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Office of the Inspector General

Folsom State Prison
Medical Inspection Results
Cycle 5

January 2018

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

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FOREWORD

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

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

In Cycle 5, for the first time, the OIG will be inspecting institutions delegated back to CDCR from the Receivership. There is no difference in the standards used for assessment of a delegated institution versus an institution not yet delegated. The Receiver delegated Folsom State Prison back to CDCR in July 2015.

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

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EXECUTIVE SUMMARY

OVERALL RATING:

ADEQUATE

The OIG performed its Cycle 5 medical inspection at Folsom State Prison (FSP) from May to July 2017. The inspection included in-depth reviews of 67 patient files conducted by clinicians, as well as reviews of documents from 393 patient files, covering 85 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 FSP using 12 health care quality indicators applicable to the institution. 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 registered nurses trained in monitoring medical policy compliance. Of the indicators, six were rated by both case review clinicians and compliance inspectors, three were rated by case review clinicians only, and three were rated by compliance inspectors only. The *FSP Executive Summary Table* on the following page identifies the applicable individual indicators and scores for this institution.

FSP Executive Summary Table

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

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

Clinical Case Review and OIG Clinician Inspection Results

The clinicians' case reviews sampled patients with high medical needs and included a review of more than 864 patient care events.[1] Of the 12 indicators applicable to FSP, 9 were evaluated by clinician case review; one was *proficient*, and eight were *adequate*. 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

- During this period of review, FSP continued the pattern from Cycle 4 of providing excellent access to care with no provider backlog in any of the clinics.

- Health care leadership at FSP was excellent with good support provided to the medical staff. This allowed each primary care team to deliver effective health care to patients. Nursing staff at the institution felt equally supported by their supervisors and the chief nurse executive (CNE). Onsite, all of FSP's providers expressed excellent job satisfaction as well as good provider morale.

- FSP continued to provide timely and appropriate specialty services to patients. Providers reported having good access to both onsite and offsite specialty reports.

Program Weaknesses — Clinical

- Only half of FSP providers had access to the diagnostic reports in the radiological information system-picture archiving and communication system (RIS-PACS). As a result, various diagnostic reports were not directly available to these providers.

- FSP providers typically did not order follow-up appointments within the appropriate time interval, especially chronic care follow-ups. This situation did not improve compared to Cycle 4.

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

Compliance Testing Results

Of the 12 health care indicators applicable to FSP, 9 were evaluated by compliance inspectors.[2] Three were *proficient*, two were *adequate*, and four were *inadequate*. There were 85 individual compliance questions within those nine indicators, generating 1,108 data points that tested FSP's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[3] Those 85 questions are detailed in *Appendix A — Compliance Test Results*.

Program Strengths — Compliance

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

- The institution provided patients with timely chronic care appointments. It also provided sick call, hospital discharge, and specialty service provider follow-up appointments within required time frames. In addition, nursing staff reviewed patient requests for health care services the same day they were received, and nursing staff conducted a face-to-face encounter with patients for health care services within required time frames. The health information management team at FSP did an excellent job of supporting overall patient health by timely and accurately scanning, updating, and maintaining medical records in patients' files.

- The institution administered tuberculosis (TB) medications to patients as ordered, and also annually screened all patients for signs and symptoms of TB as required by CCHCS policy. Furthermore, the institution generally offered influenza immunizations and cancer screenings to applicable patients.

- FSP denied requested specialty service appointments deemed unnecessary for patients within required time frames, and providers communicated these specialty service denials and discussed alternative treatment strategies with patients as required by CCHCS policy.

- The institution performed well with administrative operations; specifically, FSP addressed patient health care appeals timely and regularly held quality management committee meetings that addressed the accuracy of the Dashboard data.

Program Weaknesses — Compliance

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

[2] The OIG's compliance inspectors are 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 for which CCHCS policies and procedures did not specifically address an issue.

- Providers did not always review radiology and pathology report results timely, and providers also did not always communicate the results of these services to patients, or communicated the results late.

- Inspectors observed several clinic locations where clinicians did not always follow good hand hygiene practices before or after patient encounters. In addition, several clinic locations did not have all necessary equipment available to clinicians, or equipment was not properly calibrated.

- Patients did not always receive their newly ordered medications timely, and several patients who were discharged from a community hospital and returned to FSP did not receive their discharge medications within required time frames. In addition, inspectors observed several medication line locations that did not properly inventory narcotic medication supplies.

Recommendations

- The OIG recommends that FSP develop monitoring strategies to ensure first medical responders check and document patients' vital signs when responding to medical emergencies.

Population-Based Metrics

In general, FSP performed well as measured by population-based metrics. In comprehensive diabetes care, FSP outperformed state and national health care plans in most of the five diabetic measures, with the diabetic measure for eye examinations being the sole exception.

Regarding immunizations, the institution scored lower than all but one health care plan for influenza immunizations for young adults; however, a high patient refusal rate negatively affected the institution's score for this measure. FSP performed comparably to other health care plans for immunizations for influenza and pneumococcal vaccinations for older adults. Regarding cancer screenings, the institution outperformed or matched all other health care plans for cervical and colorectal cancer screenings, but scored lower than all but one health care plan for breast cancer screenings.

Overall, FSP has a well-functioning chronic care program compared to the other state and national health care plans reviewed. The institution can improve its performance for influenza immunizations for younger adults and breast cancer screenings by educating patients about the benefits of these preventive services.

INTRODUCTION

Pursuant to California Penal Code Section 6126 et seq., which assigns the Office of the Inspector General (OIG) responsibility for oversight of the California Department of Corrections and Rehabilitation (CDCR), and at the request of the federal Receiver, the OIG developed a comprehensive medical inspection program to evaluate the delivery of medical care at each of CDCR's 35 adult prisons. The OIG conducts a clinical case review and a compliance inspection, ensuring a thorough, end-to-end assessment of medical care within CDCR.

Folsom State Prison (FSP) was the 14th medical inspection of Cycle 5. During the inspection process, the OIG assessed the delivery of medical care to patients using the primary clinical health care indicators applicable to the institution. The *Administrative Operations* indicator is purely administrative and is not reflective of the actual clinical care provided.

ABOUT THE INSTITUTION

Located in the city of Folsom, in Sacramento County, FSP is California's second-oldest prison. The institution primarily houses medium-security general population Level II male patients. Additionally, the institution houses minimum-security Level I male patients within a minimum security facility located adjacent to the main security perimeter. FSP offers rehabilitative programs in academic courses and career technical education, as well as many volunteer-run rehabilitative programs. FSP is the state's only prison with a mixed population of men and women. Under FSP's administration, Folsom Women's Facility (FWF) was activated in January 2013; it includes a 523-bed stand-alone facility that provides housing, rehabilitative and re-entry programming, substance abuse treatment, and job training to its minimum- and medium-security female population. Together, FSP and FWF run eight medical clinics where staff members handle non-urgent requests for medical services. FSP also treats patients requiring urgent or emergent care in its two triage and treatment areas (TTAs).

The institution has been designated as an "intermediate care prison"; these institutions are predominantly located in urban areas close to tertiary care centers and specialty care providers likely to be necessary for a population with moderately high medical needs.

FSP received national accreditation from the Commission on Accreditation for Corrections on February 6, 2017. This accreditation program is a professional peer review process based on national standards set by the American Correctional Association.

Based on staffing data the OIG obtained from the institution, FSP's vacancy rate among medical managers, primary care providers, supervisors, and rank-and-file nurses was 19 percent in May 2017, with the highest vacancy percentage among rank-and-file nurses at 23 percent, which equated to 20.4 vacant positions. Among primary care providers, the vacancy rate was 6 percent.

FSP Health Care Staffing Resources as of May 2017

	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff		Totals	
Description	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Authorized Positions	5	4%	8.5	7%	15	13%	88.5	76%	117	100%
Filled Positions	5	100%	8	94%	14	93%	68.1	77%	95.1	81%
Vacancies	0	0%	0.5	6%	1	7%	20.4	23%	21.9	19%
Recent Hires (within 12 months)	1	20%	1	13%	3	21%	9	13%	14	15%
Staff Utilized from Registry	0	0%	1	13%	0	0%	1	1%	2	2%
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	7%	2	3%	3	3%

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

As of May 8, 2017, the Master Registry for FSP showed that the institution had a total population of 3,053. Within that total population, 1.9 percent was designated as high medical risk, Priority 1 (High 1), and 6.7 percent was designated as high medical risk, Priority 2 (High 2). Patients' assigned risk levels are based on the complexity of their required medical care related to their specific diagnoses, frequency of higher levels of care, age, and abnormal laboratory results 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 are 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.

FSP Master Registry Data as of May 8, 2017

Medical Risk Level	# of Patients	Percentage
High 1	58	1.9%
High 2	204	6.7%
Medium	1,117	36.6%
Low	1,674	54.8%
Total	**3,053**	**100.0%**

OBJECTIVES, SCOPE, AND METHODOLOGY

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

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

The OIG rates each of the quality indicators applicable to the institution under inspection based on case reviews conducted by OIG clinicians and compliance tests conducted by OIG registered nurses. The 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 done by clinicians, while the ratings for the primary quality indicators *Health Care Environment* and *Preventive Services* are derived entirely from compliance testing done by registered nurse inspectors. As another example, primary quality indicators such as *Diagnostic Services* and *Specialty Services* receive ratings derived from both sources.

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 a patient needing immediate care, the OIG notifies the chief executive officer of health care services and requests a status report. Additionally, if the OIG learns of significant departures from community standards, it may report such departures to the institution's chief executive officer or to CCHCS. Because these matters involve confidential medical information protected by state and federal privacy laws, 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 added case reviews to the Cycle 4 medical inspections at the recommendation of its stakeholders, which continues in Cycle 5 medical inspections. 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: FSP Sample Sets*, the OIG clinicians evaluated medical charts for 67 unique patients. *Appendix B, Table B-4: FSP Case Review Sample Summary* clarifies that both nurses and physicians reviewed charts for 16 of those patients, for 83 reviews in total. Physicians performed detailed reviews of 26 charts, and nurses performed detailed reviews of

15 charts, totaling 41 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 42 patients. These generated 864 clinical events for review (*Appendix B, Table B-3: FSP 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: FSP Sample Sets*), the 67 unique patients sampled included patients with 197 chronic care diagnoses, including 14 additional patients with diabetes (for a total of 17) (*Appendix B, Table B-2: FSP 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 was 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 found the Cycle 4 medical inspection sample size of 30 for detailed physician reviews far exceeded the saturation point necessary for an adequate qualitative review. At the end of Cycle 4 inspections, the case review results were re-analyzed using 50 percent of the cases; there were no significant differences in the ratings. To improve inspection efficiency while preserving the quality of the inspection, the samples for Cycle 5 medical inspections were reduced in number. In Cycle 5, for basic institutions with small high-risk populations, case review will use a sample size of detailed physician-reviewed cases 67 percent as large as that used in Cycle 4. For intermediate institutions and basic institutions housing many high-risk patients, case review physicians will use a sample 83 percent as large as that in Cycle 4. Finally, for the most medically complex institution, California Health Care Facility (CHCF), the OIG will continue to use a sample size 100 percent as large as that used in Cycle 4. FSP is an intermediate facility, and the physician sample was 83 percent of the Cycle 4 sample.

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 *proficient* (excellent), *adequate* (passing), *inadequate* (failing), or *not applicable*. A separate confidential *FSP 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 July 2017, registered nurse inspectors obtained answers to 85 objective medical inspection test (MIT) questions designed to assess the institution's compliance with critical policies and procedures applicable to the delivery of medical care. To conduct most tests, inspectors randomly selected samples of patients for whom the testing objectives were applicable and reviewed their electronic unit health records. In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed health records for 393 individual patients and analyzed specific transactions within their records for evidence that critical events occurred. Inspectors also reviewed management reports and meeting minutes to assess certain administrative operations. In addition, during the week of May 22, 2017, registered nurse field inspectors conducted a detailed onsite inspection of FSP's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,108 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 FSP's plant infrastructure, protocols for tracking medical appeals and local operating procedures, and staffing resources.

For Cycle 5 medical inspection testing, the OIG reduced the number of compliance samples tested for 18 indicator tests from a sample of 30 patients to a sample of 25 patients. The OIG also removed some inspection tests upon stakeholder agreement that either were duplicated in the case reviews or had limited value. Lastly, for Cycle 4 medical inspections, the OIG tested two secondary (administrative) indicators, *Internal Monitoring, Quality Improvement, and Administrative Operations*, and *Job Performance, Training, Licensing, and Certifications*, and have combined these tests into one *Administrative Operations* indicator for Cycle 5 inspections.

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

Scoring of Compliance Testing Results

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

OVERALL QUALITY INDICATOR RATING FOR CASE REVIEWS AND COMPLIANCE TESTING

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

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

POPULATION-BASED METRICS

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

MEDICAL INSPECTION RESULTS

The quality indicators assess the clinical aspects of health care. As shown on the *FSP Executive Summary Table* on page *iv* of this report, 12 of the OIG's indicators were applicable to FSP. Of those 12 indicators, 6 were rated by both the case review and compliance components of the inspection, 3 were rated by the case review component alone, and 3 were rated by the compliance component alone. The *Administrative Operations* indicator is a secondary indicator, and, therefore, was not relied upon for the overall score for the institution. Based on the analysis and results in all the primary indicators, the OIG experts made a considered and measured opinion that the quality of health care at FSP was ***adequate***.

Summary of Case Review Results: The clinical case review component assessed nine primary (clinical) indicators applicable to FSP. Of these nine indicators, OIG clinicians rated one *proficient* and eight *adequate*.

The OIG physicians rated the overall adequacy of care for each of the 25 detailed case reviews they conducted. Of these 25 cases, 20 were *adequate*, and 5 were *inadequate*. In the 864 events reviewed, there were 167 deficiencies, of which 50 were considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

Adverse Events Identified During Case Review: Adverse events are medical errors that cause serious patient harm. Medical care is a complex and dynamic process with many moving parts, subject to human error even within the best health care organizations. 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 nature of these events, the OIG cautions against drawing inappropriate conclusions regarding the institution based solely on adverse events.

Two adverse events were identified in the case reviews at FSP. These events are discussed in the *Quality of Provider Performance* indicator.

- In case 17, the provider failed to perform a rectal exam to check for active bleeding after the patient reported having "red brown stool." The patient was also hypertensive (an abnormally high blood pressure) and tachycardic (an abnormally fast heart rate). However, the provider failed to address the patient's abnormal vital signs and also erroneously documented that the patient's heart rate was regular on examination despite the tachycardia found on the monitor. The patient's risk of developing an adverse cardiac event or a fatal bleed was increased due to the medical provider's inappropriate management of his symptoms.

- Also in case 17, the same provider inappropriately ordered a pain medication that was well-known to increase the risk of gastrointestinal bleeding, despite having documented that the

patient had experienced more episodes of "blood in stools" within the past few hours. This same provider also failed to return to the institution while on call to perform a rectal exam to determine whether the patient actually had an active gastrointestinal bleed. These errors also increased the patient's risk of developing an adverse cardiac event or a fatal bleed. Fortunately, the patient did not have a bleed, and his condition spontaneously improved.

Summary of Compliance Results: The compliance component assessed 9 of the 12 indicators applicable to FSP. Of these nine indicators, OIG inspectors rated three *proficient*, two *adequate*, and four *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*.

1 — *ACCESS TO CARE*

This indicator evaluates the institution's ability to provide patients with timely clinical appointments. Areas specific to 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 a 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 patients have Health Care Services Request forms (CDCR Form 7362) available in their housing units.

Case Review Rating:
Proficient
Compliance Score:
Proficient
(91.3%)
Overall Rating:
Proficient

Case Review Results

The OIG clinicians reviewed 367 provider, nursing, specialty, and outside hospital encounters that required a follow-up appointment, and identified 14 deficiencies relating to *Access to Care*. Of these 14 deficiencies, 3 were significant and placed the patient at risk of harm if allowed to persist and not be rectified.

Provider-to-Provider Follow-up Appointments

FSP continued to perform very well 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. The OIG clinicians reviewed 212 outpatient provider encounters and did not identify any deficiencies due to scheduling oversight.

Failure to accommodate provider-ordered appointments within the specified time frame can often result in delays or even lapses in medical care. Therefore, this deficiency is also considered an access to care issue. FSP performed well in this area, and OIG clinicians identified this deficiency in two cases.

RN Sick Call Access

FSP performed effectively with registered nurse (RN) sick call access and experienced no backlogs in nursing appointments. The OIG clinicians reviewed 121 sick call encounters and found two deficiencies. Only one significant deficiency was noted in the following case:

- In case 14, the nurse requested two nursing appointments for the patient, who reported having kidney stones and pain, and who also requested colostomy supplies. Neither of the appointments occurred. Two weeks later, the patient submitted another request for the supplies. There was no evidence the patient's report of kidney stones and pain had been addressed.

RN-to-Provider Referrals

Nurses performing sick call assessments are required to refer the patient to a provider if a situation requires a higher level of care. FSP providers saw patients who were referred by a nurse within the required time frame. There were only three minor deficiencies in which a provider appointment was delayed.

Provider Follow-up After Specialty Service

FSP consistently provided patients with a provider follow-up after specialty services. The OIG clinicians reviewed 86 diagnostic and consultative specialty services, and found two instances in which provider follow-ups were delayed. The OIG clinicians identified these deficiencies in case 17 and the following case.

- In case 23, a dermatologist evaluated the patient for a non-healing skin lesion on his back. The dermatologist recommended a biopsy due to concerns that the lesion may have been malignant. However, the patient's specialty service follow-up appointment did not occur within the required time frame, which resulted in a three-month delay to schedule the patient's biopsy.

Intra-System Transfers

Nurses assessed newly transferred patients and always referred them to a provider as was observed in Cycle 4. The OIG clinicians reviewed four transfer-in patients and found no deficiencies with access to care in this area.

Follow-up After Hospitalization

FSP had no difficulty ensuring that providers saw their patients after they returned from an outside hospital or an emergency department. FSP had 27 hospitalizations and outside emergency events. There were no deficiencies with access to care in this area.

Urgent/Emergent Care

FSP performed sufficiently in ensuring that a primary care provider or the clinic nurse evaluated patients in the TTA. The OIG clinicians reviewed 30 urgent or emergent encounters, 12 of which required a primary care provider or a nurse follow-up. The OIG clinicians found no deficiencies in provider or nurse follow-ups from the TTA.

Specialized Medical Housing

Because FSP had neither an outpatient housing unit (OHU) nor a correctional treatment center (CTC), no review was necessary.

RN Case Management

FSP had only recently started a pilot case management program seven months before the review period began. The *Quality of Nursing Performance* indicator offers additional details for this area.

Specialty Access

Access to specialty services is discussed in the *Specialty Services* indicator.

Clinician Onsite Inspection

At the onsite inspection, the OIG clinicians learned that FSP had 2,988 patients, which included the women's yard, with no provider backlog in any of the clinics. This zero backlog was due to FSP having a full staff, many of whom were highly experienced physicians. Seven full-time providers worked in the clinics, and one nurse practitioner covered the TTA. On average, providers saw between seven and ten patients per day, which allowed enough time for providers to also treat any patient walk-in issues that might arise. Furthermore, some of these physicians had worked at FSP for more than ten years, often in the same clinic for a long period of time. This consistency provided patients with not only continuity of care, but also allowed them to benefit from having providers who had an extensive understanding of their patient panel along with a wealth of experience in managing a provider line.

The OIG clinicians were initially concerned that a mid-level provider was covering the TTA in an institution that was fully staffed with physicians. However, the chief executive officer (CEO) and the chief medical executive (CME) assured the OIG clinicians that the majority of patients at FSP were low-to-no-risk medical patients. Only about 180 patients at FSP were actually characterized as medically high-risk individuals. In addition, the chief physician and surgeon (CP&S) was available to assist the mid-level provider for any possible complex medical issues that might have arisen in the TTA. Despite those assurances, the OIG clinicians' concerns about the mid-level provider covering the TTA remained, particularly since the institution was fully staffed with physicians.

Case Review Conclusion

Overall, FSP has continued the pattern from Cycle 4 in demonstrating an excellent ability to provide patients with access to care. The institution was fully staffed with no provider backlog in any of the clinics. Appointments were timely in all aspects except for a few delays in provider follow-ups from specialty services. Therefore, this indicator was rated *proficient*.

Compliance Testing Results

The institution performed in the *proficient* range in the *Access to Care* indicator, with a compliance score of 91.3 percent. The following tests received scores in the proficient range:

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

- All 25 sampled patients who were discharged from a community hospital received a timely provider follow-up appointment on their return to FSP (MIT 1.007).

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

- OIG inspectors sampled 35 health care services request forms submitted by patients across all facility clinics. Nursing staff reviewed 34 of these forms (97 percent) on the same day they were received. For one form tested, no evidence was found that the nurse reviewed it on the same day it was received (MIT 1.003).

- For 34 of the 35 patients sampled who submitted health care services request forms (97 percent), nursing staff completed a face-to-face encounter with the patient within one business day of reviewing the form. For one patient, the nurse conducted the visit seven days late (MIT 1.004).

- OIG inspectors reviewed recent appointments for 25 patients with chronic care conditions and found that 22 (88 percent) received timely routine appointments. Appointments for three patients were 4, 10, and 25 days late (MIT 1.001).

The following two tests received *adequate* scores:

- OIG inspectors sampled 27 patients who received a high priority or routine specialty service; 23 of them (85 percent) received a timely follow-up appointment with a provider. Three patients received follow-up appointments from one to seven days late; one final patient received his follow-up appointment 69 days late (MIT 1.008).

- For 18 health care service requests sampled in which nursing staff referred the patient for a provider appointment, 15 of the patients (83 percent) received timely appointments. For three patients, the follow-up appointment occurred 3, 8, and 14 days late (MIT 1.005).

- Provider visits occurred timely for 17 of the 24 applicable sampled patients who either transferred into FSP with a pre-existing chronic care provider appointment or upon arrival, received a new provider referral from the FSP screening nurse (71 percent). For four patients, the appointments occurred between one and six days late; two patients' appointments occurred 12 and 20 days late; and for one final patient, no evidence was found that he ever received an appointment (MIT 1.002).

2 — *DIAGNOSTIC SERVICES*

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(70.0%)
Overall Rating:
Adequate

This indicator addresses several types of diagnostic services. Specifically, it addresses whether radiology and laboratory services were timely provided to patients, whether the primary care provider timely reviewed the results, and whether the results were communicated to the 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.

In this indicator, the OIG's case review and compliance review processes yielded different results, with case review giving an *adequate* rating and compliance tests resulting in an *inadequate* score. As noted below, the primary reason for compliance review's rating of *inadequate* was that pathology reports were not reviewed by providers and were not communicated to patients in a timely manner. However, the provider progress notes indicated that the pathology findings and recommendations had been reviewed. Similarly, while providers did not directly sign off on pathology reports, the reports were reviewed, with their results ultimately communicated to patients. After considering both case review and compliance review results, as well as the totality and significance of the issues identified, the final overall rating was found to be *adequate.*

Case Review Results

The OIG clinicians reviewed 123 diagnostic-related events and found 11 deficiencies with no significant deficiencies identified. Of those 11 deficiencies, 9 were related to health information management and 2 were related to diagnostic test orders that were not completed within the ordered time frame. Within health information management, test reports that were never retrieved or reviewed were considered just as severe a problem as tests that were not completed as ordered.

Since Cycle 4, the institution has displayed tremendous improvement in performing diagnostic services in a timely manner and completing provider-ordered diagnostic tests. All laboratory tests ordered by FSP providers were processed and completed by the laboratory. All diagnostic scans ordered by FSP providers were completed. One error and one delay were observed in the following two cases:

- In case 22, only one error occurred in the collection and processing of laboratory tests when the laboratory prematurely completed the tests before the requested date.
- In case 24, the provider ordered several laboratory tests, but the laboratory delayed collecting them for nearly two months.

Within the *Health Information Management* indicator, only nine minor deficiencies were identified. In general, FSP consistently reviewed diagnostic and laboratory results in a timely manner.

- In case 22, a delay in reviewing a diagnostic report was identified.
- In case 7, providers never did review a laboratory report.
- In cases 18, 19, 20, and two times in case 16, the institution scanned diagnostic and laboratory reports that lacked either a provider signature or initials.
- In cases 21 and 23, OIG clinicians found diagnostic reports that lacked a date for the provider signature or initials.

Clinical Onsite Inspection

Although the occurrence was very low, the OIG clinicians inquired about the few laboratory tests that were not completed at FSP. The laboratory supervisor explained that a few of these tests had not been completed because no orders had been received.

At the onsite inspection, the OIG clinicians discovered that approximately half the providers at FSP had no access to the RIS-PACS, which meant various diagnostic reports were unavailable to them. However, the specialty service scheduler, the X-ray technician, and the CME all had direct access to RIS-PACS and could obtain all of these reports. When a provider without access to the RIS-PACS needed to review a diagnostic report, that provider had to contact the specialty service scheduler, the X-ray technician, or the CME to request access or assistance with using RIS-PACS. While this process offered a temporary solution, all providers need their own access to RIS-PACS to deliver efficient patient care.

During the onsite interviews with providers, the OIG clinicians discovered a few of them had been able to access the diagnostic reports directly through the new electronic health record system (EHRS). These providers reported, however, this access was not reliable, as they often could not consistently view these reports on the EHRS.

This issue of accessing diagnostic reports was discussed with the CME, who appeared to be unaware that half the providers could not view diagnostic reports through either the RIS-PACS or the EHRS.

Case Review Conclusion

FSP displayed tremendous improvement in all aspects of diagnostic services since Cycle 4. FSP had no difficulty collecting and processing diagnostic laboratory tests within the time frames requested by providers. All diagnostic scans were performed and completed in a timely manner. However, not all FSP providers had access to the RIS-PACS. Overall, this indicator was rated *adequate.*

Compliance Testing Results

The institution received a compliance score of 70.0 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

- For all of the ten ordered radiology services sampled, the service was timely performed (MIT 2.001). For six of the ten radiology services sampled (60 percent), the provider initialed and dated the report within the required time frame per CCHCS policy; two reports were reviewed 3 and 18 days late; and for two other reports, no evidence was found they were reviewed (MIT 2.002). Providers timely communicated radiology report results to patients for six of the ten services sampled (60 percent); two results were communicated 3 and 20 days late; and for two final services, no evidence was found that the reports were communicated to the patient (MIT 2.003).

Laboratory Services

- For seven of the ten ordered laboratory services sampled (70 percent), the service was timely performed; three of the services were performed one, six, and seven days late (MIT 2.004). For all ten of the laboratory services sampled, the provider timely reviewed the corresponding diagnostic report result (MIT 2.005). Providers timely communicated laboratory report results to patients for eight of the ten services sampled (80 percent); one result was communicated 37 days late; and for one final service, no evidence was found that the report was communicated to the patient (MIT 2.006).

Pathology Services

- FSP timely received the final pathology reports for all ten ordered services sampled by the OIG inspectors (MIT 2.007). Providers at FSP properly evidenced their review of pathology results for only three of the ten sampled services (30 percent); three reports were reviewed two, five, and seven days late; four other reports evidenced no provider review (MIT 2.008). Finally, providers timely communicated the final pathology results for only three of the ten services sampled (30 percent). Three results were communicated to patients two, five, and seven days late; for four other samples, no evidence was found that the provider communicated results to patients (MIT 2.009).

3 — *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 30 urgent/emergent events and found 23 deficiencies with various aspects of emergency care, 6 of which were significant.

CPR Response

During the review period, no patients required CPR intervention.

Provider Performance

Provider performance in emergency services was sufficient and is discussed in *the Quality of Provider Performance* indicator.

Nursing Performance

The FSP TTA nurses generally provided prompt emergency care. There were no delays in the emergency medical response times by the first medical responders. Nursing assessments and interventions were mostly appropriate to the patient's needs. Nursing staff contacted medical providers timely for orders and to communicate patients' clinical findings, with the exception of the following case:

- In case 17, the TTA nurse did not report significantly elevated blood pressure readings to the medical provider for the patient with chest pain, did not assess the patient's response to pain medication, and did not re-assess an alarmingly high blood-pressure reading. This resulted in the patient remaining in the TTA for several hours before he was transferred to a higher level of care for chest pain management.

At times, the first medical responder did not complete nursing assessments such as pain assessment, vital signs assessment, or blood sugar assessment upon arriving at the scene of medical emergencies. The following case is an example of incomplete nursing assessment by the first medical responder:

- In case 20, the first medical responder did not assess the blood sugar level and vital signs prior to administering a glucose tablet for a patient with a possible low blood sugar level who was drowsy, perspiring, and non-verbal. The patient was taken to the TTA where the TTA nurse checked his vital signs and blood sugar level.

The OIG clinicians noted a pattern of minor deficiencies in which the first medical responder (being the first nurse or provider to assess the patient) did not check the patient's vital signs, as identified in the cases below:

- In case 3, the patient had left-sided weakness and came to the TTA with elevated blood pressure. The first medical responder did not check the patient's vital signs.

- In case 5, the patient jumped from Tier 5 in the housing unit, sustaining multiple injuries. The first medical responder did not check the patient's vital signs.

- In cases 13 and 17, the patients reported chest pain. The first medical responder did not check vital signs for either of these patients.

For the above cases, the first medical responders did not assess the patients' vital signs at the scene of the emergency medical response, but instead deferred these important assessments to the TTA nurse upon the patient's arrival in the TTA.

Nursing Documentation

The institution used the EHRS for clinical documentation. The nursing documentation was generally complete and reflective of nursing assessments and interventions. The OIG clinicians identified a few issues with nursing documentation, but these did not appear to affect patient care. The documentation errors were limited to capturing incorrect times for various nursing interventions or patient dispositions.

Emergency Medical Response Review Committee

The Emergency Medical Response Review Committee (EMRRC) reviewed the emergency medical response cases, identified deficiencies, and provided staff training as necessary for many cases.

- In case 17, the EMRRC did not identify the nursing care and documentation deficiencies regarding the patient who remained in the TTA for several hours prior to being transferred to a higher level of care.

Clinician Onsite Inspection

FSP has one TTA, while FWF has its own separate TTA. The FSP TTA is staffed with two RNs for each shift. One TTA nurse and the building nurses respond to medical emergencies that occur in the patient's housing area or in the institution's yard. A medical provider is assigned to the TTA, and is available in person during the second watch and by telephone on the first and third watches.

Many patients walk to the TTA to seek care or report a medical emergency to the TTA staff. Patients must climb several stair steps inside the main medical building to reach the TTA. If gurney transportation is needed, custody officers physically lift the gurney—with the patient in it—up and over the stair steps to enter the TTA. In the cases reviewed, some patients who should have been transported by wheelchair or gurney instead walked to the TTA themselves. Nursing documentation showed that a patient with chest pain walked to the TTA and informed the staff about his emergent medical condition. In another case, the patient with left-sided weakness and possible stroke requested to walk to the TTA from the telemedicine clinic, which is located a short distance from the TTA and separated by the stairs. In a third case, the patient walked from the housing unit to the TTA and reported breathing difficulties. All three patients were transferred to a higher level of care from the TTA.

FSP management informed the OIG clinicians that CCHCS policy does not require the first medical responder to perform vital signs' checks. Therefore, at FSP, the first medical responders only provided basic life support and transferred the patient to the TTA.

Case Review Conclusion

FSP performed sufficiently with regard to *Emergency Services*, and the indicator rating was thus *adequate*.

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4 — *HEALTH INFORMATION MANAGEMENT*

Case Review Rating:
Adequate
Compliance Score:
Proficient
(95.2%)
Overall Rating:
Proficient

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 health record; whether the various medical records (internal and external, e.g., hospital and specialty reports and progress notes) are obtained and scanned timely into the patient's electronic health record; whether records routed to clinicians include legible signatures or stamps; and whether hospital discharge reports include key elements and are timely reviewed by providers.

For this indicator, the case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance review resulting in a *proficient* score. The OIG's internal review process considered the factors that led to both results and ultimately rated this indicator *proficient.* FSP utilized a true electronic health record, which largely mitigated previous electronic unit health record (eUHR) scanning concerns, and the case review testing found no significant deficiencies in the delivery of care related to health information management. As a result, the OIG inspection team concluded that the compliance review's *proficient* score was a more appropriate overall rating for this indicator.

FSP converted to the new electronic health record system (EHRS) in October 2015. As a result, all testing was completed in the EHRS.

Case Review Results

The OIG clinicians reviewed 860 events and found 30 deficiencies related to health information management. No significant deficiencies were identified.

Inter-Departmental Transmission

FSP performed adequately with the inter-departmental transmission of information except when the nurse failed to communicate vital information to the providers in the following case:

- In case 17, the patient had chest pain with severely elevated blood pressure while being monitored in the TTA. However, the TTA nurse failed for several hours to transmit this vital information to the on-call physician. When the on-call physician was finally notified by the TTA nurse, the patient had to be emergently transferred to an outside hospital. This delay increased the patient's risk of developing a cardiac event or a stroke.

The OIG inspectors found no missing documents across various areas of the institution. FSP continued to perform well in ensuring that provider notes, nursing notes, onsite and offsite specialty

notes, and medication administration records were available to the medical staff. FSP displayed great improvement over Cycle 4 in retrieving and scanning hospital records in a timely manner, which ensured that records were available for providers during subsequent patient follow-ups from the outside hospital.

Since Cycle 4, FSP has greatly improved in completing provider orders across various health care departments of the institution via its implementation of the EHRS. In Cycle 4, the OIG clinicians had noted the presence of a low rate of laboratory, radiology, and medication orders not being properly transmitted to various departments. Consequently, these orders were not being appropriately processed and completed. This issue was thought to be due to the older paper-based medical system (eUHR), which has now been replaced by the EHRS.

Dictated Progress Notes

During Cycle 4, most providers had used handwritten progress notes before the transition from the older eUHR to the new EHRS. Handwritten progress notes were no longer an issue once FSP transitioned to the EHRS because providers were required to type or dictate their notes directly into this new system.

Hospital Records

FSP displayed great improvement with retrieving emergency department (ED) physician reports and hospital discharge summaries compared to Cycle 4. The OIG clinicians reviewed 28 ED and community hospital events. All ED reports and discharge summaries were retrieved and scanned in a timely manner. Similarly, all hospital records were retrieved and scanned into the EHRS. All hospital and ED records were appropriately reviewed, dated, and signed by a provider except for one time in case 13 and two times in case 17.

Specialty Services

FSP continued to perform well in the health information management area for specialty services with only minor issues discovered. These findings are discussed in detail in the *Specialty Services* indicator.

Diagnostic Reports

The OIG clinicians also found significant improvement in the health information management area for diagnostic services since Cycle 4 with only minor issues discovered. These findings are also discussed in the *Diagnostic Services* indicator.

Urgent/Emergent Records

FSP on-call providers performed well with documenting their telephone encounters. No missing on-call provider documentation was identified. FSP nurses had appropriate documentation in most

cases with OIG clinicians identifying only some minor documentation deficiencies. These findings are discussed under nursing documentation in the *Quality of Nursing Performance* indicator.

Scanning Performance

The OIG clinicians identified mistakes in the document scanning process as mislabeled, misfiled (filed in the wrong chart), or incorrectly dated. Erroneously scanned documents can create delays or lapses in care by hindering providers' ability to locate relevant clinical information. FSP performed well in this area. Some issues were noted concerning mislabeled and improperly dated documents in two cases, and in one case, a document was scanned into the EHRS twice. Only a few cases were identified in which FSP had issues with duplication in scanning offsite specialty reports. These findings are further discussed in the *Specialty Services* indicator.

Legibility

Provider documentation was generally good except for that of one provider. The *Quality of Provider Performance* indicator offers further details.

Illegible progress notes, signatures, or initials were not an issue in Cycle 5, because FSP providers were either typing their progress notes, or were using voice recognition software to transcribe their notes, directly into the EHRS. Furthermore, provider signatures were no longer an issue since providers were now electronically signing their progress notes directly in the EHRS.

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 processed, especially how clinical care occurred outside the clinics and after-hours. The OIG clinicians found that the process used by FSP to transmit information among the various care teams was appropriate and consistent. While a standard huddle report agenda was used, the OIG clinicians observed that important after-hours clinical information was distributed and discussed by the care teams during the morning huddles. Patient medications that required renewal were also reviewed and discussed at these huddles. Patients who required follow-up appointments but were out of policy compliance were discussed by the care teams as well.

Case Review Conclusion

FSP showed significant improvement in this indicator since Cycle 4. FSP displayed good performance in retrieving hospital and outside ED reports, and in onsite and offsite specialty notes. The retrieval of provider and nurse progress notes was no longer an issue in Cycle 5 due to the implementation of the new EHRS. Furthermore, the process used by FSP to transmit clinical information among departments and various medical staff was appropriate. Therefore, case review clinicians rated this indicator *adequate*.

Compliance Testing Results

The institution scored 95.2 percent in this indicator, scoring in the *proficient* range in all five applicable tests:

- The institution timely scanned all ten applicable sampled non-dictated health care documents reviewed by the OIG inspectors (MIT 4.001).
- Health information management staff at FSP scored 100 percent in the labeling and filing of documents scanned into patients' electronic health records (MIT 4.006).
- OIG inspectors reviewed hospital discharge reports for 25 patients who were admitted to a community hospital and then returned to FSP. Providers reviewed the hospital discharge reports within three calendar days of discharge for 24 of 25 sampled patients (96 percent). A provider reviewed one report two days late (MIT 4.007).
- Institution staff timely scanned 18 of 20 specialty service consultant reports sampled into the patients' electronic health care records (90 percent). Two other specialty reports were scanned 12 and 49 days late (MIT 4.003).
- FSP timely scanned community hospital discharge reports or treatment records into patients' electronic medical records for 18 of the 20 sampled reports (90 percent). Two reports were scanned one day late (MIT 4.004).

5 — *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 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
(61.6%)

Overall Rating:
Inadequate

This indicator is evaluated entirely by compliance testing. There is no case review portion.

Compliance Testing Results

The institution received an *inadequate* compliance score of 61.6 percent in the *Health Care Environment* indicator, with the following areas showing room for improvement:

- The non-clinic bulk medical supply storage areas did not meet the supply management process and support needs of the medical health care program, earning a score of zero in this test. Multiple medical supplies were found stored beyond the manufacturers' guidelines, and other medical supplies were stored directly on the floor (*Figure 1*) (MIT 5.106).

Figure 1: Medical supplies stored on the floor

- Only 2 of the 13 clinic locations (15 percent) met compliance requirements for essential core medical equipment and supplies. The remaining 11 clinics were missing one or more functional pieces of properly calibrated core equipment or other medical supplies necessary to conduct a comprehensive exam. The missing items included a nebulization unit, hemoccult cards and developer, an examination table with disposable paper, glucometer and strips, lubricating jelly, an oto-ophthalmoscope, tips for an otoscope, and gloves. In addition, a nebulization unit, a weight scale, and automated external defibrillators (AEDs) had expired calibration stickers (MIT 5.108).

- OIG inspectors observed clinician encounters with patients in 13 clinics. Clinicians followed good hand hygiene practices in only four clinics (31 percent). At nine clinic locations, clinicians failed to wash their hands before or after patient contact, or before applying gloves (MIT 5.104).

- Only 6 of 13 clinic exam rooms observed (46 percent) had appropriate space, configuration, supplies, and equipment to allow clinicians to perform a proper clinical examination. Seven clinics had one or more of the following deficiencies identified: patients could not fully recline on the examination table due to physical obstructions (*Figure 2*); examination tables had torn vinyl covers; an examination room did not have enough space to perform patient examinations (*Figure 3*); a patient encounter was conducted in close proximity to other patients waiting to receive their medications; and another patient encounter was conducted in a hallway, which did not offer auditory or visual privacy (MIT 5.110).

Figure 2: Obstructed examination table, preventing patients from fully reclining

- OIG inspectors examined emergency medical response bags (EMRBs) to determine if they were inspected daily and inventoried monthly, and whether they contained all essential items. EMRBs were compliant in seven of the ten clinical locations where they were stored (70 percent). One or more of the following deficiencies were observed at three locations: one location's EMRB log was missing two entries evidencing staff had verified the bag's compartments were sealed and intact; at a second location, the EMRB oxygen tank was not fully charged; and at a third location, the crash cart was missing minimum par levels of medical supplies at the time of inspection (MIT 5.111).

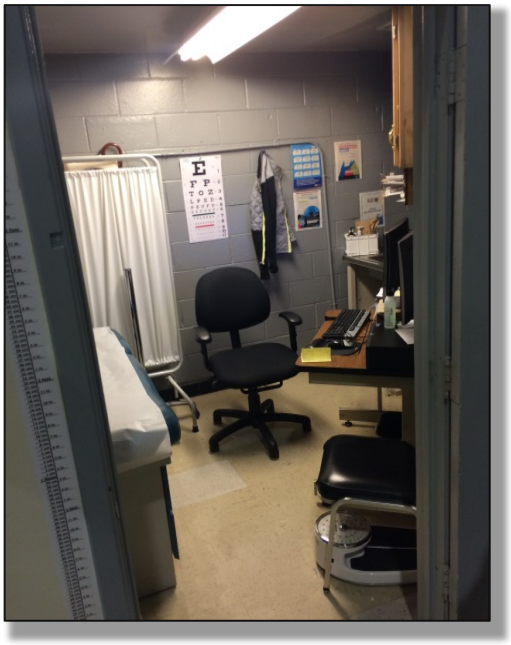

Figure 3: Examination room without adequate space (measured 82 sq. ft.)

Two tests received scores in the *adequate* range:

- Clinic common areas at 10 of the 13 clinics (77 percent) had environments conducive to providing medical services; three clinics, however, did lack wheelchair mobility access and did not provide auditory privacy during checks of vital signs (MIT 5.109).

- Inspectors found that 11 of the 13 clinics (85 percent) followed adequate medical supply storage and management protocols. In two clinics, however, personal items belonging to

staff were found stored in the same area as medical supplies, and germicidal disposable cloths were stored together with medical supplies (MIT 5.107).

One test received a score of *proficient*:

- Health care staff at all 13 clinics followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste (MIT 5.105).

Non-Scored Results

- The OIG gathered information to determine whether 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. When OIG inspectors interviewed health care managers, they did not have any concerns concerning the facility's infrastructure or its effect on the staff's ability to provide adequate health care. The institution had several ongoing projects underway for building new clinic space at the minimum-support facility and several buildings, as well as renovation projects in clinics and medication-line locations at several buildings. These projects were started in the fall of 2015 and are projected to be completed by the spring of 2018 (MIT 5.999).

6 — *INTER- AND INTRA-SYSTEM TRANSFERS*

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(72.6%)
Overall Rating:
Adequate

This indicator focuses on the management of patients' medical needs and continuity of patient care during the inter- and intra-system transfer process. The patients reviewed for this indicator include those received from, as well as those transferring out to, other CDCR institutions. 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 patients who transfer out of the institution, 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.

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 testing resulting in an *inadequate* score. The compliance review found that nursing staff did not always document specialty services appointments that were pending upon patient transfer to a receiving institution on the health care transfer information form. However, the case review found that these specialty appointments had occurred, and the quality of care was not affected. After considering both case review and compliance testing results, the OIG inspection team determined the final overall rating to be *adequate*.

Case Review Results

The OIG clinicians reviewed 34 inter- and intra-system transfer events, including information from both the sending and receiving institutions. These included 27 hospitalization and outside emergency room events, each of which resulted in a transfer back to the institution. There were seven deficiencies, one of which was significant.

Transfers In

The transfer process was sufficient for patients transferring into FSP. The OIG clinicians reviewed four patients who were transferred to FSP from other CDCR institutions and found only two minor deficiencies, with no significant issues. The receiving and release (R&R) nurses reviewed the health care transfer information, appropriately assessed the patients, ordered medications, and followed up with referrals. Patients received their prescribed medications timely. The quality of nursing care provided during the transfer process was excellent.

- In case 27, the nurse provided a thorough nursing assessment of the diabetic patient, ordered his prescribed medications, and made referrals to specialists for pending appointments including chronic care, podiatry, optometry, and laboratory requests for diagnostic bloodwork. Consequently, the patient received timely nursing, dental, mental health, medical, and specialty care.

Transfers Out

The OIG clinicians reviewed three patients who transferred out of FSP to other CDCR institutions. One minor deficiency was identified in the cases reviewed, with no significant issues found. The FSP nurses performed face-to-face evaluations and completed the documentation prior to patient transfers in most of the cases. The transfer form is used to communicate pertinent patient information with the receiving institution.

- In case 68, excellent care was provided to a patient who had demonstrated depression and suicide ideation, although the R&R nurse did not complete the health care transfer information form. The FSP nurses monitored the patient every 15 minutes for suicide watch until the medical provider cleared the patient for transfer. The receiving institution admitted the patient to an alternative housing unit for close monitoring. Consequently, the patient received adequate care, and his health was not compromised as a result of the missing transfer form.

In the other cases reviewed, the FSP nurses did send the health care transfer information, medications, and health care equipment with the patient to the receiving institution. The FSP nurses performed satisfactorily in the transfer-out process.

Hospitalizations

Patients returning from hospitalizations are some of the highest-risk encounters due to two factors. First, these patients are generally hospitalized for a severe illness or injury. Second, potential lapses in patient care can occur during any transfer. The OIG clinicians reviewed 27 events in which patients returned to FSP from an offsite hospital or emergency department. Only one significant deficiency was identified, which is discussed below:

- In case 21, the provider failed to thoroughly review the patient's hospital discharge report. As a result, an eight-day delay occurred before the provider ordered the patient's surgical staples removed. This was a significant delay in the patient's medical treatment.

Clinician Onsite Inspection

The R&R clinics in both FSP and FWF offered adequate space for private patient screening and physical assessment.

FSP had sufficient staffing coverage with one RN on the second watch, and a second RN was available with flexibility to cover the busy periods. The R&R nurse was very knowledgeable about

the transfer process. The nurses documented pertinent patient information in the EHRS and used a transfer checklist for enhanced inter-institutional communication. The transfer checklist did not become a part of the patient's medical record. The documentation issues encountered in Cycle 4 were not evident in this cycle.

The R&R nurses counted all of the medications in the patient's belongings for inventory purposes. The nurses ordered any missing doses to make up a 30-day supply. FSP nurses explained that this strategy is a cost-savings initiative that reduces the need to routinely order extra medications.

Similarly, the nurses procured any missing durable medical equipment items for the patient, which ensured continuity of patient care and patient safety, and prevented unnecessary delays in obtaining the necessary equipment.

FSP honored the patient's pre-existing schedule for medical appointments. The R&R nurses contacted the receiving institution via telephone to collect any missing information necessary to process the request for service (RFS), and then printed, scanned, and e-mailed the RFS and patient summary documents to the utilization management nurse. The nurses referred high-risk patients to a medical provider within 7 days, and chronic-care patients within 30 days per current CCHCS policy.

Case Review Conclusion

FSP performed appropriately with regard to the *Inter- and Intra-System Transfers* indicator. Therefore, the OIG clinicians rated this indicator *adequate*.

Compliance Testing Results

The institution obtained an *inadequate* score of 72.6 percent in this indicator, with the following area showing room for improvement:

- Among nine sampled patients who transferred out of FSP to other CDCR institutions, only one (11 percent) had his scheduled specialty service appointment properly included on the health care transfer form. For six patients, the specialty service was not identified on the transfer form; for two other patients, no transfer form was found in the electronic medical record (MIT 6.004).

Two tests received scores in the *adequate* range:

- Of the 25 sampled patients who transferred into FSP, 13 had an existing medication order that required nursing staff to issue or administer medications on arrival. Of those 13 applicable patients, 10 received their medications timely (77 percent). Three patients did not receive their ordered medication without interruption (MIT 6.003).

- The OIG inspected the transfer packages of eight patients who were transferring out of FSP and FWF facilities to determine whether the packages included required medications and

support documentation. Inspectors also verified that the patients had their rescue medications on their person. Inspectors concluded that six of the eight transfer packages were compliant (75 percent). However, two of the sampled patients did not have their transfer checklist, medication reconciliation, and medication administration record included in the transfer packets (MIT 6.101).

Two tests received scores of *proficient*:

- For all 25 sampled patients who transferred into FSP from another CDCR facility, nursing staff completed an Initial Health Screening form (CDCR Form 7277) on the same day the patient arrived (MIT 6.001).

- FSP nursing staff timely completed the assessment and disposition sections of the screening form for all 25 patients who transferred into the institution (MIT 6.002).

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7 — *PHARMACY AND MEDICATION MANAGEMENT*

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(71.9%)
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. Because effective medication management is affected by numerous entities across various departments, this assessment considers internal review and approval processes, pharmacy, nursing, health information systems, custody processes, and actions taken by the prescriber, staff, and patient.

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 *inadequate*. While case review focused on medication administration, the compliance testing was a more robust assessment of medication administration and pharmacy protocols combined with onsite observations of medication and pharmacy operations. As a result, the compliance score of *inadequate* was deemed appropriate for the overall indicator rating.

Case Review Results

The OIG clinicians reviewed 20 events related to medications and found three significant deficiencies.

Medication Continuity

Patients generally received their medications as prescribed and scheduled. There were no deficiency patterns in this area. The OIG clinicians identified the following significant deficiencies in medication delivery:

- In case 13, the patient with asthma did not receive his Dulera (asthma medication) refill. The nurse documented that the medication was not available. The medication delivery occurred the following month. Patients with asthma need access to their inhalers to quickly manage respiratory distress symptoms.
- In case 15, the patient with chronic obstructive pulmonary disease (COPD, a lung disease) requested ranitidine (heartburn medication) and ipratropium inhaler (COPD medication) refills, but did not receive them. He requested refills a second time during the month, but he did not receive the medications until the following month. Although patients can purchase

heartburn medication in the institution's canteen, patients with lung diseases such as COPD and asthma need access to their prescribed inhalers to manage their respiratory distress symptoms.

The FSP nurses re-ordered medications for patients who transferred to FSP from other CDCR institutions and for patients who transferred back to FSP after a hospital discharge. This resulted in timely medication continuity for patients who had transferred or had returned to FSP. Additionally, to ensure medication continuity the FSP nurses routinely communicated the list of medications to the receiving institutions for those patients who transferred out of FSP.

Medication Administration

FSP nurses administered medications timely and accurately. No deficiency patterns in medication administration were noted. However, nurses did not always document the correct medication administration times in medical emergency situations. This is further discussed in the *Quality of Nursing Performance* indicator. The TTA nurses reviewed the medical charts for patients who had returned to FSP after a hospital discharge and re-ordered their medications after contacting a medical provider. The R&R nurses counted all of the medications in the patients' belongings and re-ordered missing doses. These practices ensured medication delivery to the patients upon transfer from other CDCR institutions and upon return to FSP from a hospital.

Physician Orders

Medical providers generally ordered medications necessary to treat patients' conditions. However, in one case, a crucial medication was not ordered:

- In case 55, the nurse assessed the patient with complaints of possible urine infection and contacted the medical provider. The provider ordered a laboratory urine test and reviewed the positive-for-infection findings, but failed to initiate antibiotics in a timely manner. The patient received the antibiotics two weeks later.

Pharmacy Errors

Case review did not encounter any pharmacy errors.

Clinician Onsite Inspection

FSP has one main pharmacy, while the FWF has a satellite pharmacy. The OIG clinicians interviewed various pharmacy, medical, and nursing staff during the onsite inspection. The pharmacist-in-charge (PIC) was knowledgeable about the workflow (the specific, orderly combination of processes that resulted in a work product) for the pharmacists and their use of the EHRS. Pharmacists reviewed the new orders in the EHRS and completed the workflow, which created a tracking number for each medication. Pharmacists then used this tracking number, which only they could access, to answer any questions about medication delivery. Pharmacists relied on the tracking number as evidence of having completed their workflow.

Case Review Conclusion

There were no problematic trends with regard to *Pharmacy and Medication Management*, and the indicator was thus rated *adequate*.

Compliance Testing Results

The institution received a compliance score of 71.9 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 *adequate* average score of 76.9 percent. The following tests showed room for improvement:

- The institution timely administered or delivered new medication orders to only 13 of the 24 patients sampled (54 percent). Ten patients received their medications one or 2 days late; and one patient received his medication 38 days late (MIT 7.002).

- FSP timely provided hospital discharge medications to only 9 of the 14 applicable sampled patients (64 percent). Five patients' medical administration records had unexplained missing dosages (MIT 7.003).

One test received an *adequate* score:

- Of the 25 sampled patients at FSP who had transferred from one housing unit to another, 19 (76 percent) received their prescribed direct observation therapy (DOT) medications without interruption. Six patients did not receive their medications at the proper dosing interval after their transfers (MIT 7.005).

Two tests received scores in the *proficient* range:

- Patients at FSP timely received ordered chronic care medications for 18 of the 20 applicable samples the OIG inspectors reviewed (90 percent). For two patients, no evidence was found they had received their ordered keep-on-person (KOP) medications (MIT 7.001).

- Nursing staff administered medications without interruption to one patient who was en route from one institution to another and had a temporary layover at FSP, resulting in a score of 100 percent (MIT 7.006).

Observed Medication Practices and Storage Controls

In this sub-indicator, the institution received a score of 65.7 percent, which was *inadequate*. Three tests showed room for improvement:

- The institution employed adequate security controls over narcotic medications in only two of the eight applicable clinic and medication line locations where narcotics were stored (25 percent). At six clinics, the following deficiencies were identified: the narcotics logbook lacked evidence on multiple dates that a controlled substance inventory was performed by two licensed nursing staff; the medication nurse waited until the end of the administration pass to update the narcotics logbook; and when OIG inspectors interviewed supervising nurses, they did not mention having reported narcotics discrepancies to the chief nurse executive (CNE) (MIT 7.101).

- Inspectors observed the medication preparation and administration processes at eight applicable medication line locations. Nursing staff were compliant regarding proper hand hygiene and contamination control protocols at only three locations (38 percent). At five locations, not all nursing staff washed or sanitized their hands when required, such as before putting on gloves or re-gloving (MIT 7.104).

- FSP properly stored non-narcotic medications not requiring refrigeration in 8 of the 12 applicable clinic and medication line storage locations (67 percent). In four locations, one or more of the following deficiencies were observed: external and internal medications were not properly separated when stored; medication rooms and cabinets were unlocked when not in active use; and multi-use medication was not labeled with the date it was opened (MIT 7.102).

One test received an *adequate* score:

- Nursing staff followed appropriate administrative controls and protocols when distributing medications to patients at six of the eight applicable medication preparation and administrative locations (75 percent). At one location, the medication nurse did always ensure whether the patient swallowed DOT medications. At another location, the medication nurse did not appropriately administer medication by crushing and floating it as ordered by the provider (MIT 7.106).

Two tests received scores in the *proficient* range:

- The institution properly stored non-narcotic refrigerated medications at nine of the ten clinics and medication line storage locations (90 percent). One location, however, did not have a clearly designated area for medications pending a return to pharmacy (MIT 7.103).

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

Pharmacy Protocols

In this sub-indicator, the institution received an average score of 74.4 percent, composed of scores received at the institution's main and satellite pharmacies. The following tests showed room for improvement, with scores falling in the *inadequate* range:

- The institution's PIC properly accounted for narcotic medications stored in FSP's main and satellite pharmacies. OIG inspectors also reviewed monthly inventories of controlled substances in the institution's clinical and medication line storage locations. However, OIG inspectors found several Medication Area Inspection Checklist forms (CDCR Form 7477) that were missing names, signatures, and dates for staff and the PIC who were responsible for completing each inventory record. As a result, the institution scored zero in this test (MIT 7.110).

- OIG inspectors examined 25 medication error follow-up reports and 5 monthly medication error statistical reports generated by the institution's PIC. Of the PIC's 25 reports, 18 were timely or correctly processed (72 percent). Seven sampled reports contained deficiencies (MIT 7.111):

    - Among the 25 medication error follow-up reports provided for OIG inspectors' review, the institution's PIC completed 7 reports 62 days late.

Three tests received scores in the *proficient* range:

- FSP's main and satellite pharmacies followed general security, organization, and cleanliness management protocols. In addition, the institution properly stored non-refrigerated and refrigerated medications (MIT 7.107, 7.108, 7.109).

Non-Scored Tests

- In addition to the OIG's testing of reported medication errors, inspectors follow up on any significant medication errors that were found during the compliance testing to determine whether the errors were properly identified and reported. The OIG provides those results for information purposes only. At FSP, the OIG did not find any applicable medication errors (MIT 7.998).

- OIG inspectors interviewed patients housed in isolation units to determine whether they had immediate access to their prescribed KOP rescue inhalers and nitroglycerin medications. Five of six applicable patients interviewed indicated they had access to their rescue medications. One patient indicated he did not have access to his rescue inhaler. The OIG

inspectors notified the CEO, who ensured that the patient received a new rescue inhaler to replace the one stored with his personal property (MIT 7.999).

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8 — *PRENATAL AND POST-DELIVERY SERVICES*

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

Although FSP has a female population at FWF, none of its patients were applicable to be sampled for this indicator.

Case Review Rating:
Not Applicable
Compliance Score:
Not Applicable

Overall Rating:
Not Applicable

9 — *PREVENTIVE SERVICES*

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

Case Review Rating:
Not Applicable
Compliance Score:
Proficient
(89.2%)
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 this indicator, with a compliance score of 89.2 percent, and several areas received high scores:

- FSP scored 100 percent for the timely administration of ordered TB medications to patients. All eight patients sampled by the OIG received their medication timely (MIT 9.001).
- The OIG found that all 30 sampled patients received annual TB screenings (MIT 9.003).
- All six sampled patients received or refused a mammogram within CCHCS policy guidelines (MIT 9.006).
- FSP timely offered Pap smear screenings to all 14 sampled patients aged 21 through 65 (MIT 9.007).
- Of 25 sampled patients, 24 either received or refused an influenza vaccination during the most recent influenza season (96 percent). OIG inspectors, however, could find no evidence that the influenza vaccination was offered to, or refused by, one sampled patient (MIT 9.004).

Two areas received scores in the *adequate* range:

- The OIG found that 21 of 25 patients sampled (84 percent) were either offered a colorectal cancer screening in the past year or had a normal colonoscopy within the past ten years. However, four patients' electronic medical records did not contain evidence that they were offered a colorectal cancer screening within the previous 12 months or had a normal colonoscopy within the past ten years (MIT 9.005).

- The OIG reviewed FSP's monitoring of eight sampled patients who received TB medications and noted that the institution was in compliance for six of them (75 percent). For two patients, monitoring did not occur at weekly intervals as required by CCHCS policy (MIT 9.002).

One area showed room for improvement:

- The OIG tested whether FSP offered required influenza, pneumonia, and hepatitis vaccinations to patients who suffered from a chronic condition; 10 of the 17 applicable patients sampled (59 percent) received them. For five patients, no evidence was found that they received or were offered all applicable immunizations (MIT 9.008).

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10 — *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 does not have a score under the OIG compliance testing component. Case reviews include face-to-face encounters and indirect activities performed by nursing staff on behalf of the patient. Review of nursing performance includes all nursing services performed onsite, such as outpatient, inpatient, urgent/emergent, patient transfers, care coordination, and medication management. The key focus areas for evaluation of 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, and accurate, thorough, and legible documentation. Although nursing services provided in specialized medical housing units are reported in the *Specialized Medical Housing* indicator, and those provided in the TTA or related to emergency medical responses are reported in the *Emergency Services* indicator, all areas of nursing services are summarized in this *Quality of Nursing Performance* indicator.

Case Review Results

The OIG clinicians reviewed 301 nursing encounters, of which 218 were outpatient nursing encounters. Most outpatient nursing encounters were for sick call requests, blood pressure monitoring, wound care, and pre-procedural instructions. In all, there were 50 deficiencies related to nursing care performance, of which 17 were significant. Three of these significant deficiencies occurred during emergency medical responses and are addressed in the *Emergency Services* indicator. Fourteen significant deficiencies occurred in outpatient care. Examples of proficient nursing care at FSP were also identified in several cases.

Nursing Assessment

Most FSP nurses performed appropriate nursing assessments based on the patient's presenting condition in the cases reviewed. However, various minor deficiencies were identified for some cases in which nurses did not provide timely assessment for sick call requests, measure vital signs, or assess a patient's response to pain medication. In other cases, the patient did receive proficient care with timely and comprehensive nursing assessment. Examples of proficient nursing assessment were found in the following two cases:

- In case 41, the TTA nurse reviewed the sick call request on the weekend and promptly assessed the patient on the same day for cold and influenza symptoms. The patient received immediate nursing and medical care, medications, laboratory orders for diagnostic blood work, a chest X-ray, and follow-up assessment. The nurse did not delay the patient's care by requesting a next-business-day nursing appointment.

- In case 62, the nurse assessed the patient for complaints of a current skin infection and a previous ear infection. The patient had refused assessment two weeks prior for the ear infection. The nurse contacted the provider, and the patient received medications, orders for diagnostic blood work, follow-up nursing assessment visits, and medical treatment for the ear infection as a result of this diligent nursing assessment.

Nursing Intervention

The FSP nurses generally initiated appropriate and timely interventions. Deficiencies in this phase of the nursing process included failure to report the patient's high blood pressure to the provider. This is further described in the *Emergency Services* indicator.

Nursing Documentation

FSP has been using the EHRS since this electronic documentation system was first launched at CDCR in October 2015. The OIG clinicians identified only minor documentation deficiencies by nurses in the TTA, R&R, and outpatient clinics. The following provide examples:

- In cases 17 and 19, nurses documented incorrect medication administration times for managing the patient with chest pain prior to transfer to a higher level of care.

- In case 53, nurses had conflicting documentation concerning the time that events occurred in the TTA, such as the times when the medical provider was contacted, when the ambulance arrived, or when medication was administered.

The OIG clinicians discussed these documentation issues with nursing managers during the onsite visit. Nurse managers explained that because nurses are busy carrying out patient care during urgent/emergent events, nursing documentation usually occurs after the event. The EHRS records the time of the nurse's documentation entry rather than the actual time the nursing care was provided.

Sick Call

The OIG clinicians reviewed 124 nursing sick call encounters. Nursing performance for sick call was appropriate to the patient's needs. Nurses reviewed most sick call requests timely and assessed patients at face-to-face clinic visits the same day or the next business day. A pattern of significant deficiencies was noted when nurses did not assess patients on the same day for potentially urgent problems or the next business day for non-urgent problems. Examples include the following cases:

- In case 5, the nurse did not assess the patient who reported anal leakage and requested a bowel cleaning solution, instead referring him for a routine provider appointment. The patient was assessed by a medical provider three weeks later and received a bowel cleaning solution one month later. The nurse should have assessed the patient on the next business day and consulted with the provider about ordering the cleaning solution.

- In case 17, the nurse did not assess the patient with abdominal pain, nausea, exhaustion, dehydration, liquid stools, and reddish streaks in the stool on the same day the patient's request for assessment was reviewed. The nurse instead assessed the patient on the following day. However, the patient's condition warranted same-day assessment to rule out the presence of blood in the stool.

- In case 47, the nurse did not assess the patient on the same day as the assessment request was reviewed concerning a possible hand fracture after a recent fall. The clinic nurse assessed the patient on the following day, contacted the medical provider, received orders for an X-ray, and referred the patient to the medical provider for further evaluation. The patient was placed in a cast for his hand fracture while awaiting assessment by the orthopedic surgeon.

Nurses generally recognized potentially urgent conditions, performed adequate assessments, and made appropriate interventions and dispositions. However, a deficiency pattern was identified for incomplete nursing assessment and referrals for follow-up appointments such as in the following case:

- In case 16, the nurse did not assess the patient who requested to have his eyes checked. The nurse ordered a 14-day nursing appointment instead. At the face-to-face assessment nine days later, the nurse did not assess the patient's visual acuity and did not refer the patient to the medical provider for ordering an optometry visit. The patient submitted another sick call request one month later for the same issue, was assessed by the nurse, and received an appointment to see the medical provider. The optometry appointment occurred three months later. This caused an unnecessary delay in the patient's care and access to optometry services for eye examination.

During the case review, the OIG clinicians noticed a pattern of face-to-face nursing assessments taking place in 14 days when patients did not specify their symptoms. For example, as noted in case 16, the patient requested to have his eyes checked, and in case 13, the patient reported having medical problems. In these cases, the nurse requested a 14-day nursing visit without assessing these patients. During the onsite visit, the nurse managers stated that all sick call requests that do not describe specific symptoms or health problems are scheduled for nursing assessment in 14 days. However, the CCHCS policy recognizes same day or next business day face-to-face nursing assessment for urgent and non-emergent medical conditions, respectively, and does not allow for a 14-day sick call nursing assessment.

Care Management

CCHCS defines the care manager as a primary care RN who develops, implements, and evaluates patient care services and care plans for an assigned patient panel. The RN care manager (RN CM) provides direction for the assigned patient panel and collaborates with the patient to develop and maintain the treatment plan. The RN CM refers to and coordinates with other services as

appropriate. The RN CM also reviews data, arranges patient care activities, provides education, and directs the members of the health care team to ensure that patients receive necessary health care services in a safe, timely, and appropriate manner.

Case review for FSP did not reveal any documentation for care management activities. During the onsite visit at FWF, a nursing supervisor stated that each month, the nurses reviewed the patients' dates of birth for that month. Female patients received a breast examination, orders for Pap tests (screening procedure for cervical cancer), and any other health maintenance activities when a nurse-patient encounter occurred during that month.

FSP had started using care managers during the seven months prior to the OIG onsite visit. Nurses described the steps in care management as tracking the patients' laboratory diagnostic values, setting goals with patients, providing patient education, and engaging in patient empowerment strategies.

Urgent/Emergent Events

The OIG clinicians reviewed 30 urgent/emergent events and found 23 deficiencies, 6 of which were considered significant. Although the first medical responder nurses showed a pattern of incomplete patient assessment, FSP nurses performed appropriately during most emergency medical responses. These findings are described in the *Emergency Services* indicator.

Post-Hospital Returns

FSP performed well for patients who returned from the hospital. No nursing deficiencies were found.

Transfers

FSP performed adequately for inmates transferring into and out of the institution. The R&R nurses reviewed the health care information and assessed newly arrived patients, ordered their medications and follow-up referrals, and provided any missing durable medical equipment to the patients. During the onsite visit, the R&R nurse explained that the nurses count the medications in the patient's belongings upon arrival to FSP and order the missing doses to make up a 30-day supply. The R&R nurses ensured that health care information, medications, and medical equipment transferred with the patients when they left the institution in most of the cases. These findings are described in the *Inter- and Intra-System Transfers* indicator.

Out-to-Medical Return and Specialty Care

The OIG clinicians reviewed 26 nursing encounters when patients returned from their specialty appointments. No deficiencies were identified.

Medication Administration

OIG clinicians reviewed 20 medication-specific events. No deficiencies were identified for medication administration. There were three significant deficiencies in KOP medication delivery with no minor deficiencies. These are discussed in the *Pharmacy and Medication Management* indicator.

Clinician Onsite Inspection

The OIG clinicians visited various clinic areas and interviewed the staff in each area. The medical and nursing staff in Building 3 at FSP utilized unique patient-empowerment techniques such as a weight-loss competition between patients and staff, comprehensive patient-education sessions, and a team approach with patient-involved medical care. The staff noticed patients were more invested in their own medical care as a result of these creative programs.

The OIG clinicians attended the outpatient morning huddles on two days of the onsite visit. FSP staff discussed and shared pertinent patient information at both huddles. The TTA nurses participated in the huddles at FWF via teleconference calls. At FWF, the institution used a unique staff participation model that involved rotating who served as the huddle coordinator. All participating staff in the huddle thus took turns serving as the coordinator.

FSP provides several onsite specialty services. There were no backlogs at the time of inspection. FSP was planning to start onsite sleep study services in September 2017. The nurses anticipated that this in-house service would result in cost savings.

The CNE worked closely with staff to improve the nursing care at FSP through incorporating evidence-based practice, new epidemiological findings, new concepts in patient care, and new care treatment findings. For example, the nurse instructor utilized a unique strategy to reinforce the classroom teaching for each area of nursing orientation. The nurses completed classroom learning modules followed by the clinical orientation for each area. After nurses completed the emergency nursing care classes, they were scheduled to work in the TTA. When the TTA cycle was completed, then nurses underwent sick call nursing classes, followed by clinical orientation in the triage nurse line. Nurses came to understand the roles and responsibilities for various nursing positions. Additionally, diabetic patients at FSP may elect to participate in insulin self-administration during medication pass, but must undergo education sessions provided by the medication nurses.

Case Review Conclusion

The OIG clinicians noted hard-working staff who voiced a sense of satisfaction derived from working at FSP. Nursing staff attested to having good access to and communication with the medical providers, supervisors, and managers. The CNE and managers were involved with their staff and invested in the nursing services at FSP. The OIG clinicians found that patients generally received good nursing care at this institution and, accordingly, rated the *Quality of Nursing Performance* indicator *adequate.*

11 — *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 225 medical provider encounters and identified 67 deficiencies related to provider performance at FSP. Of the 67 deficiencies identified, 27 were considered significant. As a whole, FSP provider performance was rated *adequate.*

Assessment and Decision-Making

FSP providers generally made sound assessments and accurate diagnoses. Poor assessment and misdiagnosis, although infrequent, did occur. Errors with provider assessment were identified in cases 3, 4, 9, 21, 24, and in the following cases:

- In case 17, the provider failed to perform a rectal exam to check for active bleeding after the patient reported having "red brown stool." The patient was also hypertensive (an abnormally high blood pressure) and tachycardic (an abnormally fast heart rate). However, the provider failed to address the patient's abnormal vital signs and also erroneously documented that the patient's heart rate was regular on exam, despite the tachycardia found on the monitor. This case is also discussed as an adverse event in the *Medical Inspection Results* section of this report.

- In case 20, the provider failed to address the patient's hypotension (abnormally low blood pressure) on multiple provider encounters. The provider failed to recheck the patient's blood pressure before discharging him back to general housing. Furthermore, the provider failed to review the patient's medication list to determine if his hypotension was medication-related. If the provider had performed the above actions, the patient's subsequent hospitalization may have been avoided.

Despite the above examples of deficiencies, good diagnostic skills were demonstrated by the majority of the providers at FSP, as documented in the following cases:

- In case 22, the providers expertly managed the patient's complex medical condition, which included metastatic colon cancer that required different offsite chemotherapy treatments. The providers also coordinated the multiple follow-ups the patient had with the offsite

specialists and ensured that laboratory tests the specialists requested were completed. Finally, the providers appropriately transferred the patient to the offsite emergency department when he developed acute lower abdominal pain.

- In case 25, the patient had a cataract (an opaque area in the normally clear lens of the eye) that required surgical extraction. The providers and the onsite optometrist (an eye doctor) closely monitored the patient after this surgical extraction. Due to the diligence of both the provider and the onsite optometrist, the offsite ophthalmologist (an eye surgeon) was quickly notified when the patient developed a complication from his surgery. The patient was then urgently scheduled for a second offsite surgical procedure.

Provider-Ordered Follow-up Intervals

FSP providers continued to struggle with ordering appropriate follow-ups, as was observed during Cycle 4, especially follow-ups related to chronic care. Inappropriate provider follow-ups were found twice in case 17, and in the cases listed below:

- In case 4, the provider inappropriately ordered a three-month follow-up without seeing the patient for his end-stage liver disease. Prior to this order, the patient had not had a chronic care follow-up appointment for five months.

- In case 9, the provider inappropriately ordered 90-day follow-ups on multiple occasions despite the patient having uncontrolled diabetes that required close monitoring.

- In case 12, the patient had uncontrolled diabetes that was steadily worsening. However, the provider never changed the patient's six-month follow-up to a shorter interval follow-up.

- In case 20, the patient was evaluated by his provider who requested a six-month follow-up. This was an inappropriate follow-up interval as the patient required closer monitoring, given his history of a recent myocardial infarction (a heart attack).

Provider Continuity

FSP has continued to provide excellent provider continuity as patients were consistently assigned to the same provider at each follow-up, thereby demonstrating its commitment to the primary care model observed in Cycle 4.

Review of Records

FSP providers generally performed adequate chart review, which greatly aided in their diagnostic assessments and their ability to provide comprehensive medical care for their patients. However, there was insufficient depth of review of medical records by providers in case 21 and in the following cases:

- In case 17, the provider failed to both perform a thorough chart review and document the patient's vital signs on the progress note. As a result, the provider failed to address the patient's significantly elevated blood pressure and inappropriately discharged him back to housing with follow-up as needed.

- In case 20, the provider failed to do a thorough review of the EHRS and, therefore, did not realize the patient had already received an echocardiogram (an ultrasound of the heart) at an outside hospital. Due to this oversight, the patient unnecessarily completed another echocardiogram.

- Also in case 20, the provider failed to do a thorough review of the EHRS and, therefore, did not realize the patient's urine culture had tested positive for a bacterial infection. Due to this significant provider oversight, the patient's urinary tract infection was not treated for more than two months.

Emergency Care

FSP emergency care provider performance was adequate. While assessments and decision-making at times were inaccurate and questionable, TTA providers were able to make appropriate decisions and sent patients to higher levels of care when indicated. This is further discussed in the *Emergency Services* indicator. Of the 30 TTA encounters reviewed, 3 significant errors occurred in the same case, and all 3 errors were attributable to different providers. The following examples are provided for quality improvement purposes only:

- In case 17, the patient was seen in the TTA for a worsening swelling and redness of his forearm. The patient's blood pressure was significantly elevated and he had tachycardia (an abnormally fast heart rate). Therefore, transferring the patient to an outside hospital via regular state car with no cardiac monitoring was inappropriate and unsafe.

- Also in case 17, the patient, who had a history of coronary artery disease and diabetes, came to the TTA for chest pain and "on and off numbness" in his hand and face. The provider failed to address the patient's tachycardia (an abnormally fast heart rate) and also failed to perform a neurological exam to fully evaluate the patient's symptoms.

- Also in case 17, the provider inappropriately ordered a pain medication despite having documented that the patient had episodes of blood in his stools. This particular medication could have worsened a potential gastrointestinal bleed. Furthermore, the provider failed to return to the institution while on call to perform a rectal exam to rule out an active gastrointestinal bleed. This case is also discussed as an adverse event in the *Medical Inspection Results* section of this report.

Chronic Care

Chronic care performance was sufficient although the overall quality of care had declined compared to Cycle 4. FSP providers demonstrated fair skill and knowledge in caring for patients even though a few providers faced challenges with patients who had complicated medical issues. FSP is classified as a medically intermediate institution, although the majority of its patients were of low medical complexity with roughly only six percent of the patient population designated as high risk. FSP had no HIV management and only a low number of patients who required anticoagulation and hepatitis C treatment. Patients were adequately monitored and assessed, with providers intervening when appropriate. While there was a limited number of events available to review for diabetic management, FSP providers generally demonstrated adequate diabetic management skills. However, FSP providers continued to struggle with ordering appropriate chronic care follow-ups as was previously discussed in Cycle 4. The following cases are presented for quality improvement purposes only:

- In case 4, the patient had a history of end-stage liver disease and received an upper endoscopy (a procedure that examines the esophagus) that revealed esophageal varices (enlarged veins in the esophagus). Despite this history, the provider failed to start the patient on a beta-blocker (a type of medication) to reduce his risk of bleeding.

- Also in case 4, the pathology report revealed the patient had gastritis (stomach inflammation) from a bacterial infection. However, the same provider never started the patient on the triple antibiotic therapy required to treat this type of infection.

- In case 9, the provider failed to order finger stick glucose checks for a patient with uncontrolled diabetes. These fingers stick checks would have allowed the provider to monitor the patient's glucose levels more closely and, therefore, to determine whether the patient required insulin sooner than when it was offered by the provider.

- Also in case 9, while the patient was compliant with his oral diabetic medications, his diabetes remained uncontrolled. Because the patient had refused insulin, the provider should have maximized the dose of the patient's oral diabetic medication, but failed to do so.

At FSP, anticoagulation management was typically managed by the providers, who also monitored the patient's anticoagulation levels. The OIG did not identify any significant deficiencies with anticoagulation management by FSP providers.

The following cases demonstrated good provider chronic care:

- In case 8, the patient was on anticoagulation medication due to an artificial heart valve replacement. The patient's INR (International Normalized Ratio, a laboratory test used to monitor anticoagulant levels) was closely followed by his provider. During the review period, the patient's INR remained well-controlled. The patient also had a history of cardiac arrhythmia (an abnormal rhythm) that required a biventricular pacemaker (a device used to

maintain a set heart rate). He was closely monitored and had his pacemaker frequently checked at the offsite hospital during this review period.

- In case 15, the provider expertly managed and coordinated the patient's care once the provider discovered the patient had a liver mass. The provider appropriately scheduled multiple diagnostic scans and procedures, which also included a computerized tomography (CT)-scan guided liver biopsy. In addition, the provider ensured the patient was seen by the oncologist (a cancer doctor), the infectious disease specialist, and diligently coordinated the multiple follow-ups the patient had with his offsite specialists. Finally, the patient's radiofrequency ablation procedure (a procedure used to destroy cancer cells) and his laboratory tests were completed in a timely manner.

Specialty Services

FSP providers appropriately referred patients for specialty services. The *Specialty Services* indicator offers further details.

Documentation Quality

Provider documentation quality was generally good with the exception of one provider, who was responsible for the majority of poor documentation found during this review. Poor documentation by this provider was observed repeatedly in cases 1 and 21. This particular provider demonstrated a pattern of misspelled words and incorrect word choices while dictating progress notes into the EHRS via Dragon Dictation software. Due to these grammatical errors, the clinical meaning of this provider's writing could often be misinterpreted. Therefore, the OIG recommends that this provider proofread and self-correct his progress notes since misinterpretation could lead to additional provider errors. However, most progress notes written by other providers were extensive and included all relevant aspects of preventive care. These providers provided thorough documentation to support their medical decisions including off-hours TTA visits.

Because all progress notes were typed, or transcribed via voice recognition software, directly into the new EHRS, legibility was not an issue with any provider progress notes. The OIG clinicians did find evidence of "cloned" progress notes in which outdated medical information was inappropriately carried forward to a current progress note. Such cloned notes were identified once in case 24, three times in case 20, and four times in case 22. The use of "cloned" progress notes also hindered the ability of providers to update their progress notes.

Health Information Management

FSP providers generally documented patient encounters on the same day. The *Health Information Management* indicator provides further details about this area.

Clinician Onsite Inspection

The OIG clinicians found that morning huddles at FSP were staggered and scheduled at different times in the morning. This was discussed further in the *Health Information Management* indicator.

Overall, FSP providers performed sufficiently, both as individual providers and as a group with the institution committed to a primary care model. All providers were satisfied with their primary care teams and reported that they found working as part of a team to be both personally and professionally rewarding.

Onsite interviews revealed that providers found the nursing staff easy to work with despite an absence of nursing continuity for the providers at the women's yard. At the women's yard, patients saw a different nurse each time.

Onsite interviews with the provider staff also revealed good job satisfaction and good provider morale. Providers felt the CP&S was an excellent and approachable leader, who provided them with the support they needed to give quality care to the patients at FSP. The CP&S was a highly experienced leader who has been at FSP for more than 19 years. Many of the providers indicated that the stability of the provider group was due in large part to the CP&S.

At the time of the onsite inspection, the CME position had recently been filled. However, the providers felt that the new CME had so far been a supportive and approachable leader as well. The medical leadership was further strengthened by the highly experienced CEO, who worked diligently alongside the medical leadership to further support FSP's providers.

Interviews with the CP&S and the CME confirmed that job performance was closely monitored. This monitoring was achieved in various ways, including annual clinical appraisals, CCHCS dashboard evaluations, and review of specialty referrals. All provider annual performance appraisals were completed and kept current. At the time of the onsite interviews, there were no provider vacancies that needed to be filled, and no problems with provider retention were identified.

Case Review Conclusion

As a whole, FSP providers performed adequately with a patient population that had a small number of high-risk patients. Providers usually made sound and accurate diagnoses with appropriate treatment plans for these less complex and generally healthier patients.

While documentation quality was at times poor, one provider was responsible for the majority of the poor documentation quality found during case review. Medical records were appropriately reviewed by the providers. Emergency care was also satisfactory. FSP providers appropriately referred patients for specialty services with the overall quality of documentation being good.

Although chronic care remained sufficient for this cycle, the quality of care will need to be closely monitored by the medical leadership at FSP. In addition, patient follow-up appointments typically were not ordered within the appropriate time intervals, especially those for chronic care. This concern has not improved from Cycle 4. Despite these issues with chronic care, FSP providers have continued to provide appropriate care to their patients. Therefore, the OIG clinicians rated this indicator *adequate*.

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12 — *RECEPTION CENTER ARRIVALS*

Case Review Rating:
Not Applicable
Compliance Score:
Not Applicable

Overall Rating:
Not Applicable

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.

As FSP did not have a reception center during the period of the OIG's inspection, this indicator did not apply.

13 — *SPECIALIZED MEDICAL HOUSING*

This indicator addresses whether the institution follows appropriate policies and procedures when admitting 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.

FSP did not have a CTC or OHU during the period of the OIG's inspection; therefore, this indicator did not apply.

Case Review Rating:
Not Applicable
Compliance Score:
Not Applicable

Overall Rating:
Not Applicable

14 — *SPECIALTY SERVICES*

Case Review Rating:
Adequate
Compliance Score:
Adequate
(81.9%)
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 patient is updated on the plan of care.

Case Review Results

The OIG clinicians reviewed 123 events related to *Specialty Services*, the majority of which were specialty consultations and procedures. The OIG clinicians found 24 deficiencies in this category with 5 significant deficiencies.

Access to Specialty Services

Case reviews found that specialty services at FSP were generally provided within proper time frames for both routine and urgent services. Nearly all of the initial referrals to specialty services were completed within an acceptable time frame except in case 15. However, a few delays in specialist follow-ups were found. Case reviews found delays in specialty provider follow-ups one time each in cases 4, 15, 17, 25, and two times in case 13. These delays did not have a significant impact on patient care.

Nursing Performance

Nursing performance was sufficient for patients returning from offsite specialty appointments. FSP nurses performed general assessments of patients, reviewed specialty recommendations, and obtained pertinent orders to provide appropriate patient care. The OIG clinicians reviewed 26 specialty events that included patient returns from offsite specialty appointments as well as follow-ups with telemedicine specialists. No deficiencies were identified.

Provider Performance

FSP providers continued to perform well when submitting referrals for patient specialty services. With the exception of one case, almost all referrals were submitted with the proper priority. The OIG clinicians only found one case in which the quality of provider performance was substandard. This case involved an onsite specialty service for a patient, as outlined in the following example:

- In case 23, the dermatologist (a skin doctor) recommended a skin biopsy to evaluate the patient for a possible skin malignancy. However, this biopsy was delayed for more than three months. One contributing factor for this delay was that the provider who was to perform the procedure actually failed to schedule the biopsy.

The OIG clinicians also identified an inappropriate overutilization of a specialty service as noted in the following example:

- In case 20, the provider failed to do a thorough review of the EHRS and, therefore, did not realize the patient had already received an echocardiogram (an ultrasound of the heart) at an outside hospital. Due to this oversight, the patient unnecessarily had a repeat echocardiogram.

Health Information Management

The OIG clinicians found no problems with the processing of specialty reports. Specialty reports and onsite specialty notes were timely retrieved and scanned into the EHRS, allowing FSP providers to have this relevant information available to them.

The majority of specialty reports were appropriately reviewed by FSP providers. Specialty reports that were not signed off or initialed by a provider were identified one time each in cases 16, 20, 21, 24, and two times each in cases 15 and 17.

- Once in case 25 and twice in case 23, specialty reports were erroneously scanned into the EHRS.

- In case 25, a specialty report was misfiled under an incorrect encounter date. Once in case 21 and twice in case 15, the specialty reports had an illegible provider signature or lacked a date.

Utilization Management

The OIG clinicians identified no significant problems with FSP's utilization management program.

Clinician Onsite Inspection

The OIG clinicians discovered that the offsite specialty nurse and the specialty service scheduler had an excellent process for retrieving and forwarding offsite specialty and hospital reports to FSP providers. The offsite specialty nurse and the specialty service scheduler diligently obtained all specialty and hospital reports. They would then notify each provider via the message center in the EHRS that these reports had arrived. The actual paper reports would be placed in the providers' folders, which were located in the specialty service office. After the providers had reviewed and signed the reports, the specialty service scheduler would deliver the signed reports to medical records for scanning into the EHRS. This process not only ensured that providers were immediately notified when reports had arrived, but also allowed the specialty service staff to track which reports

had been reviewed by the providers, thereby mitigating any lapses in medical information transmission between offsite locations and FSP.

Finally, the specialty service scheduler made hard copies of the reports that were sent to medical records for scanning. These reports were then stored in the specialty service office for up to three months in case the original reports were lost to scan.

Case Review Conclusion

FSP has continued to perform well in the management of specialty services since Cycle 4. Specialty services for routine and urgent services were still provided within adequate time frames. FSP providers reported having good access to onsite and offsite specialty reports due to the diligence of the offsite specialty nurse and the specialty service scheduler. In addition, FSP providers did a good job of identifying and referring patients appropriately when needed. Therefore, this indicator was rated *adequate*.

Compliance Testing Results

The institution received an *adequate* compliance score of 81.9 percent in this indicator. Three areas received scores in the *proficient* range:

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

- FSP received a score of 100 percent when the OIG tested the timeliness of the institution's denial of providers' specialty services requests for 20 patients (MIT 14.006).

- For 19 sampled patients who had a specialty service denied by FSP's health care management, 18 patients (95 percent) received timely notification of the denied service, including the provider meeting with the patient within 30 days to discuss alternative treatment strategies. One patient's visit was three days late (MIT 14.007).

Two areas received scores in the *adequate* range:

- Providers timely received and reviewed the specialists' reports for 10 of the 12 sampled patients who received a high priority specialty service (83 percent). For two patients, the provider reviewed the specialists' reports six and seven days late (MIT 14.002).

- Of the 15 sampled patients, 12 of them (80 percent) received or refused their high priority specialty services within 14 calendar days of the provider's order. Two patients received their specialty services one and three days late. One patient's service was received 14 days late (MIT 14.001).

Two areas received scores in the *inadequate* range:

- When patients are approved or scheduled for specialty services at one institution and then transfer to another, policy requires that the receiving institution reschedule and provide the patient's appointment within the required time frame. Only 11 of the 20 applicable patients sampled who transferred to FSP with an approved specialty service (55 percent) received it within the required time frame. The remaining nine sampled patients did not timely receive their previously approved services. Three patients received their approved services 3, 17, and 27 days late; two other patients received their services 60 and 63 days late; one patient was offered his service 86 days late; one patient received his service 104 days late; and for two final patients, no evidence was found that they ever received their ordered specialty service (MIT 14.005).

- Providers timely received and reviewed the routine priority specialists' reports for only 9 of the 15 patients sampled (60 percent). For four patients, providers reviewed the reports from 3 to 11 days late, and a fifth report was reviewed 90 days late. For the final patient, an exact compliance date could not be determined, but the report was reviewed 71 days after the original visit, far exceeding CCHCS policy guidelines (MIT 14.004).

15 — *ADMINISTRATIVE OPERATIONS (SECONDARY)*

Case Review Rating:
Not Applicable
Compliance Score:
Adequate
(80.9%)
Overall Rating:
Adequate

This indicator focuses on the institution's administrative health care oversight functions. The OIG evaluates whether the institution promptly processes patient medical appeals and addresses all appealed issues. Inspectors also verify that the institution follows reporting requirements for adverse/sentinel events and inmate deaths. The OIG verifies that the Emergency Medical Response Review Committee (EMRRC) performs required reviews and that staff perform required emergency response drills. Inspectors also assess whether the Quality Management Committee (QMC) meets regularly and adequately addresses program performance. For those institutions with licensed facilities, inspectors also verify that required committee meetings are held. In addition, 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. The *Administrative Operations* indicator is a secondary indicator, and, therefore, was not relied on for the overall score for the institution.

Compliance Testing Results

The institution received an *adequate* compliance score 80.9 percent in the *Administrative Operations* indicator. The following tests received scores in the *proficient* range:

- The institution promptly processed all patient medical appeals in each of the most recent 12 months (MIT 15.001).
- FSP's Quality Management Committee (QMC) met monthly, evaluated program performance, and took action when management identified areas for improvement opportunities (MIT 15.003).
- FSP took adequate steps to ensure the accuracy of its Dashboard data reporting (MIT 15.004).
- The OIG inspected incident package documentation for 12 emergency medical responses reviewed by FSP's EMRRC during the prior six-month period; all 12 sampled packages complied with policy (MIT 15.005).
- Based on a sample of ten second-level medical appeals, the institution's responses addressed all of the patients' appealed issues (MIT 15.102).

- Medical staff promptly submitted the initial Inmate Death Report (CDCR Form 7229A/7229B) to CCHCS's Death Review Unit for all three applicable deaths that occurred at FSP in the prior 12-month period (MIT 15.103).

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

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

- Seven of eight FSP providers had a proper clinical performance appraisal completed by their supervisor (88 percent). One provider's most recently completed second probation appraisal did not include the required primary care provider 360-degree evaluation (MIT 15.106).

The following tests received scores in the *inadequate* range:

- Seven of the ten nurses sampled (70 percent) were current on their clinical competency validations. Three nurses did not receive a clinical competency validation within the required time frame (MIT 15.105).

- Inspectors reviewed drill packages for three emergency medical response drills conducted in the prior quarter. Only two of the three drill packages were properly completed (67 percent). For one drill package, staff did not complete the recommendations for areas needing improvement or additional training (MIT 15.101).

- Required emergency response certifications were current for all providers and nurses. However, the tracking system the institution used for nurses showed two nursing staff had expired CPR certifications. The institution was able to provide evidence at a later time for the two nursing staff thus identified. OIG is taking an exemption for custody staff and managers. As a result, the institution received a score of 50 percent for this test area (MIT 15.108).

- The OIG inspected records from March 2017 for five nurses to determine whether their nursing supervisors had properly completed monthly performance reviews and found only two that were compliant. Inspectors identified the following deficiencies for the other three nurses' monthly nursing reviews (MIT 15.104):

    - The supervisor did not complete the required number of reviews.

    - Nursing review findings were not discussed on a monthly basis.

- The PIC serving both FSP and FWF did not have a system to ensure that providers' DEA licenses were not expiring. The PIC relies on the credentialing unit, as do both the CME and the CP&S's office technician (MIT 15.110).

Non-Scored Results

- The OIG gathered non-scored data regarding the completion of death review reports by CCHCS's Death Review Committee (DRC). Three deaths occurred at FSP during the OIG's review period, two unexpected (Level 1) deaths and one expected (Level 2) death. The DRC was required to complete its death review summary report within 60 days from the date of death for the Level 1 death and within 30 days from the dates of death for the Level 2 deaths; the reports should then be submitted to the institution's CEO within seven calendar days thereafter. However, for one of the Level 1 deaths, the DRC completed its report 105 days late (165 days after death) and submitted it to FSP's CEO 272 days late; for the Level 2 death, the DRC completed its report 35 days late (65 days after death) and submitted it to the CEO 48 days late. For the other Level 1 death that occurred, no final report had been issued at the time of the OIG inspection (MIT 15.998).

RECOMMENDATIONS

- The OIG recommends that FSP develop monitoring strategies to ensure first medical responders check and document patients' vital signs when responding to medical emergencies.

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 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 electronic health record, the Master Registry (maintained by CCHCS), as well as a random sample of patient records analyzed and abstracted by trained personnel. Data obtained from the CCHCS Master Registry and Diabetic Registry was not independently validated by the OIG and is presumed to be accurate. For some measures, the OIG used the entire population rather than statistically random samples. While the OIG is not a certified HEDIS compliance auditor, the OIG uses similar methods to ensure that measures are comparable to those published by other organizations.

Comparison of Population-Based Metrics

For Folsom State Prison, 11 HEDIS measures were selected are listed in the following *FSP 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 Metrics Comparison

Comprehensive Diabetes Care

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

When compared statewide, FSP outperformed Medi-Cal in all five diabetic measures selected and outperformed Kaiser Permanente (both North and South regions) in four of five diabetic measures selected. Kaiser, South, scored slightly higher than FSP for eye exams. When compared nationally, FSP outperformed Medicaid, commercial plans, and Medicare in all five measures and outperformed the United States Department of Veterans Affairs (VA) in three of the four applicable measures. FSP scored lower than did the VA in diabetic eye exams.

Immunizations

Comparative data for immunizations was only fully available for the VA and partially available for Kaiser, commercial plans, Medicaid, and Medicare. With respect to administering influenza vaccinations to younger adults, FSP scored lower than all statewide and national plans, except for Medicaid. The 55 percent refusal rate negatively affected the institution's score. When administering influenza vaccinations to older adults, FSP performed slightly lower than did the VA and Medicare. With regard to administering pneumococcal vaccines to older adults, FSP scored higher than did Medicare and slightly lower than did the VA.

Cancer Screening

With respect to colorectal cancer screenings, FSP outperformed all state and national healthcare providers. For cervical cancer screenings, FSP matched the VA and outperformed the remaining State and national entities. Relative to breast cancer screenings, FSP was outperformed by all state and national health care plans, with the exception of Medicaid. However, one-third of the sampled patients refused the breast cancer screening, which negatively affected the institution's score.

Summary

FSP's population-based metrics performance reflected a well-functioning chronic care program, compared to other state and national health care entities. The institution may improve its scores for immunizations for young adults and breast cancer screening by educating patients about the benefits of these preventive services.

FSP Results Compared to State and National HEDIS Scores

Clinical Measures	California				National			
	FSP Cycle 5 Results[1]	HEDIS Medi-Cal 2015[2]	HEDIS Kaiser (No. CA) 2016[3]	HEDIS Kaiser (So. CA) 2016[3]	HEDIS Medicaid 2016[4]	HEDIS Com-mercial 2016[4]	HEDIS Medicare 2016[4]	VA Average 2015[5]
Comprehensive Diabetes Care								
HbA1c Testing (Monitoring)	**100%**	86%	94%	94%	86%	90%	93%	98%
Poor HbA1c Control (>9.0%)[6, 7]	**12%**	39%	20%	23%	45%	34%	27%	19%
HbA1c Control (<8.0%)[6]	**79%**	49%	70%	63%	46%	55%	63%	-
Blood Pressure Control (<140/90)	**89%**	63%	83%	83%	59%	60%	62%	74%
Eye Exams	**78%**	53%	68%	81%	53%	54%	69%	89%
Immunizations								
Influenza Shots - Adults (18–64)	**45%**	-	56%	57%	39%	48%	-	55%
Influenza Shots - Adults (65+)	**71%**	-	-	-	-	-	72%	76%
Immunizations: Pneumococcal	**87%**	-	-	-	-	-	71%	93%
Cancer Screening								
Breast Cancer Screening (50–74)[8]	**67%**	-	87%	87%	59%	73%	73%	86%
Cervical Cancer Screening[9]	**93%**	59%	91%	85%	56%	75%	-	93%
Colorectal Cancer Screening	**93%**	-	79%	82%	-	63%	67%	82%

1. Unless otherwise stated, data was collected in May 2017 by reviewing medical records from a sample of FSP's population of applicable 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 measure only, the data was obtained from the *VHA Facility Quality and Safety Report - Fiscal Year 2012 Data*.

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

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

8. The Kaiser HEDIS data age range is 52–74 and the VA is 50–69.

9. The HEDIS data age range is 21–64, while the CCHCS policy age range is 21–65. No patients aged 65 were randomly sampled.

APPENDIX A — COMPLIANCE TEST RESULTS

Folsom State Prison **Range of Summary Scores:** 61.61% – 95.20%	
Indicator	**Compliance Score (Yes %)**
1–***Access to Care***	91.29%
2–***Diagnostic Services***	70.00%
3–***Emergency Services***	Not Applicable
4–***Health Information Management (Medical Records)***	95.20%
5–***Health Care Environment***	61.61%
6–***Inter- and Intra-System Transfers***	72.61%
7–***Pharmacy and Medication Management***	71.91%
8–***Prenatal and Post-Delivery Services***	Not Applicable
9–***Preventive Services***	89.23%
10–***Quality of Nursing Performance***	Not Applicable
11–***Quality of Provider Performance***	Not Applicable
12–***Reception Center Arrivals***	Not Applicable
13–***Specialized Medical Housing (OHU, CTC, SNF, Hospice)***	Not Applicable
14–***Specialty Services***	81.87%
15–***Administrative Operations***	80.94%

Reference Number	1 – *Access to Care*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
1.001	Chronic care follow-up appointments: Was the patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter?	22	3	25	88.00%	0
1.002	For endorsed patients received from another CDCR institution: If the nurse referred the patient to a provider during the initial health screening, was the patient seen within the required time frame?	17	7	24	70.83%	1
1.003	Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received?	34	1	35	97.14%	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?	34	1	35	97.14%	0
1.005	Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter?	15	3	18	83.33%	17
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?	4	0	4	100%	31
1.007	Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame?	25	0	25	100%	0
1.008	Specialty service follow-up appointments: Do specialty service primary care physician follow-up visits occur within required time frames?	23	4	27	85.19%	3
1.101	Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms?	6	0	6	100%	0
Overall percentage:					**91.29%**	

Reference Number	2 – *Diagnostic Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
2.001	Radiology: Was the radiology service provided within the time frame specified in the provider's order?	10	0	10	100%	0
2.002	Radiology: Did the primary care provider review and initial the diagnostic report within specified time frames?	6	4	10	60.00%	0
2.003	Radiology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	6	4	10	60.00%	0
2.004	Laboratory: Was the laboratory service provided within the time frame specified in the provider's order?	7	3	10	70.00%	0
2.005	Laboratory: Did the primary care provider review and initial the diagnostic report within specified time frames?	10	0	10	100%	0
2.006	Laboratory: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	8	2	10	80.00%	0
2.007	Pathology: Did the institution receive the final diagnostic report within the required time frames?	10	0	10	100%	0
2.008	Pathology: Did the primary care provider review and initial the diagnostic report within specified time frames?	3	7	10	30.00%	0
2.009	Pathology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	3	7	10	30.00%	0
Overall percentage:					**70.00%**	

3 – *Emergency Services*

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

Reference Number	4 – *Health Information Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated healthcare documents (provider progress notes) scanned within 3 calendar days of the patient encounter date?	10	0	10	100%	0
4.002	Are dictated/transcribed documents scanned into the patient's electronic health record within five calendar days of the encounter date?	Not Applicable				
4.003	Are High-Priority specialty notes (either a Form 7243 or other scanned consulting report) scanned within the required time frame?	18	2	20	90.00%	0
4.004	Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge?	18	2	20	90.00%	0
4.005	Are medication administration records (MARs) scanned into the patient's electronic health record within the required time frames?	Not Applicable				
4.006	During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files?	24	0	24	100%	0
4.007	For patients discharged from a community hospital: Did the preliminary hospital discharge report include key elements and did a primary care provider review the report within three calendar days of discharge?	24	1	25	96.00%	0
Overall percentage:					**95.20%**	

Reference Number	5 – *Health Care Environment*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
5.101	Are clinical health care areas appropriately disinfected, cleaned and sanitary?	11	2	13	84.62%	0
5.102	Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	12	1	13	92.31%	0
5.103	Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	10	3	13	76.92%	0
5.104	Does clinical health care staff adhere to universal hand hygiene precautions?	4	9	13	30.77%	0
5.105	Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	13	0	13	100%	0
5.106	Warehouse, Conex and other non-clinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program?	0	1	1	0.00%	0
5.107	Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	11	2	13	84.62%	0
5.108	Do clinic common areas and exam rooms have essential core medical equipment and supplies?	2	11	13	15.38%	0
5.109	Do clinic common areas have an adequate environment conducive to providing medical services?	10	3	13	76.92%	0
5.110	Do clinic exam rooms have an adequate environment conducive to providing medical services?	6	7	13	46.15%	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?	7	3	10	70.00%	3
Overall percentage:					**61.61%**	

Reference Number	6 – *Inter- and Intra-System Transfers*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
6.001	For endorsed patients received from another CDCR institution or COCF: Did nursing staff complete the initial health screening and answer all screening questions on the same day the patient arrived at the institution?	25	0	25	100%	0
6.002	For endorsed patients received from another CDCR institution or COCF: When required, did the RN complete the assessment and disposition section of the health screening form; refer the patient to the TTA, if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening?	25	0	25	100%	0
6.003	For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption?	10	3	13	76.92%	12
6.004	For patients transferred out of the facility: Were scheduled specialty service appointments identified on the patient's health care transfer information form?	1	8	9	11.11%	0
6.101	For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents?	6	2	8	75.00%	0
Overall percentage:					**72.61%**	

Reference Number	*7 – Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.001	Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows?	18	2	20	90.00%	5
7.002	Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames?	13	11	24	54.17%	1
7.003	Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames?	9	5	14	64.29%	11
7.004	For patients received from a county jail: Were all medications ordered by the institution's reception center provider administered, made available, or delivered to the patient within the required time frames?	Not Applicable				
7.005	Upon the patient's transfer from one housing unit to another: Were medications continued without interruption?	19	6	25	76.00%	0
7.006	For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption?	1	0	1	100%	0
7.101	All clinical and medication line storage areas for narcotic medications: Does the Institution employ strong medication security over narcotic medications assigned to its clinical areas?	2	6	8	25.00%	5
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?	8	4	12	66.67%	1
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?	9	1	10	90.00%	3
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	5	8	37.50%	5
7.105	Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients?	8	0	8	100%	5
7.106	Medication preparation and administration areas: Does the Institution employ appropriate administrative controls and protocols when distributing medications to patients?	6	2	8	75.00%	5
7.107	Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and satellite pharmacies?	2	0	2	100%	0

Reference Number	7 – *Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.108	Pharmacy: Does the institution's pharmacy properly store non-refrigerated medications?	2	0	2	100%	0
7.109	Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications?	2	0	2	100%	0
7.110	Pharmacy: Does the institution's pharmacy properly account for narcotic medications?	0	2	2	0.00%	0
7.111	Does the institution follow key medication error reporting protocols?	18	7	25	72.00%	0
Overall percentage:					**71.91%**	

8 – *Prenatal and Post-Delivery Services*

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

Reference Number	9 – *Preventive Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
9.001	Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed?	8	0	8	100%	0
9.002	Patients prescribed TB medication: Did the institution monitor the patient monthly for the most recent three months he or she was on the medication?	6	2	8	75.00%	0
9.003	Annual TB Screening: Was the patient screened for TB within the last year?	30	0	30	100%	0
9.004	Were all patients offered an influenza vaccination for the most recent influenza season?	24	1	25	96.00%	0
9.005	All patients from the age of 50–75: Was the patient offered colorectal cancer screening?	21	4	25	84.00%	0
9.006	Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy?	6	0	6	100%	0
9.007	Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy?	14	0	14	100%	0
9.008	Are required immunizations being offered for chronic care patients?	10	7	17	58.82%	8
9.009	Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	Not Applicable				
Overall percentage:					**89.23%**	

10 – *Quality of Nursing Performance*

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

11 – *Quality of Provider Performance*

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

12 – *Reception Center Arrivals*

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

13 – *Specialized Medical Housing*

The institution has no specialized medical housing, so this indicator is not applicable.

Reference Number	14 – *Specialty Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	Did the patient receive the high priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service?	12	3	15	80.00%	0
14.002	Did the primary care provider review the high priority specialty service consultant report within the required time frame?	10	2	12	83.33%	3
14.003	Did the patient receive the routine specialty service within 90 calendar days of the primary care provider order or Physician Request for Service?	15	0	15	100%	0
14.004	Did the primary care provider review the routine specialty service consultant report within the required time frame?	9	6	15	60.00%	0
14.005	For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames?	11	9	20	55.00%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	20	0	20	100%	0
14.007	Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame?	18	1	19	94.74%	1
Overall percentage:					**81.87%**	

Reference Number	15 – *Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.001	Did the institution promptly process inmate medical appeals during the most recent 12 months?	12	0	12	100%	0
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%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	1	0	1	100%	0
15.005	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	12	0	12	100%	0
15.006	For institutions with licensed care facilities: Does the Local Governing Body (LGB), or its equivalent, meet quarterly and exercise its overall responsibilities for the quality management of patient health care?	Not Applicable				
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?	2	1	3	66.67%	0
15.102	Did the institution's second level medical appeal response address all of the patient's appealed issues?	10	0	10	100%	0
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?	3	0	3	100%	0
15.104	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	2	3	5	40.00%	0
15.105	Are nursing staff who administer medications current on their clinical competency validation?	7	3	10	70.00%	0
15.106	Are structured clinical performance appraisals completed timely?	7	1	8	87.50%	0
15.107	Do all providers maintain a current medical license?	10	0	10	100%	0
15.108	Are staff current with required medical emergency response certifications?	1	1	2	50.00%	1
15.109	Are nursing staff and the Pharmacist-in-Charge current with their professional licenses and certifications, and is the pharmacy licensed as a correctional pharmacy by the California State Board of Pharmacy?	6	0	6	100%	0

Reference Number	15 – *Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.110	Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	0	2	2	0.00%	0
15.111	Are nursing staff current with required new employee orientation?	1	0	1	100%	0
Overall percentage:					**80.94%**	

APPENDIX B — CLINICAL DATA

Table B-1: FSP Sample Sets

Sample Set	Total
Anticoagulation	3
Death Review/Sentinel Events	3
Diabetes	3
Emergency Services – Non-CPR	3
High Risk	5
Hospitalization	4
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	36
Specialty Services	4
	67

Table B-2: FSP Chronic Care Diagnoses

Diagnosis	Total
Anemia	2
Anticoagulation	3
Arthritis/Degenerative Joint Disease	6
Asthma	9
COPD	9
Cancer	11
Cardiovascular Disease	12
Chronic Kidney Disease	2
Chronic Pain	12
Cirrhosis/End-Stage Liver Disease	6
Diabetes	17
Gastroesophageal Reflux Disease	12
Hepatitis C	17
Hyperlipidemia	24
Hypertension	34
Mental Health	8
Migraine Headaches	3
Seizure Disorder	2
Sleep Apnea	1
Thyroid Disease	7
	197

Table B-3: FSP Event – Program

Program	Total
Diagnostic Services	123
Emergency Care	56
Hospitalization	43
Intra-System Transfers In	4
Intra-System Transfers Out	3
Not Specified	1
Outpatient Care	506
Specialty Services	128
	864

Table B-4: FSP Review Sample Summary

	Total
MD Reviews Detailed	26
MD Reviews Focused	0
RN Reviews Detailed	15
RN Reviews Focused	42
Total Reviews	83
Total Unique Cases	67
Overlapping Reviews (MD & RN)	16

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

Folsom State Prison (FSP)

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Access to Care			
MIT 1.001	Chronic Care Patients (25)	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • **Randomize**
MIT 1.002	Nursing Referrals (25)	OIG Q: 6.001	• See ***Intra-System Transfers***
MITs 1.003–006	Nursing Sick Call (5 per clinic) (35)	MedSATS	• Clinic (each clinic tested) • Appointment date (2–9 months) • **Randomize**
MIT 1.007	Returns from Community Hospital (25)	OIG Q: 4.007	• See ***Health Information Management (Medical Records)*** (returns from community hospital)
MIT 1.008	Specialty Services Follow-up (30)	OIG Q: 14.001 & 14.003	• See ***Specialty Services***
MIT 1.101	Availability of Health Care Services Request Forms (6)	OIG onsite review	• Randomly select one housing unit from each yard
Diagnostic Services			
MITs 2.001–003	Radiology (10)	Radiology Logs	• Appointment date (90 days–9 months) • **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 (10)	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	(0)	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: 4.007	• Community hospital discharge documents • First 20 IPs selected
MIT 4.005	(0)	OIG Q: 7.001	• MARs • First 20 IPs selected
MIT 4.006	(0)	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (12 or more = No)
MIT 4.007	Returns From Community Hospital (25)	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 patients from each of the 6 months (if not 5 in a month, supplement from another, as needed)
Health Care Environment			
MITs 5.101–105 MITs 5.107–111	Clinical Areas (13)	OIG inspector onsite review	• Identify and inspect all onsite clinical areas.
Inter- and Intra-System Transfers			
MITs 6.001–003	Intra-System Transfers (25)	SOMS	• Arrival date (3–9 months) • Arrived from (another CDCR facility) • Rx count • **Randomize**
MIT 6.004	Specialty Services Send-Outs (9)	MedSATS	• Date of transfer (3–9 months) • **Randomize**
MIT 6.101	Transfers Out (8)	OIG inspector onsite review	• R&R IP transfers with medication

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Pharmacy and Medication Management			
MIT 7.001	Chronic Care Medication (25)	OIG Q: 1.001	*See* ***Access to Care*** • At least one condition per patient—any risk level • **Randomize**
MIT 7.002	New Medication Orders (25)	Master Registry	• Rx count • **Randomize** • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns from Community Hospital (25)	OIG Q: 4.007	• See ***Health Information Management (Medical Records)*** *(returns from community hospital)*
MIT 7.004	RC Arrivals – Medication Orders *N/A at this institution*	OIG Q: 12.001	• See ***Reception Center Arrivals***
MIT 7.005	Intra-Facility Moves (25)	MAPIP transfer data	• Date of transfer (2–8 months) • 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 (1)	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 (2)	OIG inspector onsite review	• Identify & inspect all onsite pharmacies
MIT 7.111	Medication Error Reporting (25)	Monthly medication error reports	• All monthly statistic reports with Level 4 or higher • Select a total of 5 months
MIT 7.999	Isolation Unit KOP Medications (6)	Onsite active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in isolation units
Prenatal and Post-Delivery Services			
MITs 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 (8)	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • **Randomize**
MIT 9.003	TB Evaluation, Annual Screening (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • Birth Month • **Randomize**
MIT 9.004	Influenza Vaccinations (25)	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 (25)	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 (25)	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 *N/A at this institution*	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • **Randomize**
Specialized Medical Housing			
MITs 13.001–004	CTC / OHU *N/A at this institution*	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 *N/A at this institution*	OIG inspector onsite review	• Review by location
Specialty Services			
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**
MITs 14.006–007	Denials (0)	InterQual	• Review date (3–9 months) • **Randomize**
	(20)	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • **Randomize**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Administrative Operations			
MIT 15.001	Medical Appeals (all)	Monthly medical appeals reports	• Medical appeals (12 months)
MIT 15.002	Adverse/Sentinel Events (0)	Adverse/sentinel events report	• Adverse/sentinel events (2–8 months)
MITs 15.003–004	QMC Meetings (6)	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.005	EMRRC (12)	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.006	LGB (N/A)	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills (3)	Onsite summary reports & documentation for ER drills	• Most recent full quarter • 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 15.104	RN Review Evaluations (5)	Onsite supervisor periodic RN reviews	• RNs who worked in clinic or emergency setting six or more days in sampled month • **Randomize**
MIT 15.105	Nursing Staff Validations (10)	Onsite nursing education files	• On duty one or more years • Nurse administers medications • **Randomize**
MIT 15.106	Provider Annual Evaluation Packets (8)	OIG Q:16.001	• All required performance evaluation documents
MIT 15.107	Provider licenses (10)	Current provider listing (at start of inspection)	• Review all

MIT 15.108	Medical Emergency Response Certifications (all)	Onsite certification tracking logs	• All staff
			  ○ Providers (ACLS)
			  ○ Nursing (BLS/CPR)
			• Custody (CPR/BLS)

MIT 15.109	Nursing staff and Pharmacist in Charge Professional Licenses and Certifications (all)	Onsite tracking system, logs, or employee files	• All required licenses and certifications

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Administrative Operations			
MIT 15.110	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations (all)	Onsite listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 15.111	Nursing Staff New Employee Orientations (all)	Nursing staff training logs	• New employees (hired within last 12 months) •
MIT 15.998	Death Review Committee (3)	OIG summary log - deaths	• Between 35 business days & 12 months prior • CCHCS death reviews

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

January 9, 2018

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

Dear Mr. Wesley:

The purpose of this letter is to inform you that the Office of the Receiver has reviewed the draft report of the Office of the Inspector General (OIG) Medical Inspection Results for Folsom State Prison (FSP) conducted from May to July 2017. California Correctional Health Care Services (CCHCS) acknowledges the OIG findings.

Thank you for preparing the report. Your efforts have advanced our mutual objective of ensuring transparency and accountability in CCHCS operations. If you have any questions or concerns, please contact me at (916) 691-3704.

Sincerely,

LARA SAICH
Deputy Director (A)
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
Bryan Beyer, Chief Deputy Inspector General, OIG
Ryan Baer, Senior Deputy Inspector General, OIG
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