significant, and most were due to medical records staff failing to timely retrieve and scan these reports into the eUHR.

- In case 35, medical records staff delayed scanning the laboratory report for the patient's bone marrow cancer into the eUHR. As a result, the report was not available to the provider at the time of the patient's follow-up. Consequently, the patient's medical care was delayed, as pertinent information was not available to the provider.

- In case 39, the patient had a CT scan of his abdomen and pelvis that revealed a large bladder tumor suggesting cancer. The tumor was later biopsied, confirming bladder cancer. Medical records failed to retrieve and scan the pathology report into the eUHR for over five months. While this could have significantly delayed treatment, the patient refused the chemotherapy eventually offered.

Diagnostic reports that either lacked a provider signature or were not dated at the time of their review were found in cases 38 and 39. Misfiled diagnostic reports were found in cases 33 and 39. These deficiencies were assigned in the *Health Information Management* indicator.

Clinician Onsite Inspection

The OIG clinicians inquired about the high, recurring rate of laboratory tests that DVI staff did not complete. While the laboratory supervisor accepted the majority of these deficiencies, the supervisor stated that the reason a few of these laboratory tests had not been completed was that the laboratory did not receive the orders.

The institution's leadership present during the onsite inspection also explained that radiology reports were not scanned into the eUHR due to a memo from CCHCS headquarters. The memo stated that these reports would no longer be scanned into the eUHR, as the Radiology Information System would be the sole report repository. However, the OIG maintains that this memo created not only an unnecessary barrier for providers to overcome to access patient information, but also an ongoing risk that lapses in patient care may occur.

Clinician Summary

DVI performed poorly with most aspects of laboratory services. There was a high, recurring rate of laboratory requests that were not completed. The retrieval of diagnostic test results was sometimes problematic with intermittent failures to scan radiology reports into the eUHR. The failure to have radiology reports as part of the primary medical record presented a significant and ongoing risk for lapses in patient care. Therefore, the OIG clinicians rated this indicator *inadequate.*

Compliance Testing Results

The institution received an *adequate* compliance score of 83.7 percent in the *Diagnostic Services* indicator, which encompasses radiology, laboratory, and pathology services. For clarity, each type of diagnostic service is discussed separately below:

Radiology Services

- Nine of the ten (90 percent) radiology services sampled were timely performed. One patient received his service 31 days late (MIT 2.001). Providers initialed and dated radiology reports to evidence their review within two business days of receipt for eight of ten patients (80 percent). One report was reviewed one day late, and the other was not reviewed at all (MIT 2.002). Lastly, providers communicated the radiology results to all ten patients within the required time frame (MIT 2.003).

Laboratory Services

- The institution completed laboratory services within the required time frame for nine of ten patients sampled (90 percent). One patient received his service ten days late (MIT 2.004). Providers initialed and reviewed laboratory reports and communicated the results to nine of ten patients (90 percent). For one patient sampled, the provider initialed and reviewed the laboratory report and communicated the results to the patient six days late (MIT 2.005, 2.006).

Pathology Services

- The institution's documented eUHR evidence showed it received a final pathology report for only seven of ten sampled patients (70 percent). For three patients, there was no evidence found that the institution received a final report (MIT 2.007). For all seven samples for

which the institution did receive a final report, providers timely reviewed the results (MIT 2.008). However, providers communicated the final pathology results to only three of the seven applicable patients within the required time frame (43 percent). Providers communicated the pathology results to three patients from one to five days late, and one provider did not communicate the pathology results to the patient (MIT 2.009).

Recommendation for CCHCS

The OIG recommends that CCHCS revise its radiological report scanning policy and allow radiology reports to be scanned into the patient's eUHR.

Recommendation for DVI

The OIG recommends DVI scan all future radiology reports into the eUHR.

EMERGENCY SERVICES

Case Review Rating:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

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

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

Case Review Results

The OIG clinicians reviewed 98 urgent or emergent events and found 42 deficiencies. All deficiencies were minor and did not significantly affect patient care. In general, patients requiring urgent or emergent services received timely and adequate care in the majority of cases reviewed.

Provider Performance

This is discussed in the *Quality of Provider Performance* indicator.

Nursing Performance

The nursing care provided during emergency medical response incidents was generally adequate. The OIG found 31 deficiencies in this area. While nursing deficiencies were minor, nursing documentation of some TTA encounters revealed a few incidents of inadequate assessment and monitoring by the nurses, as illustrated by the following examples:

- In case 2, the patient had numerous emergency responses and TTA encounters due to seizures. Nurses did not always document adequate descriptions of seizure activity or perform adequate after-seizure assessments for injuries. Also in case 2, the TTA nurses responded to the outpatient housing unit on two occasions and assessed the patient because he was having seizures. The nurses failed to document both of these encounters.

- In case 24, the TTA nurses delayed administering nitroglycerine and chewable aspirin per the nursing protocol for chest pain.

- In case 27, nurses neither monitored vital signs nor reassessed the patients' condition with adequate frequency to ensure the patient was not deteriorating.

Nurses failed to describe the emergency medical response activity, including a timeline of events, in cases 2, 3, and 4. Without this information, it was difficult to determine if the care provided was timely and appropriate.

Emergency Medical Response Review Committee

The OIG clinicians reviewed the committee minutes for six of the emergency responses reviewed, and found the committee timely reviewed cases and correctly identified training issues.

Clinician Onsite Inspection

The institution's TTA accommodated three patients. During the onsite visit, the OIG clinicians found the patient care environment to have an adequate number of nurses for the usual TTA activities.

Clinician Summary

The OIG rated the *Emergency Services* indicator at DVI *adequate.*

Recommendations

No specific recommendations.

HEALTH INFORMATION MANAGEMENT (MEDICAL RECORDS)

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

Case Review Rating:
Adequate
Compliance Score:
Adequate
(75.7%)

Overall Rating:
Adequate

Case Review Results

The OIG clinicians found minor deficiencies during the case review of DVI's health information management. Out of 534 (total) deficiencies identified from the case reviews, 112 related to health information management processes. The OIG noted 12 significant deficiencies (twice in cases 31 and 33, and once in cases 20, 21, 24, 28, 34, 35, 38, and 39). The case review rating for the *Health Information Management* indicator for DVI was *adequate*.

Inter-Departmental Transmission

The institution performed adequately with interdepartmental transmission except for deficiencies related to the transmission of diagnostic reports. Furthermore, a significant transmission error was identified in case 24, in which critical laboratory studies were not transmitted to headquarters. Because of this error, the patient's medical treatment was not started until a later date. Deficiencies involving the transmission of diagnostic reports are discussed in the *Diagnostic Services* indicator.

DVI demonstrated a moderate pattern of missing documents across various aspects of the institution. Missing documents included clinic provider notes, nursing notes, transfer-out forms, an emergency room visit report, and a hospital visit report. Missing documents were identified in cases 9, 10, 20, 22, 24, 27, 36, and 38.

Documentation Quality and Legibility

Most providers handwrote or typed their progress notes, but on occasion, they used dictation. No transcription delays were identified due to the limited use of the dictation service by providers.

Provider documentation was at times scant with providers failing to document their thought processes and reasoning in their progress notes. This resulted in inadequate care management at times.

Illegible provider orders, signatures, or initials were identified in cases 3, 5, and 34. Illegible progress notes pose a significant medical risk to patients, especially when the medical care must be reviewed by other staff or if a patient is transferred to a different care team. Since the dictation service was rarely used by DVI providers, some of their progress notes were difficult to read.

Providers neglected to sign diagnostic reports, offsite specialty reports, hospital, and emergency room records in cases 1, 2, 3, 4, 20, 24, 25, 26, 27, 28, 36, and 39.

Providers incorrectly documented the date of an offsite specialty report after having reviewed it in case 26.

The provider signatures were either not dated or timed by a provider in cases 2, 17, 20, and 39.

Hospital Records

DVI did very well with the retrieval of emergency department (ED) physician reports and hospital discharge summaries. The OIG clinicians reviewed 13 ED events and 24 community hospital events. All ED reports and discharge summaries were retrieved and scanned in a timely manner.

The institution performed poorly with having the ED physician report or the hospital discharge summary reviewed and initialed by a provider. The majority of outside ED and hospital reports were not initialed by DVI providers. This is discussed in more detail in the Documentation Quality section of this indicator.

Specialty Services

Health information management for specialty services was poor at DVI, and there were some problems in the retrieval of specialty reports. These findings are also discussed in the health information management section of the *Specialty Services* indicator.

Diagnostic Reports

The OIG clinicians found problems in the retrieval and scanning of diagnostic reports. Furthermore, diagnostic reports were often not timely scanned. These findings are discussed in detail in the health information management section of the *Diagnostic Services* indicator.

Urgent/Emergent Records

On-call providers did not reliably document their telephone encounters. Missing on-call provider documentation was identified in cases 1, 2, 3, 24, 25, 27, 38, and 39.

Nursing staff sometimes did not properly document their urgent and emergent encounters. Missing nursing documentation was identified in cases 2, 3, 4, 5, 24, and 27.

Scanning Performance

Several scanned documents either were mislabeled or misfiled. Erroneously scanned documents can create delays or lapses in care by hindering providers' ability to find relevant clinical information. DVI performed adequately in this area. Case review found mislabeled documents in the eUHR in cases 5, 25, 27, 31, 41, and 42. Misfiled documents (filed in the wrong chart) were found in cases 12, 24, 33, and 35.

Scanning times for most documents were generally good. However, a few cases were identified where DVI performed poorly scanning offsite specialty progress notes into the eUHR timely. These findings are discussed in detail in the *Specialty Services* indicator.

Clinician Onsite Inspection

The OIG clinicians observed clinical information transmission during the daily morning huddles. In addition, the OIG clinicians interviewed various health care staff regarding how information was handled, especially how clinical care occurred outside clinic and after regular hours. The OIG clinicians determined the process used by DVI to transmit information was excellent. Important afterhours clinical information was first distributed every morning in the provider meetings attended by the CME, CP&S, and all the medical providers. Providers were also given laboratory studies and offsite reports to review during these meetings. Once provider meetings were completed, each provider would then go to either the reception clinic for the reception center huddle or the mainline clinic for the mainline huddle. These interdisciplinary huddles consisted of all the medical providers, nurses, case managers, schedulers, and mental health providers for each respective clinic. Any nursing, mental health or medical provider issues were raised and addressed at that time. Once these interdisciplinary huddles were completed, each provider would meet with their respective nurses and schedulers for the provider line huddle. It was during these provider line huddles that specific patients, offsite patient visits, and patient follow-ups were discussed. Furthermore, patient medications were reviewed and renewed as needed during these physician line huddles. While these meetings may have appeared redundant, this constant review of information helped mitigate or prevent any lapses in the transmission of medical information between the different medical departments and staff at DVI.

Clinician Summary

DVI performed poorly documenting important health care information providers had reviewed. Furthermore, providers failed to consistently document they reviewed hospital discharge summaries as well as emergency department reports in their progress notes. While DVI providers displayed poor legibility in the majority of the cases reviewed, these deficiencies did not significantly affect patient health care. DVI also performed well with the retrieval of outside ER reports and hospital discharge summaries. The overall scanning time of documents was good. In addition, DVI had an excellent process in place for the transmission of clinical information not only between departments and various medical staff, but also within the provider group itself. Therefore, the OIG clinicians rated this indicator *adequate*.

Compliance Testing Results

The institution received an *adequate* compliance score of 75.7 percent in the *Health Information Management (Medical Records)* indicator and scored in the *proficient* range for the following tests:

- DVI's medical records staff timely scanned all 20 sampled miscellaneous non-dictated documents such as provider progress notes, nursing initial health screening forms, and patient requests for health care services within three calendar days of the patient's encounter (MIT 4.001).

- Inspectors tested five provider-dictated progress notes to determine if staff scanned the documents within five calendar days of the patient encounter date; all five documents were scanned timely (MIT 4.002).

- DVI staff scanned all 20 sampled specialty service consultant reports into the eUHR within the required time frame (MIT 4.003).

- Health records administrative staff timely scanned community hospital discharge records into the patients' eUHR for 19 of the 20 sampled records (95 percent); one record was scanned one day late (MIT 4.004).

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

- When the OIG reviewed various medical documents such as hospital discharge reports, initial health screening forms, certain medication administration records, and specialty service reports to ensure that clinical staff legibly documented their names on the forms, 33 of 40 samples (83 percent) showed compliance (MIT 4.007).

The institution performed in the *inadequate* range for the following tests areas:

- There were several instances found of incorrectly labeled documents scanned into patients' electronic unit health records. For example, physician orders and progress notes were incorrectly scanned as patient refusal documents. For this test, once the OIG identifies 12 mislabeled or misfiled documents, the maximum points are lost and the resulting score would be zero. During the DVI medical inspection, inspectors identified 13 documents with filing errors, which is one over the maximum allowed to receive a score (MIT 4.006).

- The OIG reviewed hospital discharge records for 30 sampled patients whom the institution sent to an outside hospital for a higher level of care. For 19 of the 30 patients (63 percent), the discharge summary reports were complete and timely reviewed by DVI providers. For 11 patients, the report was reviewed one to two days late (MIT 4.008).

- DVI staff timely scanned medication administration records (MARs) into the patient's eUHR files for 13 of 20 samples tested (65 percent). Seven of the MARs were scanned between two to nine days late (MIT 4.005).

Recommendations

No specific recommendations.

HEALTH CARE ENVIRONMENT

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

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(59.9%)

Overall Rating:
Inadequate

Compliance Testing Results

The institution received an *inadequate* compliance score of 59.9 percent in the *Health Care Environment* indicator, scoring poorly in 6 of 11 test areas, as described below:

- Inspectors observed clinician encounters with patients at 11 clinics to determine if clinical staff practiced universal hand hygiene precautions. Staff members were not compliant at any of the clinic locations. DVI clinicians did not always wash or sanitize their hands before putting on gloves and before or after patient contact (MIT 5.104).

- Only one out of 12 clinics (8 percent) inspected followed adequate medical supply storage and management protocol. Medical supplies in 11 clinics were not clearly labeled for easy identification. In addition, one of the 11 clinics had hand lotion stored in the same area with medical supplies, and another location had personal food items stored with medical supplies (MIT 5.107).

- Inspectors examined 12 clinics to determine if they had appropriate space, configuration, supplies, and equipment to allow clinicians to perform proper clinical exam, and found only three clinics (25 percent) were in compliance. Nine clinics had exam areas that were unacceptable for a variety of reasons. Eight clinics did not provide visual and auditory privacy for patients during clinical encounters, or had exam area cabinets and drawers that were not labeled for easy identification. Exam rooms in three clinic locations did not have adequate space to perform a proper patient examination. Two clinics had confidential records easily accessible by inmate-porters. One clinic contained an exam table and exam chair with ripped vinyl covering that could harbor infectious agents (*Figure 1*); and one other clinic had an exam

Figure 1: Exam table with torn vinyl

table with impeded access. Lastly, a clinic location had an oto-ophthalmoscope that was not easily accessible to the clinician (MIT 5.110).

- Only 4 of the 12 clinic common areas and exam rooms (33 percent) had all core medical equipment and supplies; the remaining eight had one or more deficiencies. Six clinics were missing either necessary supplies or functional core equipment essential to conduct a comprehensive exam, such as an automated external defibrillator (AED), disposable paper for exam table, hemoccult cards and developer, lubricating jelly, tips for oto-ophthalmoscope device, tongue depressors, or a clearly established permanent distance marker for the Snellen eye chart. Four clinics had ophthalmoscopes and vital sign machines that were not operational (*Figure 2*). One clinic had an oto-ophthalmoscope with missing heads so it was not readily available for use, and another clinic was missing a glucometer and strips, and a medication refrigerator. The receiving and release (R&R) clinical area was missing an exam table (MIT 5.108).

Figure 2: Non-functional Oto-ophthalmoscope missing heads

- When inspecting for proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste, only 7 of 12 clinics (58 percent) were compliant. Exam rooms in four clinics did not have a sharps container. Two clinics did not have adequate supplies of personal protective equipment accessible to staff (MIT 5.105).

- Only five of eight clinic common areas (63 percent) had an environment conducive to providing medical services. The location of vital sign and blood draw stations in three clinics compromised patient's auditory privacy (MIT 5.109).

The following test area received a score in the *adequate* range:

- At four of the five sampled clinical locations (80 percent), clinical staff inspected emergency response bags daily, inventoried them monthly, and ensured they contained all essential items. However, one clinic's emergency response bag had an oxygen tank that did not have a full charge (MIT 5.111).

The institution performed within the *proficient* range in the following four tests:

- Health care staff at all 11 clinics ensured that non-invasive medical equipment was properly sterilized and disinfected (MIT 5.102).

- All 12 applicable clinics had operable sinks and sufficient quantities of hand hygiene supplies in clinical areas (MIT 5.103).

- The institution's non-clinic bulk medical supply storage areas met the supply management process and support needs of the medical health care program (MIT 5.106).

- Staff appropriately disinfected, cleaned, and sanitized 11 of its 12 clinic locations (92 percent). One clinic had dust and cobwebs on the floor (MIT 5.101).

Other Information Obtained from Non-Scored Results

The OIG gathered information to determine if the institution's physical infrastructure was maintained in a manner that supported health care management's ability to provide timely or adequate health care. This question was not scored. In general, DVI's health care management did not have any significant concerns about the institution's existing infrastructure or its ability to provide adequate health care to the inmate population. However, as discussed below, there were several projects underway to improve the delivery of health care at DVI, and there was a system in place to identify and report facility infrastructure problems when they occurred. At the time of the OIG's inspection, DVI had five ongoing projects. These consisted of remodeling and major renovations to the TTA, the primary care clinics and reception center clinic, a pharmacy addition, and new construction for the minimum-security facility clinic. These projects began in October 2015 and are projected to be completed by July 2017 (MIT 5.999).

Recommendation for CCHCS

The OIG recommends that CCHCS develop a statewide policy to identify required core equipment and supplies for each type of clinical setting, including primary care clinics, specialty clinics, TTA, R&R, and inpatient units.

Recommendation for DVI

The OIG recommends the institution develop local operating procedures that help to ensure that all clinical areas supply a standardized full complement of core equipment. Specifically, clinic areas should include a medication refrigerator, AED, working oto-ophthalmoscopes and vital sign machines, tongue depressors, glucometer and strips, lubricating jelly, disposable paper for exam tables, and a clearly marked line for the Snellen eye chart.

INTER- AND INTRA-SYSTEM TRANSFERS

Case Review Rating:
Adequate
Compliance Score:
Adequate
(80.0%)
Overall Rating:
Adequate

This indicator focuses on the management of inmate-patients' medical needs and continuity of patient care during the inter- and intra-facility transfer process. The patients reviewed for *Inter- and Intra-System Transfers* include inmates received from other CDCR facilities and inmates transferring out of DVI to another CDCR facility. The OIG review includes evaluation of the institution's ability to provide and document health screening assessments, initiation of relevant referrals based on patient needs, and the continuity of medication delivery to patients arriving from another institution. For those patients, the OIG clinicians also review the timely completion of pending health appointments, tests, and requests for specialty services. For inmate-patients who transfer out of the facility, the OIG evaluates the ability of the institution to document transfer information that includes pre-existing health conditions, pending appointments, tests and requests for specialty services, medication transfer packages, and medication administration prior to transfer. The OIG clinicians also evaluate the care provided to patients returning to the institution from an outside hospital and check to ensure appropriate implementation of the hospital assessment and treatment plans.

Case Review Results

The OIG clinicians reviewed 89 encounters for the *Inter- and Intra-System Transfers* indicator, including information from both the sending and receiving institutions. These included 40 hospitalization events, each of which resulted in a transfer back to the institution. The OIG identified 39 deficiencies and none of the deficiencies was significant. In general, the inter- and intra-system transfer processes at DVI were *adequate*.

Transfers In

There were several deficiencies in cases involving patients transferring into DVI from other CDCR institutions, primarily related to incomplete nursing documentation and referrals for initial provider visits. The following cases illustrate these types of deficiencies:

- In case 6, the receiving and release nurse did not provide a wheelchair as required by the patient's disability accommodation order and did not evaluate an open wound on the patient's leg.

- In case 7, the receiving and release nurse did not provide a cane and mobility vest as required by the patient's disability accommodation order. The nurse did not refer the patient to the provider for a follow-up chronic care visit.

Transfers Out

Deficiencies found with inmates transferring out of DVI were largely incomplete nursing documentation of significant medical information on the Health Care Transfer Information form (CDCR Form 7371). In most cases, the nurses noted that they had attached a patient summary and other pertinent documents, but information on the transfer form was not always accurate or complete.

The OIG clinicians found several incomplete or inaccurate transfer documents:

- In case 9, the receiving and release nurse incorrectly noted on the CDCR Form 7371 that the patient's last tuberculosis (TB) test was negative. However, the patient had a history of a positive TB test and was currently receiving treatment with weekly TB monitoring.

- In case 10, the receiving and release nurse did not list the patient's HIV diagnosis, and did not document when the patient's next HIV clinic visit was to occur.

- In case 40, the provider ordered a new asthma inhaler two days before the receiving and release nurse completed the transfer-out form. The nurse was not aware of the order. The patient did not receive the inhaler prior to transfer or at the receiving institution.

Hospitalizations

Patients returning from hospitalizations or from outside emergency departments (EDs) are some of the highest-risk encounters due to two factors. These patients are of higher acuity since they had just been hospitalized for a severe illness in most cases. These patients are doubly at risk due to the potential lapses that can occur during any hand-off in care. TTA nurses processed patients discharged from the hospital upon their return to DVI. Most discharge summaries were retrieved from community hospitals and scanned into the eUHR timely, but discharge summaries were often not signed or dated by a provider. This is further discussed in the *Health Information Management* and *Specialty Services* indicators. In the majority of cases, nurses appropriately reviewed the discharge medications and plans of care, and obtained physician orders. However, the cases below illustrate how the lack of attention to detail can result in transfer errors or risk of harm for patients returning from the hospital. These cases are provided for quality improvement purposes:

- In case 25, the nurse obtained an incorrect medication order from the on-call provider when the patient returned from the hospital.

- In case 29, the patient returned from a hospitalization for sepsis (infection in the blood). The nurse failed to obtain the medication from the after-hours medication supply, and the patient missed the first two doses of his prescribed antibiotic.

Clinician Onsite Inspection

The receiving and release nurse's room did not have an examination table. The area had supplies for minor dressing changes. The nurse reported easy access to the on-call provider. The receiving and release nurse reported that the transfer-out list was usually received the day before transfer. Self-administered medications were delivered to the TTA in the evening so the nurse could replace any missing medications. In the morning, the first watch nurse gave patients their morning medications prior to departure from DVI.

Compliance Testing Results

The institution obtained an *adequate* compliance score of 80.0 percent in the *Inter- and Intra-System Transfers* indicator. DVI performed in the *proficient* range in the tests below:

- The institution scored 100 percent when the OIG tested transfer packages for nine patients who transferred out of DVI and had been prescribed medications during the OIG's onsite inspection. All nine transfer packages included the required medications and related documentation (MIT 6.101).

- For 28 of 30 sampled patients who transferred into the institution (93 percent), nursing staff completed an Initial Health Screening form (CDCR Form 7277) on the same day the patient arrived. For one patient, the screening nurse did not answer all of the necessary questions on the form, and for one other, the nurse included the incorrect date on the form (MIT 6.001). For all 30 of the same sampled patients, nursing staff timely completed the assessment and disposition sections of the form on the same day they performed the patient's screening (MIT 6.002).

The institution scored within the *adequate* range for the following test:

- Out of 30 sampled patients who transferred into the institution, 17 had an existing medication order upon arrival. Inspectors tested those 17 patients' records to determine if they received their medications without interruption, and found 13 of the 17 patients (76 percent) received their medication timely. Two patients received their medication two days late, and two other patients received their medication one day late (MIT 6.003).

The institution scored poorly in the following area:

- Inspectors tested 20 patients who transferred out of DVI to another CDCR institution to determine whether their scheduled specialty service appointments were listed on the transfer information form. Staff identified the scheduled appointments on the transfer forms for only 6 of the 20 patients sampled (30 percent) (MIT 6.004).

Recommendations

No specific recommendations.

PHARMACY AND MEDICATION MANAGEMENT

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(55.0%)
Overall Rating:
Inadequate

This indicator is an evaluation of the institution's ability to provide appropriate pharmaceutical administration and security management, encompassing the process from the written prescription to the administration of the medication. By combining both a quantitative compliance test with case review analysis, this assessment identifies issues in various stages of the medication management process, including ordering and prescribing, transcribing and verifying, dispensing and delivering, administering, and documenting and reporting. Since effective medication management may be affected by numerous entities across various departments, this assessment includes the prescriber, internal review/approval processes, pharmacy, nursing, health information systems, custody processes/staff, and the patient. The OIG evaluated pharmacy and medication management by both case review and a detailed analysis of specific compliance criteria. Therefore, this indicator will include a compliance score as well as a case review rating along with specific case examples to support findings.

In this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *adequate* rating, and the compliance review resulted in an *inadequate* score. The OIG's internal review process considered those factors that led to both scores and ultimately rated this indicator *inadequate*. While case review focused on medication administration, the compliance testing was a more robust sample of medication administration, pharmacy protocols, and onsite observations of medication and pharmacy operations. As a result, the compliance review rating of *inadequate* was deemed appropriate for the overall indicator rating.

Case Review Results

The OIG clinicians evaluate pharmacy and medication management as secondary processes as they relate to the quality of clinical care provided. Compliance testing is a more targeted approach and is heavily relied on for the overall rating for this indicator. Pharmacy and medication administration performance was rated *adequate* by the case review clinicians.

Nursing Medication Errors

The majority of medication management nursing events in case reviews demonstrated that patients received medications timely and as prescribed. Of the 36 medication errors that were found during the case review, 13 were significant. The following cases are examples of nursing deficiencies:

- In case 20, the provider ordered to hold, i.e., not administer, a medication after receiving abnormal laboratory test results. The nurse did not transcribe the order until the next day.

- In case 20, the nurse transcribed the provider's orders for an antibiotic, but failed to check the patient's medication allergies before sending the order to pharmacy. The patient was allergic to the antibiotic.

- In case 21, the nurse assessed the patient during sick call and obtained an order for antibiotics from the provider. The nurse transcribed the order, but failed to check the patient's medication allergies before sending the order to pharmacy.

- In case 25, the nurse obtained an incorrect medication order from the on-call provider when the patient returned from surgery.

- In case 29, the nurse failed to obtain an antibiotic from the after-hours supply for the patient who had been hospitalized for sepsis (an infection in the blood).

Pharmacy Errors

- In case 2, the pharmacy filled a duplicate medication order and the nurses administered double-doses of the medication to the patient for six days.

- In case 15, the pharmacy filled a provider's medication order twice for seven days before correcting the order. Therefore, the medication was administered by the nurses and also self-administered by the patient in error for those seven days.

Medication Continuity

Medication continuity was maintained for the majority of patients transferring into the institution, returning from a community hospital, and receiving chronic care medications.

- In case 55, the nurse failed to research why the patient was not receiving one of his chronic heart medications. This was a significant deficiency as the pharmacy had failed to refill the medication at the beginning of the month. As a result of this failure, the patient did not receive his heart medication for eight days.

Clinician Onsite Inspection

During the onsite visit, the OIG clinicians met with medical, nursing, and pharmacy representatives regarding case review findings. DVI had a supervising registered nurse for medication management who observed the medication nurses as they prepared and administered medications and processed medication orders. The supervisor held monthly staff meetings, performed monthly medication area inspections with the pharmacist, and performed random audits of medication administration records and random checks of medication carts.

Compliance Testing Results

The institution received an *inadequate* compliance score of 55.0 percent in the *Pharmacy and Medication Management* indicator. For discussion purposes below, this indicator is divided into three sub-indicators: medication administration, observed medication practices and storage controls, and pharmacy protocols.

Medication Administration

In this sub-indicator, the institution received an *inadequate* average score of 71.8 percent, showing room for improvement in the following medication administration areas:

- The OIG sampled ten patients who were in transit to another institution and temporarily laid over at DVI; only five (50 percent) received their medications without interruption. The initial health screening forms indicated that four of the patients arrived with their keep-on-person (KOP) medication, but the institution did not issue any MARs to indicate the medications were given to them during their layover. One other patient did not receive his nurse-administered evening medication dose on the day of arrival (MIT 7.006).

- Clinical staff timely provided new and previously prescribed medications to only 17 of the 30 patients sampled (57 percent) who were recently discharged from a community hospital and returned to the institution. Twelve patients received their medication between one and seven days late. and one patient continued to receive prescribed medication after a provider stopped the medication upon the patient's return from the hospital (MIT 7.003).

- Only six of the nine sampled patients received from a county jail (67 percent) were delivered or administered their ordered medications within the required time frames. Two patients received their medication one and two days late, and one other patient never received his medication (MIT 7.004).

- Only 22 of 30 (73 percent) patients sampled who transferred from one housing unit to another received their medication at the next dosing interval. There was no evidence in the eUHR that eight patients received their medication at the next dosing interval (MIT 7.005).

The institution scored in the *proficient* and *adequate* range in the following medication administration areas:

- All 30 patients sampled received their new order prescription medications timely (MIT 7.002).

- Chronic care medications were provided timely to 21 of the 25 patients sampled (84 percent). Four patients had no eUHR evidence that they received their medication for an entire month in February or March 2016 (MIT 7.001).

Observed Medication Practices and Storage Controls

In this sub-indicator, the institution received an *inadequate* score of 37.5 percent, showing room for improvement in the following areas:

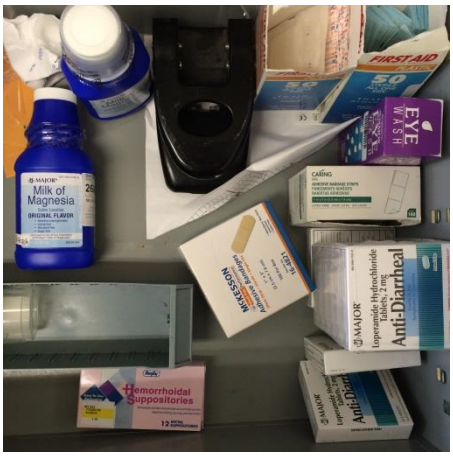

Figure 3: Oral and external medications stored together

- Non-narcotic medications not requiring refrigeration were not properly stored at all 12 clinics and medication storage locations. None of the 12 locations had an established system in place for medications pending return to pharmacy. In two locations, internal (oral) and external (topical) medications were not stored separately (figure 3), and at one other location, medication carts remained unlocked while not in active use (MIT 7.102).

- When the OIG tested seven clinic locations to determine if non-narcotic medications requiring refrigeration were stored properly, none of the seven locations was in compliance. At all seven locations, staff did not have a designated area for return to pharmacy medications. One location's historical temperature logs showed recorded refrigerator temperature readings outside the allowable range (MIT 7.103).

- The OIG interviewed nursing staff and inspected storage areas specifically for the storage of narcotics at eight applicable locations to assess whether strong narcotics security controls existed. Only two of the eight areas (25 percent) were adequately controlled. All six exceptions related to missing signatures in the narcotics logbook, indicating habitual lack of physical shift inventories performed by nursing staff to safeguard narcotics (MIT 7.101).

- Nursing staff at three of the six sampled medication preparation and administration locations (50 percent) followed proper hand hygiene contamination control protocols during the medication preparation and administration processes. Nurses at three locations did not sanitize their hands when required, such as prior to initially putting on gloves and before each subsequent re-gloving (MIT 7.104).

- Only three of six applicable medication preparation and administration locations (50 percent) employed appropriate administrative controls and protocols when distributing medications to patients. At two inspection locations, nursing staff did not verify the patients' identity by a form of picture identification; and nursing staff did not immediately record their initials after administering medications. At one other location, nursing staff did not always require patients on directly observed therapy (DOT) medications to demonstrate that they swallowed their medication (MIT 7.106).

The institution received 100 percent on the following test:

- Nursing staff at all six medication and preparation administration locations employed appropriate administrative controls and protocols during medication preparation (MIT 7.105).

Pharmacy Protocols

In this sub-indicator, the institution received an average score of 56 percent, and scored a zero percent in the following two tests:

- In its main pharmacy, DVI did not follow general security, organization, and cleanliness management protocols. The narcotic vault was found unlocked when it was not in active use (MIT 7.107).

- DVI's main pharmacy did not properly store non-refrigerated medication. Inspectors found medication bins on the floor of the pharmacy (MIT 7.108).

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

- The institution's pharmacist-in-charge (PIC) followed required protocols for 24 of the 30 medication error reports and monthly statistical reports reviewed (80 percent). For five errors, the error report was completed one to nine days late, and one other report was 19 calendar days late (MIT 7.111).

The institution was *proficient* in the following tests:

- The institution's main pharmacy properly stored refrigerated or frozen medications; and properly accounted for all narcotic medications (MIT 7.109, 7.110).

Non-Scored Tests

In addition to testing reported medication errors, OIG inspectors follow up on any significant medication errors found during the case reviews or compliance testing to determine whether the errors were properly identified and reported. The OIG provides those results for information purposes only; however, at DVI, the OIG compliance inspectors did not find any applicable medication errors (MIT 7.998).

The OIG tested patients housed in isolation units to determine if they had immediate access to their prescribed KOP rescue inhalers and nitroglycerin medications. At DVI, three applicable patients housed in isolation units claimed they did not have immediate access to their prescribed KOP rescue medications. One patient was uncooperative, and did not provide a reason to inspectors as to why he did not have his inhaler. Another patient did not think he previously needed an inhaler, but requested one from the OIG inspectors. A third patient told inspectors his inhaler was taken by custody staff, claiming they said it could be used as a weapon. Inspectors immediately notified the

institution's CEO, who took timely action to ensure the inhalers were issued to all three patients (MIT 7.999).

Recommendations

No specific recommendations.

PREVENTIVE SERVICES

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

Case Review Rating:
Not Applicable
Compliance Score:
Proficient
(90.8%)

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 performed in the *proficient* range in the *Preventive Services* indicator, with a compliance score of 90.8 percent. The institution scored in the *proficient* range for the following five tests:

- The institution timely offered patients an influenza vaccination to all 30 sampled patients (MIT 9.004).
- DVI completed the required weekly and monthly TB monitoring for 29 of the 30 patients sampled (97 percent). For one patient, the weekly monitoring form was not timely scanned (MIT 9.002).
- The institution provided colorectal cancer screenings to 29 of 30 sampled patients subject to the annual screening requirement (97 percent). One patient had an abnormal colonoscopy result in February 2012 (with an order to repeat the colonoscopy in five years), but there was no evidence found showing the patient was offered or refused a fecal occult blood test within the previous 12 months (MIT 9.005).
- The institution scored 87 percent for administering timely TB medications to patients with TB, with 26 of 30 patients that received their medication timely. Three patients missed required TB medication doses and did not receive the required provider counseling for the missed dosage, and one patient received extra doses of TB medication after the provider discontinued the medication (MIT 9.001).
- The OIG tested whether the institution offered vaccinations for influenza, pneumonia, and hepatitis to patients who suffered from a chronic care condition; 15 of the 17 sampled patients (88 percent) received all recommended vaccinations at the required interval. For two patients, there was no evidence found in the eUHR that the institution offered a pneumococcal vaccination (MIT 9.008).

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

- The institution scored 77 percent for conducting annual TB screenings. For this test, 15 patients sampled were identified as Code 22 patients, which requires the institution's staff to administer a TB test and check the patient for signs and symptoms of TB, and 15 patients that were identified as Code 34, which requires the institutions staff only to check the patient for signs and symptoms of TB. Although all 30 patients sampled were screened for TB within the prior year, only 8 of the 15 patients classified as Code 22 (requiring a TB skin test in addition to signs and symptoms screening) were properly tested. For seven sampled Code 22 patient screenings, inspectors found the following deficiencies: for two samples an LVN, rather than an RN, public health nurse, or primary care provider, read the skin test results, and five samples tested where nursing staff did not read the TB test within the required 48-to-72-hour time frame. All 15 Code 34 patients were properly screened for signs and symptoms of TB (MIT 9.003).

Recommendations

No specific recommendations.

QUALITY OF NURSING PERFORMANCE

Case Review Rating:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

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

Case Review Results

The OIG evaluated 462 nursing encounters for case review of which 184 were outpatient-nursing encounters. Of the 184 outpatient nursing encounters reviewed, approximately 115 were for sick call requests or primary care clinic nurse follow-up visits, 24 were for RN case management, and the others were for other outpatient nursing encounters such as public health, wound care, vital signs, and specialty care nurses. In general, DVI nursing services performed well. All 68 deficiencies in outpatient nursing services were minor. Nevertheless, these deficient areas are clearly established in CCHCS policy as requirements for nursing care and practice, and therefore require quality improvement strategies.

Nursing Sick Call

The majority of sick call nurses appropriately assessed complaints and symptoms, and provided necessary interventions for patients presenting with medical issues in the outpatient nursing clinics. The following examples demonstrate types of deficiencies found in the sick call process:

- In case 5, the patient submitted a sick call complaint for back pain after a fall. The nurse was not aware of the patient's TTA visit the previous day for the same complaint. The TTA visit should have been discussed with the provider during the morning huddle.

- In case 23, the sick call nurse did not follow-up on an order for medical device supplies. The patient did not receive the supplies for 32 days.

- In case 47, the sick call nurse missed an opportunity to follow-up on the effectiveness of new orders from a provider visit for the same complaint four days earlier.

Inadequate or incomplete assessments were found in cases 5, 7, 23 (two events), 27, 46, 47, 50, 55, 56, 57, 58, and 59.

RN Case Management

CCHCS defines a case manager as a primary care RN who develops, implements, and evaluates patient care, services, and care plans for an assigned patient panel. The case manager collaborates with the patients and all other members of the care team to ensure that the patients receive necessary health care services in a safe, timely, and medically appropriate manner. The OIG nurse clinician reviewed ten RN case manager events. The following two deficiencies are reported for quality improvement purposes:

- In case 23, the RN case manager saw the patient for hypertension (high blood pressure) and hyperlipidemia (increased level of fats in the blood). The nurse noted the patient denied any gastrointestinal issues but was aware of his chronic diarrhea. The nurse educated the patient about the proper diet for hyperlipidemia. Some of the items the nurse advised the patient to eat and drink could have worsened his diarrhea.

- In case 24, the patient was seen by the RN case manager for diabetes, cardiovascular disease, and hepatitis C. Although the nurse advised the patient to keep all medical appointments, the nurse failed to discuss the patient's reasons for refusing podiatry and ophthalmology consults and did not have a plan for compliance.

Other Outpatient Nursing Encounters

In cases 4, 6, and 20, nurses did not perform dressing changes as frequently as the provider had ordered.

Medication Administration

See the *Pharmacy and Medication Management* indicator for specific findings.

Emergency Care

See the *Emergency Services* indicator for specific findings.

Inter- and Intra-System Transfers

See the *Inter- and Intra-System Transfers* and *Reception Center Arrivals* indicators for specific findings.

Specialized Medical Housing

See the *Specialized Medical Housing* indicator for specific findings.

Clinician Onsite Inspection

During the onsite visit, the OIG clinicians found nurses in outpatient clinic settings at DVI to be active participants in the primary care team morning huddles. Providers met each morning prior to the huddles to review orders, test results, and specialty and diagnostic reports. The clinic huddles started and ended on time, and were well attended by the providers, sick call primary care nurses, RN case managers, clinic licensed vocational nurses, the medication line supervising registered nurse, and schedulers. The provider facilitated the morning report and discussions about currently hospitalized and newly discharged patients, TTA visits, provider on-call reports, mental health concerns, soon-to-expire medications, and any other issues related to current patient issues and the day's clinic schedule. All staff members had the opportunity to participate in the team discussions.

During walking rounds, the RN and LVN staff reported having no major barriers with initiating communication with nursing supervisors, providers, and custody officers regarding patient care needs. The utilization management nurse, specialty nurses, and their support staff developed communication systems to ensure DVI providers closely followed hospitalized patients, and that specialty consultations were completed on time. Nurses at DVI were enthusiastic about their assignments and reported good morale. Nurses in all areas reported good working relationships with providers.

Recommendations

No specific recommendations.

QUALITY OF PROVIDER PERFORMANCE

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

Case Review Rating:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

Case Review Results

The OIG clinicians reviewed 342 medical provider encounters and identified 99 deficiencies related to provider performance at DVI. Of the 99 deficiencies identified, 7 were significant. As a whole, DVI provider performance was rated *adequate.*

Assessment and Decision-Making

Providers generally made sound assessments and accurate diagnoses. Poor assessment and misdiagnosis, although infrequent, did occur. Errors with provider assessment were identified in cases 25, 28, 29, and the following:

- In case 2, the patient had recurrent seizures. The providers should have ordered an urgent, rather than routine, neurology evaluation.

- In case 3, the provider started the patient on a medication to treat symptoms of an enlarged prostate. This was not an appropriate choice of medication as the medication could have caused a drop in blood pressure when standing. In addition, the patient had been seen recently in the TTA for low blood pressure. This patient was later transferred to an outside hospital due to low blood pressure.

- In case 20, the patient was recently discharged from the hospital for heart failure and atrial fibrillation (irregular heartbeat). The provider failed to address the patient's fast heart rate or consider increasing one of his heart medications to slow his heart rate. Furthermore, the provider should have at least rechecked the patient's heart rate before discharging him to general housing.

Despite the above examples, good provider diagnostic skills were demonstrated in the majority of cases:

- In case 26, the providers expertly managed the patient's complex medical condition and coordinated his multiple follow-ups with the offsite surgeon. The providers also transferred

the patient to the hospital on several occasions when necessary. Finally, the patient had timely follow-ups with his providers after each of his hospital discharges.

- In case 36, the patient had chronic neck pain and left-sided weakness due to a structural defect in his brain. These symptoms failed to resolve after his first surgical repair. The provider appropriately referred the patient for muscle and nerve conduction tests as well as a CT scan of his neck. The provider also appropriately coordinated the patient's specialty care between his ear, nose, and throat (ENT) doctor and the neurosurgeon.

Review of Records

A mild pattern of inadequate record review was identified in cases 2, 25, and the following:

- In case 5, the provider did not realize the patient's urine lab test was positive for blood and that the complete urinalysis had never been completed by the laboratory. This was due to the provider's failure to review the eUHR carefully. As a result, the provider never reordered a urinalysis, and the cause of the patient's blood in the urine was never diagnosed while the patient was at DVI.

The majority of errors in this area were minor and often inconsequential. The OIG clinicians did not detect any fundamental issues with DVI provider work habits during this period of review. In the majority of these encounters, DVI providers performed an adequate review of records when caring for their patients.

Emergency Care

Emergency care provider performance was excellent. The OIG clinicians found that only two deficiencies that occurred during the 52 reviewed TTA encounters were attributable to providers. Furthermore, no provider deficiency was found that significantly affected medical care. In general, TTA and on-call providers made accurate assessments and triage decisions. Patients requiring higher level of care were appropriately sent to outside hospitals.

Provider-Ordered Follow-up Intervals

The OIG clinicians found only a mild pattern of providers not ordering appropriate follow-ups for their patients. This occurred in case 34 and the following:

- In case 28, the provider ordered "follow-up as needed" for the patient after his oncology visit. This was not an appropriate order as it could have led to a dropped appointment or an unnecessary delay in the patient's follow-up. Either outcome would have been inappropriate for this patient since his positron emission tomography (PET) scan revealed two liver tumors that required immediate medical attention.

Chronic Care

Chronic care provider performance was adequate. DVI providers demonstrated adequate skill and knowledge in caring for patients even though a few providers struggled with patients who had complicated chronic medical issues. The majority of patients at DVI were of low medical complexity and did not require management of HIV or hepatitis C treatment. Patients were properly monitored and assessed with providers intervening when appropriate. The following cases demonstrated minor deficiencies only:

- In case 20, the patient had multiple provider encounters in which his provider failed to address tachycardia (a fast heart rate). In addition, the patient's heart rate should have been rechecked before he was sent back to general housing. The patient was found to have anemia (low blood count) while he was taking warfarin (blood thinner). However, the provider failed to address his anemia for over a month, which increased the patient's risk of an undiagnosed bleed.

- In case 32, the provider failed to perform and document a foot exam for a diabetic patient.

Diabetic management at DVI was adequate based on the limited number of events available to review. DVI providers generally demonstrated adequate diabetic management skills.

The institution only had two patients taking warfarin (cases 30 and 31). The OIG clinicians did not identify any significant deficiencies with anticoagulation management by DVI providers.

Specialty Services

DVI providers appropriately referred patients for specialty services. Please refer to the *Specialty Services* indicator for further details.

Documentation Quality

Provider documentation quality was extremely poor. Many instances of insufficient documentation were identified during this case review, the most common of which were failure to address one or more medical problems or acute medical issues, inadequate documentation to support a medical decision, or the lack of documentation altogether, particularly regarding after-hours TTA visits. Poor documentation was identified in cases 1, 2, 3, 4, 19, 20, 21, 22, 25, 28, 29, 32, 33, 34, 35, 37, 38, 39, and the following:

- In case 23, the provider failed to document why atenolol was still being used to treat the patient's high blood pressure, when the patient had multiple cardiac scans that were negative for any signs of cardiovascular disease. Current literature does not support the use of this class of blood pressure medication as a sole therapy for the treatment of high blood pressure in elderly patients without documented heart attack or heart failure.

- In case 27, the provider failed to document the patient's TTA visit on a telephone provider note to explain why the patient had been transferred to the emergency department at an outside hospital. This pattern of poor documentation involving patient transfers to the ER or outside hospital was a common occurrence at DVI.

- In case 31, the provider documented the patient had a gunshot wound to his abdomen that was chronically not healing. The provider should have performed and documented a thorough exam of the wound site because the patient was a new arrival to DVI.

The majority of progress notes were handwritten by the providers at DVI. Therefore, only minor evidence of "cloned" progress notes (where outdated medical information was inappropriately carried forward to a current progress note) were found.

Provider Continuity

Case review found provider continuity to be adequate in a majority of the outpatient cases. Only a small number of follow-ups occurred outside the time interval requested by the providers. The majority of these delays in provider follow-up did not significantly affect medical care. This is discussed further in the *Access to Care* indicator.

Health Information Management

DVI providers generally documented patient encounters on the same day. Most providers used handwritten or self-typed progress notes, but on occasion used dictation. No transcription delays were identified due to the limited use of the dictation service by providers. Please refer to the *Health Information Management* indicator for further details.

Clinician Onsite Inspection

DVI had several types of morning huddles that were scheduled at different times in the morning. This allowed for excellent transmission of clinical information between departments and various medical staff as well as within the provider group itself. Please refer to the *Health Information Management* indicator for further details.

Providers at DVI performed adequately not only as individual providers, but also as a group, with the institution fully committed to a primary care model. All providers were satisfied with their primary care teams and reported they found working as a team to be personally and professionally rewarding.

Onsite interviews with the provider staff revealed excellent job satisfaction and good provider morale. Providers felt that the CME was an excellent and approachable leader who provided the support they needed to give quality care to their patients. A few of the providers reported a long history of poor morale within the provider group that had changed due to the current CME. At the time of the onsite inspection, the chief physician and surgeon position had just been filled.

Interviews with the CME confirmed that job performance was closely monitored in various ways, including annual clinical appraisals, CCHCS dashboard evaluations, and careful review of specialty referrals. All provider annual performance appraisals were completed and current. At the time of the onsite interviews, no problems with provider retention or provider recruitment were identified.

Clinician Summary

As a whole, DVI providers performed adequately. Providers usually made sound and accurate diagnoses with appropriate treatment plans, but documentation was often poor. Providers generally reviewed medical records thoroughly. Emergency care and diabetes management were also adequate. Anticoagulation management was adequate as well, based on the limited number of events to review. DVI providers appropriately referred patients for specialty services with the general quality of documentation being fair. Although there were a few issues with provider follow-ups, the majority were ordered within an appropriate time interval. Due to the care provided by DVI, the OIG clinicians rated this indicator *adequate.*

Recommendations

No specific recommendations.

RECEPTION CENTER ARRIVALS

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(72.2%)

Overall Rating:
Adequate

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

In this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance review resulting in an *inadequate* score. The OIG's internal review process considered those factors that led to both scores and ultimately rated this indicator *adequate*. The key factor warranting the higher rating was that the compliance deficiencies were not directly related to essential patient care. As a result, the case review rating of *adequate* was deemed a more appropriate reflection of the overall indicator rating.

Case Review Results

The institution provided adequate care to patients arriving from county jails and other non-CDCR facilities. Nurses generally performed thorough assessments. A provider reviewed the Initial Health Screening forms (CDCR Form 7277) and clinical information from the sending facilities, and then ordered essential medications and required laboratory tests. The OIG clinicians reviewed 52 reception center patient encounters from 15 cases and identified 14 deficiencies. None of the deficiencies was significant. In cases 3 and 15, there were short delays in administering essential medications. In case 4, the reception center nurse did not evaluate the patient's wound dressing, and did not obtain orders for wound care. In cases 12, 13, 14, 15, 16, 27, and 28, the reception center nurse did not perform pain assessments or take complete vital signs.

Conclusion

The OIG clinicians rated the *Reception Center* indicator at DVI *adequate*.

Compliance Testing Results

The institution received an *inadequate* score of 72.2 percent in the *Reception Center Arrivals* indicator. The institution showed room for improvement for the following tests:

- Eighteen sampled patients were screened for TB at the DVI reception center; however, only one patient (6 percent) had the TB test read by a registered nurse. Sixteen patients had their TB tests results read by a license vocational nurse, not a registered nurse, public health

nurse, or provider as required by CCHCS policy. Of those 16, 2 were not screened for TB history, signs, and symptoms, and one patient's TB test was not administered within 72 hours of arrival. Finally, one patient was code 33 (not infectious but on TB medication) when received at DVI, a chest x-ray was not ordered as required, and the patient was not screened for signs and symptoms of TB (MIT 12.007).

- Inspectors sampled 20 reception center patients to ensure that they received timely health screenings upon arrival at the institution. Nursing staff conducted timely and complete screenings for only four (20 percent). During the other 16 screenings, nurses did not complete pain assessment and document height as required by policy (MIT 12.001).

In the following test area, DVI scored in the *adequate* range:

- Inspectors sampled 20 reception center patients for required laboratory intake tests; 16 of them (80 percent) timely received all applicable tests. For three patients, the laboratory tests were one to eight days late. For one other patient, there was no evidence that the laboratory tests were performed (MIT 12.005).

As indicated below, DVI scored in the *proficient* range in four areas:

- The OIG tested 20 patients who arrived at the DVI reception center; nursing staff timely completed the assessment and disposition section of the screening form for all 20 patients, and providers timely completed a written history and physical examination within seven calendar days of their arrival (MIT 12.002, 12.004).

- Providers timely reviewed and communicated the results for 19 patients' intake laboratory tests (MIT 12.006).

- The institution offered or administered a timely coccidioidomycosis skin test to all 20 patients sampled (MIT 12.008).

Recommendations

No specific recommendations.

SPECIALIZED MEDICAL HOUSING (OHU, CTC, SNF, HOSPICE)

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

Case Review Rating:
Adequate
Compliance Score:
Adequate
(82.0%)

Overall Rating:
Adequate

Case Review Results

DVI had 17 medical patients in specialized medical housing at the time of the OIG medical inspection. The OIG reviewed 91 provider and 151 nursing encounters in 11 cases of patients admitted to the OHU for a higher level of supervision, observation, or assistance. The OIG clinicians identified 131 deficiencies, of which nine were significant. The areas for improvement in both nursing and provider care are demonstrated in the following case review examples.

Nursing Performance

The OHU nursing performance was adequate in general. Various practice improvement issues were identified, the majority of which involved inadequate assessment, intervention, and documentation by nursing staff.

Inadequate Nursing Monitoring

- In case 25, the patient had chronic kidney disease and was being prepared for dialysis. Nurses monitored the patient's fluid intake and urine output but did not do so consistently on each watch and did not consistently document total amounts for each 24-hour period. Nurses did not consistently document the presence or absence of swelling in the patient's legs and did not implement several provider orders to weigh the patient.

- In case 26, the patient had a tube in his abdomen to drain fluid from a surgery site. Nurses did not always document the amount of drainage on each watch, even after the provider ordered strict monitoring. Nurses did not change the dressing until 18 days after the patient returned from the hospital with the drain. On three occasions, nurses failed to monitor rashes identified and treated by the provider.

- In case 27, the provider ordered fluid restriction, but nurses did not consistently monitor the patient's fluid intake.

- In case 41, the patient was an 83-year-old male admitted to the OHU to promote healing of a pressure sore. Nurses did not change the dressing as frequently as ordered by the provider. In addition, nurses did not document the patient's specific position in bed at each 30-minute

check to ensure he changed position at least every two hours to relieve pressure on the wound and promote healing.

- In case 43, nurses were not aware of the patient's respiratory status and did not evaluate the effectiveness of breathing treatments. On several occasions, nurses documented the patient had no respiratory complaints, and was not short of breath. However, the patient had in fact requested his rescue inhaler and nebulizer treatments to help with shortness of breath.

Inadequate Nursing Documentation

Nurses monitor patients' meal intake, physical activity, and bowel movements so they can identify issues before serious problems develop. This is especially important for patients who are confused, are physically inactive, have chronic medical conditions, or have wounds. The OHU nurses' documentation did not reflect that nurses monitored these issues and initiated interventions when problems were evident (cases 25, 26, 41, and 42).

Clinician Onsite Inspection

The institution's OHU did not have a patient call-light system and, therefore, nurses observed each patient through the cell door window at least every 30 minutes. Change-of-watch reports between nurses were given both verbally and in writing. The OHU nurse attended huddles and then communicated patient information to the medication nurse and other nursing staff as needed.

Paper documentation such as daily nurses' notes was kept on the unit at the nurses' stations. Therefore, these notes were readily available for clinicians to review until they were picked up by medical records to be scanned into the electronic unit health record. No individual provider was responsible for OHU patients. Instead, each patient was assigned to a provider based on the patient's CDCR number.

Clinician Summary

DVI provided adequate OHU care to patients in general. While there were nine significant deficiencies identified in the case reviews by the OIG clinicians, the number of significant deficiencies was low relative to the number of encounters reviewed, and the rating of *adequate* was appropriate.

Compliance Testing Results

The institution received an *adequate* score of 82.0 percent in the *Specialized Medical Housing* indicator, which focused on the institution's OHU. The institution scored in the *proficient* range for the following tests:

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

- DVI did not use a call button system, and instead conducted 30-minute welfare checks on patients. Inspectors reviewed the logs, and found nursing staff did welfare checks every 30 minutes per CCHCS policy. According to knowledgeable staff who regularly worked in the OHU, during an emergent event, responding staff could generally access a patient's room in under a minute, and management believed the average response time was reasonable (MIT 13.101).

The institution performed in the *adequate* range in two test areas:

- For eight of ten sampled patients (80 percent), providers performed a face to face evaluation within 24 hours of OHU admission. Two patients received their provider evaluation two days late (MIT 13.002).

- Providers completed their Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes at required 14-day intervals for eight of ten sampled patients, scoring 80 percent. Two patients received provider visits more than 14 days apart, contrary to CCHCS policy (MIT 13.004).

DVI performed poorly in the follow test:

- Providers completed a history and physical examination (H&P) within 72 hours for five of ten patients (50 percent). For five patients sampled, inspectors could find no evidence in the eUHR that the patient received an H&P (MIT 13.003).

Recommendations

No specific recommendations.

SPECIALTY SERVICES

Case Review Rating:
Adequate
Compliance Score:
Adequate
(84.4%)

Overall Rating:
Adequate

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

Case Review Results

The OIG clinicians reviewed 247 events related to the *Specialty Services* indicator, which included 150 specialty consultations and procedures and 63 nursing encounters. The OIG found 67 deficiencies in this category, 16 of which were significant.

Access to Specialty Services

Follow-ups with specialty services were not generally provided within adequate time frames for routine and urgent services. The majority of initial referrals to specialty services at DVI were completed within an acceptable time frame except in cases 3, 8, 22, 27, and 38. However, delays in specialist follow-ups were found in cases 22, 25, 28, 33, 35, 36, 41, 42, and the case listed below. In case 36, there was a one-month delay in surgical follow-up, which significantly impaired further diagnostic testing and pain management. Finally, a specialist follow-up did not occur in case 8.

- In case 38, the patient had blurry vision due to a fracture of the eye socket. The provider submitted an urgent referral for an ENT specialist to evaluate the patient for a possible surgical repair of this fracture, but the patient was not seen by the specialist for over one month.

- Also in case 38, the patient had eye pain. The provider ordered an urgent next-day follow-up with the optometrist (another type of eye doctor). This urgent follow-up never occurred, which placed the patient at increased risk of further injury to his eye. Fortunately, no harm came to the patient.

Nursing Performance

Nurses performed adequate assessments for patients being prepared for or returning from specialty appointments, except in the following two cases:

- In case 25, the patient returned from cataract surgery. While the ophthalmologist had recommended medications for his right eye only, the patient was given medications in both of his eyes for eight days. This was a nursing error.

- In case 43, neither the TTA nor the OHU nurse assessed the patient to determine if he was stable when returned from his onsite colonoscopy with sedation.

Provider Performance

Providers generally made appropriate referrals for specialty services. In only one instance was a referral not submitted without proper priority, as discussed below:

- In case 2, the patient had recurring seizures. Instead of ordering an urgent neurology evaluation, the provider ordered the referral with only a routine priority. This could have delayed the patient's neurological evaluation.

Health Information Management

There were problems with the institution's processing of specialty reports. Specialty reports and onsite specialty notes were either not retrieved or retrieved but not scanned into the eUHR within the required time frame. As a result, providers did not have timely and relevant patient information available. Even if the ordering provider was notified and had reviewed the report, that information would not be readily available to any subsequent medical staff. Therefore, the absence of specialty reports creates a significant barrier for any provider or nurse to overcome to provide quality and continuity of care to patients. This deficiency was identified in case 21 and the following case:

- In case 28, medical records failed to retrieve and scan the PET scan report from the outside hospital into the eUHR, which resulted in a significant lapse in medical care for this patient with colon cancer that had spread to his liver. The provider needed the report to guide his care plan.

If specialty reports were retrieved, they were often retrieved late. Delays in the retrieval of specialty reports significantly increased the risk of delays or lapses in care. This deficiency was identified in cases 20, 25, 26, 27, 33, 34, and 38.

If available, the majority of specialty reports were appropriately reviewed as they were properly signed or initialed by a provider.

A specialty report with an illegible signature was identified in case 24. Specialty reports that were not dated or were incorrectly dated were found in cases 26 and 39.

Utilization Management

The OIG clinicians did not identify any significant problems with DVI's utilization management program.

Clinician Onsite Inspection

The telemedicine clinic was clean and adequate. The nurse kept an organized tracking and scheduling system for all telemedicine appointments, and there was no backlog of appointments. Providers received their clinics' offsite reports for review and signing during the provider handoff meetings that took place before morning huddles. However, these reports were sometimes missing. A few of the providers reported having to call the offsite specialist or hospitals in order to obtain these reports.

Clinician Summary

DVI performed adequately in specialty services. While providers did an adequate job identifying and initially referring patients when needed, some issues with delays in specialist follow-ups were identified that could have potentially negatively affected patient care. Despite these few delays, access to specialty services was generally adequate. Specialty report handling was also adequate even though there were some delays in the retrieval of specialty reports. In general, DVI provided patients with the necessary specialty care. Therefore, this indicator was rated *adequate*.

Compliance Testing Results

The institution received an *adequate* compliance score of 84.4 percent in the *Specialty Services* indicator, scoring within the *proficient* range in the following test areas:

- All 15 sampled patients' routine specialty service appointment occurred within 90 calendar days of the provider's order (MIT 14.003).
- For 14 of the 15 sampled patients who received a routine specialty service appointment, the institution received and providers reviewed the specialists' reports within the required time frame (93 percent). For one patient, the provider documented discussing the specialty report in progress notes, but there was no evidence of the specialty report in the eUHR (MIT 14.004).
- The institution timely denied providers' specialty service requests for 18 of 20 patients sampled (90 percent). Two specialty services requests were denied 4 and 74 days late (MIT 14.006).

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

- For 12 of the 15 patients sampled (80 percent), high-priority specialty services appointments occurred within 14 calendar days of the provider's order. Three patients received their specialty service from two to five days late (MIT 14.001).
- For 12 of 15 sampled patients receiving a high-priority specialty service, providers timely received and reviewed the specialists' reports (80 percent). The institution received the specialty report for one patient a day late, and although the provider discussed the specialty

report on the progress notes for two other patients, no evidence of the report was found in the eUHR (MIT 14.002).

- When a patient at one institution has an approved pending or scheduled specialty services appointment and then transfers to a different institution, policy requires that the receiving institution reschedule or provide the patient's appointment within the required time frame. Of the 20 sampled patients who transferred to DVI with an approved pending specialty service appointment, 15 patients (75 percent) timely received their specialty services upon arrival. Of those five patients who did not receive their services timely, two patients did not receive them at all. For another patient, the provider did not indicate the reason for canceling the specialty service appointment. The remaining two patients received their scheduled specialty service appointments from two to ten days late (MIT 14.005).

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

- For 18 patients sampled who had a specialty service denied by the institution's health care management, only 13 patients (72 percent) received timely notification of the denied service that included the provider meeting with the patient within 30 days to discuss alternate treatment strategies. For five patients sampled, inspectors did not find any evidence that the provider ever discussed the denial with the patient (MIT 14.007).

Recommendations

No specific recommendations.

SECONDARY (ADMINISTRATIVE) QUALITY INDICATORS OF HEALTH CARE

The last two quality indicators (*Internal Monitoring, Quality Improvement, and Administrative Operations*; and *Job Performance, Training, Licensing, and Certifications*) involve health care administrative systems and processes. Testing in these areas applies only to the compliance component of the process. Therefore, there is no case review assessment associated with either of the two indicators. As part of the compliance component of the first of these two indicators, the OIG did not score several questions. Instead, the OIG presented the findings for informational purposes only. For example, the OIG described certain local processes in place at DVI.

To test both the scored and non-scored areas within these two secondary quality indicators, OIG inspectors interviewed key institutional employees and reviewed documents during their onsite visit to DVI in May 2016. They also reviewed documents obtained from the institution and from CCHCS prior to the start of the inspection. Of these two secondary indicators, OIG compliance inspectors rated one *proficient* and one *inadequate*. The test questions used to assess compliance for each indicator are detailed in *Appendix A.*

INTERNAL MONITORING, QUALITY IMPROVEMENT, AND ADMINISTRATIVE OPERATIONS

Case Review Rating:
Not Applicable
Compliance Score:
Proficient
(88.3%)

Overall Rating:
Proficient

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

Compliance Testing Results

The institution received a *proficient* compliance score of 88.3 percent in the *Internal Monitoring, Quality Improvement, and Administrative Operations* indicator. DVI scored 100 percent in the following test areas:

- The institution promptly processed all inmate medical appeals in each of the most recent 12 months. Inspectors sampled ten second-level inmate medical appeals, and all of the appeal responses addressed the inmate's initial complaint (MIT 15.001, 15.102).
- The institution's QMC met monthly, evaluated program performance, and took action when improvement opportunities were identified. Also, the institution took adequate steps to ensure the accuracy of its Dashboard data reporting (MIT 15.003, 15.004).
- The OIG inspected documentation for 12 emergency medical response incidents reviewed by DVI's Emergency Medical Response Review Committee during the prior six-month period, and all incident packages complied with policy (MIT 15.007).
- Inspectors reviewed documentation for three medical emergency response drills conducted in the prior quarter. The packages contained all the required summary reports and related records. In addition, the drills included participation by both health care and custody staff as required by policy (MIT 15.101).

The institution showed room for improvement in the following areas:

- DVI's 2015 Performance Improvement Work Plan included adequate evidence that demonstrated the institution's progress in achieving targeted performance objectives for two of its five quality improvement initiatives, scoring 40 percent for this test. For three

performance improvement measures, the institution did not reach the target goals for the measure (MIT 15.005).

- Medical staff promptly submitted the Initial Inmate Death Report (CDCR Form 7229A) to the CCHCS Death Review Unit for two of the three inmate deaths that occurred at DVI in the prior 12-month period (67 percent); the remaining report was one day late (MIT 15.103).

Other Information Obtained from Non-Scored Areas

- The OIG gathered non-scored data regarding the completion of death review reports. CCHCS's Death Review Committee (DRC) did not timely complete its death review summary for the three deaths that occurred during the testing period. The DRC is required to complete a death review summary within 30 business days of the death and submit it to the institution's CEO. However, the DRC completed its death review summaries 49 to 57 days late (94 to 100 calendar days after the deaths) and submitted the summary to the CEO from 48 to 58 days late (MIT 15.996).

- Inspectors met with the institution's CEO to inquire about DVI's protocols for tracking appeals. According to the CEO, the appeals manager reported monthly and on a real-time basis. The appeals manager reported and worked closely with the CEO to discuss pertinent appeals and staff issues. The report was broken down by category and status for health care areas and infrastructure issues. The management team members discussed the workload report data at weekly meetings to address adverse trends and potential issues. The CEO reported one specific healthcare and infrastructure issue within the most recent six months. Specifically, construction in health care areas was affecting the ability to deliver health care services. This issue was promptly resolved by coordinating with the contractor to begin construction at the end of the day when DVI clinicians had completed appointments (MIT 15.997).

- When a new local operating procedure (LOP) was required, the LOP coordinator met with the executive team to coordinate an update to the policy. The institution engaged subject matter experts to assist in the revision of the LOP as necessary. Once the LOP was completed, it was sent to medical and custody management for approval. Once approved, the policy was placed on the computer network for all staff to access, and supervisors discussed the new LOP with staff as necessary. The institution showed room for improvement in developing LOPs. At the time of the OIG's inspection, DVI had implemented 36 of the 49 applicable LOPs that related to the core topical areas recommended by the clinical experts who helped develop the OIG's medical inspection compliance program (MIT 15.998).

- The OIG discusses the institution's health care staffing resources in the *About the Institution* section on page *2* of this report (MIT 15.999).

Recommendations

No specific recommendations.

JOB PERFORMANCE, TRAINING, LICENSING, AND CERTIFICATIONS

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

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(70.8%)

Overall Rating:
Inadequate

Compliance Testing Results

The institution received an *inadequate* compliance score of 70.8 percent in the *Job Performance Training, Licensing, and Certifications* indicator, scoring in the *inadequate* range on the following three tests:

- Inspectors examined records to determine if nursing supervisors completed the required number of monthly performance reviews for subordinate nurses and discussed the results of those reviews with staff. Inspectors sampled five reviews for subordinate nurses; four of them had the required number of reviews completed by their supervisors; however, in each instance, the nursing supervisor did not address the positive, well-performed aspects of the employee's performance as CCHCS policy requires. For one staff member, the supervising nurse did not complete the monthly audit tool. As a result, DVI scored zero on this test (MIT 16.101).

- Two nurse employees hired within the past year did not complete new employee orientation training within 60 days of hire. As a result, DVI scored zero on this test (MIT 16.107).

- OIG inspectors examined provider, nursing, and custody staff records to determine if the institution ensured staff members had current emergency response certifications. DVI's provider and nursing staff were all compliant, but custody staff did not always have current certifications. Specifically, managerial custody officers above the rank of captain did not have current certifications. Although the California Penal Code exempts custody managers primarily performing managerial duties from medical emergency response certification training, CCHCS policy does not allow for such an exemption. As a result, the institution received a score of 67 percent in this inspection area (MIT 16.104).

While DVI scored poorly in the areas above, it received *proficient* scores in the following test areas:

- All providers were current with their professional licenses, and nursing staff and the pharmacist in charge were current with their professional licenses and certification requirements (MIT 16.001, 16.105).

- All ten nurses sampled were current on their clinical competency validations (MIT 16.102).
- All seven DVI providers had an appropriate clinical performance appraisal within the required time frame (MIT 16.103).
- The pharmacy and providers who prescribed controlled substances had current Drug Enforcement Agency registrations (MIT 16.106).

Recommendations

No specific recommendations.

POPULATION-BASED METRICS

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

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

Methodology

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

Comparison of Population-Based Metrics

For Deuel Vocational Institution (DVI), nine HEDIS measures were selected for comparison and are listed in the following *DVI Results Compared to State and National HEDIS Scores* table. Multiple health plans publish their HEDIS performance measures at the State and national levels. The OIG has provided selected results for several health plans in both categories for comparative purposes.

Results of Population-Based Metric Comparison

Comprehensive Diabetes Care

For chronic care management, the OIG chose measures related to the management of diabetes. Diabetes is the most complex common chronic disease requiring a high level of intervention on the part of the health care system in order to produce optimal results. DVI either outperformed or performed similarly to other entities in all the five diabetic measures selected.

When compared statewide, DVI outperformed Medi-Cal in all five diabetic measures and scored higher than Kaiser did in four of the five of those measures. Kaiser, North region, performed 6 percentage points higher than DVI for diabetics under good control.

When compared nationally, DVI outperformed Medicaid and commercial health plans (based on data obtained from health maintenance organizations) in all of the five diabetic measures. DVI performed better than Medicare in four of the diabetic measures, but scored 1 percentage point lower for the diabetics under good control measure. DVI outperformed the U.S. Department of Veterans Affairs (VA) in three of the applicable measures, but scored 6 percentage points lower than the VA for diabetic eye exams.

Immunizations

Comparative data for immunizations was only fully available for the VA and partially available for Kaiser Permanente, commercial plans, and Medicare. Regarding the administration of influenza immunizations to younger adults, DVI scored lower than all applicable statewide and national entities. A high patient refusal rate of 67 percent significantly affected the institution's score for this measure. However, DVI outperformed both Medicare and the VA in administering influenza immunizations to older adults by 15 and 11 percentage points, respectively. Lastly, the institution outperformed Medicare and matched the VA for the administration of pneumococcal immunizations.

Cancer Screening

For colorectal cancer screenings, DVI had mixed results. Statewide, DVI's score was lower than Kaiser's scores, both Northern and Southern California regions, by 11 and 13 percent, respectively. When compared nationally, DVI outperformed both commercial plans and Medicare, but scored 13 percentage points lower than the VA. Again, the high patient refusal rate of 26 percent negatively affected the institution's score.

Summary

DVI's population-based metrics performance reflected an *adequate* chronic care program, corroborated by the institutions *proficient* rating in the *Preventive Services* indicator and *adequate* rating in the *Access to Care* indicator. While the institution scored comparatively well in the areas of comprehensive diabetic care, influenza immunizations for older adults, and pneumococcal immunizations, DVI showed room for improvement in influenza immunizations for younger adults and colorectal cancer screenings. The institution can improve results by increasing patient education to reduce refusals.

DVI Results Compared to State and National HEDIS Scores

Clinical Measures	California				National			
	DVI Cycle 4 Results[1]	HEDIS Medi-Cal 2015[2]	HEDIS Kaiser (No. CA) 2015[3]	HEDIS Kaiser (So.CA) 2015[3]	HEDIS Medicaid 2015[4]	HEDIS Com-mercial 2015[4]	HEDIS Medicare 2015[4]	VA Average 2014[5]
Comprehensive Diabetes Care								
HbA1c Testing (Monitoring)	**100%**	86%	95%	94%	86%	91%	93%	99%
Poor HbA1c Control (>9.0%)[6, 7]	**13%**	39%	18%	24%	44%	31%	25%	19%
HbA1c Control (<8.0%)[6]	**64%**	49%	70%	62%	47%	58%	65%	-
Blood Pressure Control (<140/90)[6]	**92%**	63%	84%	85%	62%	65%	65%	78%
Eye Exams	**84%**	53%	69%	81%	54%	56%	69%	90%
Immunizations								
Influenza Shots - Adults (18–64)[8]	**33%**	-	54%	55%	-	50%	-	58%
Influenza Shots - Adults (65+)[6]	**87%**	-	-	-	-	-	72%	76%
Immunizations: Pneumococcal[6]	**93%**	-	-	-	-	-	70%	93%
Cancer Screening								
Colorectal Cancer Screening	**69%**	-	80%	82%	-	64%	67%	82%

1. Unless otherwise stated, data was collected in May 2016 by reviewing medical records from a sample of DVI's population of applicable inmate-patients. These random statistical sample sizes were based on a 95 percent confidence level with a 15 percent maximum margin of error.

2. HEDIS Medi-Cal data was obtained from the California Department of Health Care Services *2015 HEDIS Aggregate Report for Medi-Cal Managed Care*.

3. Data was obtained from Kaiser Permanente November 2015 reports for the Northern and Southern California regions.

4. National HEDIS data for Medicaid, commercial plans, and Medicare was obtained from the 2015 *State of Health Care Quality Report*, available on the NCQA website: www.ncqa.org. The results for commercial plans were based on data received from various health maintenance organizations.

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

6. For this indicator, the entire applicable DVI population was tested.

7. For this measure only, a lower score is better. For Kaiser, the OIG derived the Poor HbA1c Control indicator using the reported data for the <9.0% HbA1c control indicator.

APPENDIX A — COMPLIANCE TEST RESULTS

Deuel Vocational Institution Range of Summary Scores: 55.04% - 90.82%	
Indicator	**Overall Score (Yes %)**
Access to Care	79.42%
Diagnostic Services	83.65%
Emergency Services	Not Applicable
Health Information Management (Medical Records)	75.73%
Health Care Environment	59.92%
Inter- and Intra-System Transfers	79.96%
Pharmacy and Medication Management	55.04%
Prenatal and Post-Delivery Services	Not Applicable
Preventive Services	90.82%
Quality of Nursing Performance	Not Applicable
Quality of Provider Performance	Not Applicable
Reception Center Arrivals	72.22%
Specialized Medical Housing (OHU, CTC, SNF, Hospice)	82.00%
Specialty Services	84.37%
Internal Monitoring, Quality Improvement, and Administrative Operations	88.33%
Job Performance, Training, Licensing, and Certifications	70.83%

Reference Number	*Access to Care*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
1.001	**Chronic care follow-up appointments:** Was the inmate-patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter?	29	1	30	96.67%	0
1.002	**For endorsed inmate-patients received from another CDCR institution:** If the nurse referred the inmate-patient to a provider during the initial health screening, was the inmate-patient seen within the required time frame?	9	10	19	47.37%	11
1.003	**Clinical appointments:** Did a registered nurse review the inmate-patient's request for service the same day it was received?	30	0	30	100.00%	0
1.004	**Clinical appointments:** Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed?	21	9	30	70.00%	0
1.005	**Clinical appointments:** If the registered nurse determined a referral to a primary care provider was necessary, was the inmate-patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter?	9	1	10	90.00%	20
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?	1	3	4	25.00%	26
1.007	**Upon the inmate-patient's discharge from the community hospital:** Did the inmate-patient receive a follow-up appointment within the required time frame?	30	0	30	100.00%	0
1.008	**Specialty service follow-up appointments:** Do specialty service primary care physician follow-up visits occur within required time frames?	24	4	28	85.71%	2
1.101	**Clinical appointments:** Do inmate-patients have a standardized process to obtain and submit health care services request forms?	6	0	6	100.00%	0
Overall Percentage:					**79.42%**	

Reference Number	*Diagnostic Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
2.001	**Radiology:** Was the radiology service provided within the time frame specified in the provider's order?	9	1	10	90.00%	0
2.002	**Radiology:** Did the primary care provider review and initial the diagnostic report within specified time frames?	8	2	10	80.00%	0
2.003	**Radiology:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	10	0	10	100.00%	0
2.004	**Laboratory:** Was the laboratory service provided within the time frame specified in the provider's order?	9	1	10	90.00%	0
2.005	**Laboratory:** Did the primary care provider review and initial the diagnostic report within specified time frames?	9	1	10	90.00%	0
2.006	**Laboratory:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	9	1	10	90.00%	0
2.007	**Pathology:** Did the institution receive the final diagnostic report within the required time frames?	7	3	10	70.00%	0
2.008	**Pathology:** Did the primary care provider review and initial the diagnostic report within specified time frames?	7	0	7	100.00%	3
2.009	**Pathology:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	3	4	7	42.86%	3
Overall Percentage:					**83.65%**	

Emergency Services	Scored Answers
Assesses reaction times and responses to emergency situations. The OIG RN clinicians will use detailed information obtained from the institution's incident packages to perform focused case reviews.	**Not Applicable**

Reference Number	*Health Information Management (Medical Records)*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated progress notes, initial health screening forms, and health care service request forms scanned into the eUHR within three calendar days of the inmate-patient encounter date?	20	0	20	100.00%	0
4.002	Are dictated / transcribed documents scanned into the eUHR within five calendar days of the inmate-patient encounter date?	5	0	5	100.00%	0
4.003	Are specialty documents scanned into the eUHR within the required time frame?	20	0	20	100.00%	0
4.004	Are community hospital discharge documents scanned into the eUHR within three calendar days of the inmate-patient date of hospital discharge?	19	1	20	95.00%	0
4.005	Are medication administration records (MARs) scanned into the eUHR within the required time frames?	13	7	20	65.00%	0
4.006	During the eUHR review, did the OIG find that documents were correctly labeled and included in the correct inmate-patient's file?	0	12	12	0.00%	0
4.007	Did clinical staff legibly sign health care records, when required?	33	7	40	82.50%	0
4.008	**For inmate-patients discharged from a community hospital:** Did the preliminary hospital discharge report include key elements and did a PCP review the report within three calendar days of discharge?	19	11	30	63.33%	0
Overall Percentage:					**75.73%**	

Reference Number	*Health Care Environment*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
5.101	**Infection Control:** Are clinical health care areas appropriately disinfected, cleaned and sanitary?	11	1	12	91.67%	0
5.102	**Infection control:** Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	11	0	11	100.00%	1
5.103	**Infection Control:** Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	12	0	12	100.00%	0
5.104	**Infection control:** Does clinical health care staff adhere to universal hand hygiene precautions?	0	11	11	0.00%	1
5.105	**Infection control:** Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	7	5	12	58.33%	0
5.106	**Warehouse, Conex and other non-clinic storage areas:** Does the medical supply management process adequately support the needs of the medical health care program?	1	0	1	100.00%	0
5.107	**Clinical areas:** Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	1	11	12	8.33%	0
5.108	**Clinical areas:** Do clinic common areas and exam rooms have essential core medical equipment and supplies?	4	8	12	33.33%	0
5.109	**Clinical areas:** Do clinic common areas have an adequate environment conducive to providing medical services?	5	3	8	62.50%	4
5.110	**Clinical areas:** Do clinic exam rooms have an adequate environment conducive to providing medical services?	3	9	12	25.00%	0
5.111	**Emergency response bags:** Are TTA and clinic emergency medical response bags inspected daily and inventoried monthly, and do they contain essential items?	4	1	5	80.00%	7
Overall Percentage:					**59.92%**	

Reference Number	*Inter- and Intra-System Transfers*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
6.001	**For endorsed inmate-patients received from another CDCR institution or COCF:** Did nursing staff complete the initial health screening and answer all screening questions on the same day the inmate-patient arrived at the institution?	28	2	30	93.33%	0
6.002	**For endorsed inmate-patients received from another CDCR institution or COCF:** When required, did the RN complete the assessment and disposition section of the health screening form; refer the inmate-patient to the TTA, if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening?	30	0	30	100.00%	0
6.003	**For endorsed inmate-patients received from another CDCR institution or COCF:** If the inmate-patient had an existing medication order upon arrival, were medications administered or delivered without interruption?	13	4	17	76.47%	13
6.004	**For inmate-patients transferred out of the facility:** Were scheduled specialty service appointments identified on the Health Care Transfer Information Form 7371?	6	14	20	30.00%	0
6.101	**For inmate-patients transferred out of the facility:** Do medication transfer packages include required medications along with the corresponding Medical Administration Record (MAR) and Medication Reconciliation?	9	0	9	100.00%	1
Overall Percentage:					**79.96%**	

Reference Number	*Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.001	Did the inmate-patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows?	21	4	25	84.00%	5
7.002	Did health care staff administer or deliver new order prescription medications to the inmate-patient within the required time frames?	30	0	30	100.00%	0
7.003	**Upon the inmate-patient's discharge from a community hospital:** Were all medications ordered by the institution's primary care provider administered or delivered to the inmate-patient within one calendar day of return?	17	13	30	56.67%	0
7.004	**For inmate-patients received from a county jail:** Were all medications ordered by the institution's reception center provider administered or delivered to the inmate-patient within the required time frames?	6	3	9	66.67%	11
7.005	**Upon the inmate-patient's transfer from one housing unit to another:** Were medications continued without interruption?	22	8	30	73.33%	0
7.006	**For inmate-patients en route who lay over at the institution:** If the temporarily housed inmate-patient had an existing medication order, were medications administered or delivered without interruption?	5	5	10	50.00%	0
7.101	**All clinical and medication line storage areas for narcotic medications:** Does the institution employ strong medication security controls over narcotic medications assigned to its clinical areas?	2	6	8	25.00%	10
7.102	**All clinical and medication line storage areas for non-narcotic medications:** Does the institution properly store non-narcotic medications that do not require refrigeration in assigned clinical areas?	0	12	12	0.00%	6
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?	0	7	7	0.00%	11
7.104	**Medication preparation and administration areas:** Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes?	3	3	6	50.00%	12
7.105	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when preparing medications for inmate-patients?	6	0	6	100.00%	12
7.106	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when distributing medications to inmate-patients?	3	3	6	50.00%	12
7.107	**Pharmacy:** Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and satellite pharmacies?	0	1	1	0.00%	0

7.108	**Pharmacy:** Does the institution's pharmacy properly store non-refrigerated medications?	0	1	1	0.00%	0
7.109	**Pharmacy:** Does the institution's pharmacy properly store refrigerated or frozen medications?	1	0	1	100.00%	0
7.110	**Pharmacy:** Does the institution's pharmacy properly account for narcotic medications?	1	0	1	100.00%	0
7.111	**Pharmacy:** Does the institution follow key medication error reporting protocols?	24	6	30	80.00%	0
7.998	**For Information Purposes Only:** During eUHR compliance testing and case reviews, did the OIG find that medication errors were properly identified and reported by the institution?	Information Only				
7.999	**For Information Purposes Only:** Do inmate-patients in isolation housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications?	Information Only				
Overall Percentage:					**55.04%**	

Prenatal and Post-Delivery Services	Scored Answers
This indicator is not applicable to this institution.	**Not Applicable**

Reference Number	*Preventive Services*	Scored Answers				
		Yes	No	Yes + No	Yes %	N/A
9.001	**Inmate-patients prescribed TB medications:** Did the institution administer the medication to the inmate-patient as prescribed?	26	4	30	86.67%	0
9.002	**Inmate-patients prescribed TB medications:** Did the institution monitor the inmate-patient monthly for the most recent three months he or she was on the medication?	29	1	30	96.67%	0
9.003	**Annual TB Screening:** Was the inmate-patient screened for TB within the last year?	23	7	30	76.67%	0
9.004	Were all inmate-patients offered an influenza vaccination for the most recent influenza season?	30	0	30	100.00%	0
9.005	**All inmate-patients from the age of 50 through the age of 75:** Was the inmate-patient offered colorectal cancer screening?	29	1	30	96.67%	0
9.006	**Female inmate-patients from the age of 50 through the age of 74:** Was the inmate-patient offered a mammogram in compliance with policy?	Not Applicable				
9.007	**Female inmate-patients from the age of 21 through the age of 65:** Was the inmate-patient offered a pap smear in compliance with policy?	Not Applicable				
9.008	Are required immunizations being offered for chronic care inmate-patients?	15	2	17	88.24%	13
9.009	Are inmate-patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	Not Applicable				
Overall Percentage:					**90.82%**	

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

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

Reference Number	*Reception Center Arrivals*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
12.001	**For inmate-patients received from a county jail:** Did nursing staff complete the initial health screening and answer all screening questions on the same day the inmate-patient arrived at the institution?	4	16	20	20.00%	0
12.002	**For inmate-patients received from a county jail:** When required, did the RN complete the assessment and disposition section of the health screening form, and sign and date the form on the same day staff completed the health screening?	20	0	20	100.00%	0
12.003	**For inmate-patients received from a county jail:** If, during the assessment, the nurse referred the inmate-patient to a provider, was the inmate-patient seen within the required time frame?	Not Applicable				20
12.004	**For inmate-patients received from a county jail:** Did the inmate-patient receive a history and physical by a primary care provider within seven calendar days?	20	0	20	100.00%	0
12.005	**For inmate-patients received from a county jail:** Were all required intake tests completed within specified timelines?	16	4	20	80.00%	0
12.006	**For inmate-patients received from a county jail:** Did the primary care provider review and communicate the intake test results to the inmate-patient within specified timelines?	19	0	19	100.00%	1
12.007	**For inmate-patients received from a county jail:** Was a tuberculin test both administered and read timely?	1	17	18	5.56%	2
12.008	**For inmate-patients received from a county jail:** Was a Coccidioidomycosis (Valley Fever) skin test offered, administered and read timely?	20	0	20	100.00%	0
Overall Percentage:					**72.22%**	

Reference Number	*Specialized Medical Housing (OHU, CTC, SNF, Hospice)*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	**For all higher-level care facilities:** Did the registered nurse complete an initial assessment of the inmate-patient on the day of admission, or within eight hours of admission to CMF's Hospice?	10	0	10	100.00%	0
13.002	**For OHU, CTC, & SNF only:** Did the primary care provider for OHU or attending physician for a CTC & SNF evaluate the inmate-patient within 24 hours of admission?	8	2	10	80.00%	0
13.003	**For OHU, CTC, & SNF only:** Was a written history and physical examination completed within 72 hours of admission?	5	5	10	50.00%	0
13.004	**For all higher-level care facilities:** Did the primary care provider complete the Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes on the inmate-patient at the minimum intervals required for the type of facility where the inmate-patient was treated?	8	2	10	80.00%	0
13.101	**For OHU and CTC Only:** Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter inmate-patient's cells?	1	0	1	100.00%	0
Overall Percentage:					**82.00%**	

Reference Number	*Specialty Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	Did the inmate-patient receive the high-priority specialty service within 14 calendar days of the PCP order?	12	3	15	80.00%	0
14.002	Did the PCP review the high priority specialty service consultant report within the required time frame?	12	3	15	80.00%	0
14.003	Did the inmate-patient receive the routine specialty service within 90 calendar days of the PCP order?	15	0	15	100.00%	0
14.004	Did the PCP review the routine specialty service consultant report within the required time frame?	14	1	15	93.33%	0
14.005	**For endorsed inmate-patients received from another CDCR institution:** If the inmate-patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames?	15	5	20	75.00%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	18	2	20	90.00%	0
14.007	Following the denial of a request for specialty services, was the inmate-patient informed of the denial within the required time frame?	13	5	18	72.22%	2
Overall Percentage:					**84.37%**	

Reference Number	*Internal Monitoring, Quality Improvement, and Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.001	Did the institution promptly process inmate medical appeals during the most recent 12 months?	12	0	12	100.00%	0
15.002	Does the institution follow adverse/sentinel event reporting requirements?	Not Applicable				
15.003	Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified?	6	0	6	100.00%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	1	0	1	100.00%	0
15.005	For each initiative in the Performance Improvement Work Plan (PIWP), has the institution performance improved or reached the targeted performance objective(s)?	2	3	5	40.00%	1
15.006	**For institutions with licensed care facilities:** Does the Local Governing Body (LGB), or its equivalent, meet quarterly and exercise its overall responsibilities for the quality management of patient health care?	Not Applicable				
15.007	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	12	0	12	100.00%	0
15.101	Did the institution complete a medical emergency response drill for each watch and include participation of health care and custody staff during the most recent full quarter?	3	0	3	100.00%	0
15.102	Did the institution's second level medical appeal response address all of the inmate-patient's appealed issues?	10	0	10	100.00%	0
15.103	Did the institution's medical staff review and submit the initial inmate death report to the Death Review Unit in a timely manner?	2	1	3	66.67%	0
15.996	**For Information Purposes Only:** Did the CCHCS Death Review Committee submit its inmate death review summary to the institution timely?	Information Only				
15.997	**For Information Purposes Only:** Identify the institution's protocols for tracking medical appeals.	Information Only				
15.998	**For Information Purposes Only:** Identify the institution's protocols for implementing health care local operating procedures.	Information Only				
15.999	**For Information Purposes Only:** Identify the institution's health care staffing resources.	Information Only				
Overall Percentage:					**88.33%**	

Reference Number	*Job Performance, Training, Licensing, and Certifications*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
16.001	Do all providers maintain a current medical license?	9	0	9	100.00%	0
16.101	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	0	5	5	0.00%	0
16.102	Are nursing staff who administer medications current on their clinical competency validation?	10	0	10	100.00%	0
16.103	Are structured clinical performance appraisals completed timely?	7	0	7	100.00%	1
16.104	Are staff current with required medical emergency response certifications?	2	1	3	66.67%	0
16.105	Are nursing staff and the Pharmacist-in-Charge current with their professional licenses and certifications?	5	0	5	100.00%	1
16.106	Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	1	0	1	100.00%	0
16.107	Are nursing staff current with required new employee orientation?	0	1	1	0.00%	0
Overall Percentage:					**70.83%**	

APPENDIX B — CLINICAL DATA

Table B-1: DVI Sample Sets	
Sample Set	**Total**
Anticoagulation	3
CTC/OHU	3
Death Review/Sentinel Events	3
Diabetes	3
Emergency Services — Non-CPR	5
High Risk	5
Hospitalization	5
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	15
Reception Center Transfers	5
Specialty Services	5
	58

Table B-2: DVI Chronic Care Diagnoses	
Diagnosis	**Total**
Anemia	5
Anticoagulation	3
Arthritis/Degenerative Joint Disease	3
Asthma	9
COPD	7
Cancer	3
Cardiovascular Disease	9
Chronic Kidney Disease	2
Chronic Pain	13
Cirrhosis/End-Stage Liver Disease	1
Coccidioidomycosis	1
DVT/PE	3
Diabetes	16
Gastroesophageal Reflux Disease	12
HIV	4
Hepatitis C	9
Hyperlipidemia	12
Hypertension	28
Mental Health	3
Migraine Headaches	1
Seizure Disorder	6
Sleep Apnea	1
Thyroid Disease	2
	153

Table B-3: DVI Event - Program	
Program	**Total**
Diagnostic Services	228
Emergency Care	98
Hospitalization	84
Intra-System Transfers In	10
Intra-System Transfers Out	6
Not Specified	1
Outpatient Care	491
Reception Center Care	47
Specialized Medical Housing	354
Specialty Services	242
	1,561

Table B-4: DVI Case Review Sample Summary	
	Total
MD Reviews, Detailed	30
MD Reviews, Focused	0
RN Reviews, Detailed	20
RN Reviews, Focused	25
Total Reviews	75
Total Unique Cases	58
Overlapping Reviews (MD & RN)	17

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

Deuel Vocational Institution			
Quality Indicator	**Sample Category (number of samples)**	**Data Source**	**Filters**
Access to Care			
MIT 1.001	Chronic Care Patients (30)	Master Registry	• Chronic care conditions (at least one condition per inmate-patient—any risk level) • **Randomize**
MIT 1.002	Nursing Referrals (30)	OIG Q: 6.001	• See ***Intra-system Transfers***
MITs 1.003-006	Nursing Sick Call (10 per clinic) 30	MedSATS	• Clinic (each clinic tested) • Appointment date (2–9 months) • **Randomize**
MIT 1.007	Returns from Community Hospital (30)	OIG Q: 4.008	• See ***Health Information Management (Medical Records)*** (returns from community hospital)
MIT 1.008	Specialty Services Follow-up (30)	OIG Q: 14.001 & 14.003	• See ***Specialty Services***
MIT 1.101	Availability of Health Care Services Request Forms (6)	OIG onsite review	• Randomly select one housing unit from each yard
Diagnostic Services			
MITs 2.001–003	Radiology (10)	Radiology Logs	• Appointment date (90 days–9 months) • **Randomize** • Abnormal
MITs 2.004–006	Laboratory (10)	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • **Randomize** • Abnormal
MITs 2.007–009	Pathology (10)	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • **Randomize**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Health Information Management (Medical Records)			
MIT 4.001	Timely Scanning (20)	OIG Qs: 1.001, 1.002, & 1.004	• Non-dictated documents • 1st 10 IPs MIT 1.001, 1st 5 IPs MITs 1.002, 1.004
MIT 4.002	(5)	OIG Q: 1.001	• Dictated documents • First 20 IPs selected
MIT 4.003	(20)	OIG Qs: 14.002 & 14.004	• Specialty documents • First 10 IPs for each question
MIT 4.004	(20)	OIG Q: 4.008	• Community hospital discharge documents • First 20 IPs selected
MIT 4.005	(20)	OIG Q: 7.001	• MARs • First 20 IPs selected
MIT 4.006	(12)	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (12 or more = No)
MIT 4.007	Legible Signatures & Review (40)	OIG Qs: 4.008, 6.001, 6.002, 7.001, 12.001, 12.002 & 14.002	• First 8 IPs sampled • One source document per IP
MIT 4.008	Returns From Community Hospital (30)	Inpatient claims data	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • **Randomize** (each month individually) • First 5 inmate-patients from each of the 6 months (if not 5 in a month, supplement from another, as needed)
Health Care Environment			
MIT 5.101-105 MIT 5.107–111	Clinical Areas (12)	OIG inspector onsite review	• Identify and inspect all onsite clinical areas.
Inter- and Intra-System Transfers			
MIT 6.001-003	Intra-System Transfers (30)	SOMS	• Arrival date (3–9 months) • Arrived from (another CDCR facility) • Rx count • **Randomize**
MIT 6.004	Specialty Services Send-Outs (20)	MedSATS	• Date of transfer (3–9 months) • **Randomize**
MIT 6.101	Transfers Out (10)	OIG inspector onsite review	• R&R IP transfers with medication

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Pharmacy and Medication Management			
MIT 7.001	Chronic Care Medication (30)	OIG Q: 1.001	*See* ***Access to Care*** • At least one condition per inmate-patient—any risk level • **Randomize**
MIT 7.002	New Medication Orders (30)	Master Registry	• Rx count • **Randomize** • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns from Community Hospital (30)	OIG Q: 4.008	• See ***Health Information Management (Medical Records)*** *(returns from community hospital)*
MIT 7.004	RC Arrivals – Medication Orders (20)	OIG Q: 12.001	• See ***Reception Center Arrivals***
MIT 7.005	Intra-Facility Moves (30)	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • **Randomize**
MIT 7.006	En Route (10)	SOMS	• Date of transfer (2–8 months) • Sending institution (another CDCR facility) • **Randomize** • NA/DOT meds
MITs 7.101-103	Medication Storage Areas (varies by test)	OIG inspector onsite review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–106	Medication Preparation and Administration Areas (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 (30)	Monthly medication error reports	• All monthly statistic reports with Level 4 or higher • Select a total of 5 months
MIT 7.999	Isolation Unit KOP Medications (12)	Onsite active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in isolation units
Prenatal and Post-Delivery Services			
MIT 8.001-007	Recent Deliveries *N/A at this institution*	OB Roster	• Delivery date (2–12 months) • **Most recent** deliveries (within date range)
	Pregnant Arrivals *N/A at this institution*	OB Roster	• Arrival date (2–12 months) • **Earliest** arrivals (within date range)

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Preventive Services			
MITs 9.001–002	TB Medications (30)	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • **Randomize**
MIT 9.003	TB Code 22, Annual TST (15)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (22) • **Randomize**
	TB Code 34, Annual Screening (15)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (34) • **Randomize**
MIT 9.004	Influenza Vaccinations (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • **Randomize** • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • **Randomize**
MIT 9.006	Mammogram *N/A at this institution*	SOMS	• Arrival date (at least 2 yrs prior to inspection) • Date of birth (age 52–74) • **Randomize**
MIT 9.007	Pap Smear *N/A at this institution*	SOMS	• Arrival date (at least three yrs prior to inspection) • Date of birth (age 24–53) • **Randomize**
MIT 9.008	Chronic Care Vaccinations (30)	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • **Randomize** • Condition must require vaccination(s)
MIT 9.009	Valley Fever (number will vary) *N/A at this institution*	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • **All**

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

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Internal Monitoring, Quality Improvement, & Administrative Operations			
MIT 15.001	Medical Appeals (all)	Monthly medical appeals reports	• Medical appeals (12 months)
MIT 15.002	Adverse/Sentinel Events (0)	Adverse/sentinel events report	• Adverse/sentinel events (2–8 months)
MITs 15.003–004	QMC Meetings (6)	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.005	Performance Improvement Work Plans (PIWP) (6)	Institution PIWP	• PIWP with updates (12 months) • Medical initiatives
MIT 15.006	LGB N/A at this institution	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.007	EMRRC (12)	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.101	Medical Emergency Response Drills (3)	Onsite summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	2nd Level Medical Appeals (10)	Onsite list of appeals/closed appeals files	• Medical appeals denied (6 months)
MIT 15.103	Death Reports (3)	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.996	Death Review Committee (3)	OIG summary log - deaths	• Between 35 business days & 12 months prior • CCHCS death reviews
MIT 15.998	Local Operating Procedures (LOPs) (all)	Institution LOPs	• All LOPs

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Job Performance, Training, Licensing, and Certifications			
MIT 16.001	Provider licenses (9)	Current provider listing (at start of inspection)	• Review all
MIT 16.101	RN Review Evaluations (5)	Onsite supervisor periodic RN reviews	• RNs who worked in clinic or emergency setting six or more days in sampled month • **Randomize**
MIT 16.102	Nursing Staff Validations (10)	Onsite nursing education files	• On duty one or more years • Nurse administers medications • **Randomize**
MIT 16.103	Provider Annual Evaluation Packets (8)	OIG Q:16.001	• All required performance evaluation documents
MIT 16.104	Medical Emergency Response Certifications (all)	Onsite certification tracking logs	• All staff o Providers (ACLS) o Nursing (BLS/CPR) o Custody (CPR/BLS)
MIT 16.105	Nursing staff and Pharmacist in Charge Professional Licenses and Certifications (all)	Onsite tracking system, logs, or employee files	• All required licenses and certifications
MIT 16.106	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations (all)	Onsite listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 16.107	Nursing Staff New Employee Orientations (all)	Nursing staff training logs	• New employees (hired within last 12 months)

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

December 30, 2016

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

Dear Mr. Barton:

The purpose of this letter is to inform you that the Office of the Receiver has reviewed the draft report of the Office of the Inspector General (OIG) Medical Inspection Results for Deuel Vocational Institution (DVI) conducted from May 2016 to August 2016. California Correctional Health Care Services (CCHCS) acknowledges all OIG findings.

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

Sincerely,

Janet Lewis

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

cc: Clark Kelso, Receiver
Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Richard Kirkland, Chief Deputy Receiver
Roy Wesley, Chief Deputy Inspector General, OIG
Christine Berthold, Senior Deputy Inspector General, OIG
Ryan Baer, Senior Deputy Inspector General (A), OIG
Scott Heatley, M.D., Ph.D., CCHP, Chief Physician and Surgeon, OIG
Penny Horper, R.N., MSN, CPHQ, Nurse Consultant Program Review, OIG
Yulanda Mynhier, Director, Health Care Policy and Administration, CCHCS
Roscoe Barrow, Chief Counsel, CCHCS Office of Legal Affairs
R. Steven Tharratt, M.D., MPVM, FACP, Director, Health Care Operations, CCHCS
Renee Kanan, M.D., Deputy Director, Medical Services, CCHCS
Jane Robinson, R. N., Deputy Director, Nursing Services, CCHCS
R. Michael Hutchinson, Regional Health Care Executive, Region II, CCHCS
David Ralston, M.D., Regional Deputy Medical Executive, Region II, CCHCS
Laura Schaper, R.N., Regional Nursing Executive, Region II, CCHCS
Nancy Guadagna, Ed.D., Chief Executive Officer (A), DVI
Annette Lambert, Deputy Director (A), Quality Management, Clinical Information and Improvement Services, CCHCS
Dawn DeVore, Staff Services Manager II, Program Compliance Section, CCHCS