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California State Prison, Los Angeles County Medical Inspection Results Cycle 5

September 2017

Fairness ◆ Integrity ◆ Respect ◆ Service ◆ Transparency

Office of the Inspector General
California State Prison,
Los Angeles County
Medical Inspection Results
Cycle 5

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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. At the time of the Cycle 5 inspection of California State Prison, Los Angeles County, the Receiver had not delegated this institution back to CDCR.

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:

Inadequate

The OIG performed its Cycle 5 medical inspection at California State Prison, Los Angeles County (LAC), from March to May 2017. The inspection included in-depth reviews of 64 patient files conducted by clinicians, as well as reviews of documents from 371 patient files, covering 90 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 LAC using 13 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, seven 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 *LAC Executive Summary Table* on the following page identifies the applicable individual indicators and scores for this institution.

LAC Executive Summary Table

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

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

** The original publication of this report inadvertently misreported the institution's Cycle 4 medical inspection ratings. Although the Cycle 4 ratings had no effect on the Cycle 5 results of this report, the OIG updated the Cycle 4 ratings for this report on December 11, 2017, to correct these errors.

Clinical Case Review and OIG Clinician Inspection Results

The clinicians' case reviews sampled patients with high medical needs and included a review of 1,305 patient care events.[1] Of the 13 indicators applicable to LAC, clinician case reviewers evaluated 10; one was *proficient*, 5 were *adequate*, and 4 were *inadequate.* When determining the overall adequacy of care, the OIG paid particular attention to the clinical nursing and provider quality indicators, as adequate health care staff can sometimes overcome suboptimal processes and programs. However, the opposite is not true; inadequate health care staff cannot provide adequate care, even though the established processes and programs onsite may be adequate. The OIG clinicians identify inadequate medical care based on the risk of significant harm to the patient, not the actual outcome.

Well-performing ancillary services are crucial to all medical facilities. For Cycle 5, LAC showed inadequacies in four indicators: *Access to Care*, *Diagnostic Services*, *Health Information Management*, and *Specialty Services*. These inadequacies negatively affected patient care. Many important provider appointments did not occur. In addition, laboratory tests that were incomplete or not conducted, inaccessible diagnostic procedures, and missed specialty services all hindered patient care.

Program Strengths — Clinical

- LAC had well-coordinated transfer processes. Patients transferring into LAC received their medications timely, and were seen by the providers and specialists as scheduled.

Program Weaknesses — Clinical

- LAC had high backlogs of provider appointments, which led to missed important provider appointments and hindered patient care.

- LAC had numerous incomplete laboratory tests and inaccessible diagnostic procedure reports, which had a negative impact on patient care. The providers and specialists were seeing patients without the requested laboratory tests having been done and without diagnostic reports.

- The OIG clinicians also noted many instances of missed or delayed specialty appointments. Several specialty consultation reports were not in the electronic Unit Health Record (eUHR), which negatively affected patient care.

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

Compliance Testing Results

Of the 13 health care indicators applicable to LAC, 10 were evaluated by compliance inspectors.[2] Of these, one was *adequate*, and nine were *inadequate*. There were 90 individual compliance questions within those 10 indicators, generating 1,127 data points that tested LAC's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[3] Those 90 questions are detailed in *Appendix A — Compliance Test Results*.

Program Strengths — Compliance

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

- Nursing staff reviewed patients' health care services requests on the same day such requests were received, and nursing staff conducted face-to-face encounters within required time frames.

- Clinic locations were appropriately disinfected, cleaned, and sanitized, and staff at those locations followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste.

- Nursing staff completed the assessment and disposition sections of the initial health care screening assessment forms.

- The institution's pharmacy maintained security and cleanliness management protocols, properly stored medications, and maintained proper control of narcotic medications.

- LAC offered patients influenza vaccinations during the most recent influenza season.

- The correctional treatment center (CTC) call button system functioned properly, and institution staff reported they were able to expeditiously access patients' locked rooms during emergent events.

- Patients received their high-priority and routine specialty service appointments within required time frames.

[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.

Program Weaknesses — Compliance

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

- Patients did not always receive their chronic care provider follow-up appointments within required time frames; also, patients who received their specialty service appointment did not always receive the appropriate provider follow-up appointment.

- Providers did not always review radiology and laboratory reports within required time frames; providers did not always communicate radiology, laboratory, and pathology results to their patients.

- When a patient returned to the institution from an outside community hospital, LAC providers did not always review the hospital discharge report within the required time frame.

- Several clinic locations at LAC did not always have essential equipment and supplies available to staff, and several clinic examination rooms did not have appropriate space configurations, supplies, or equipment available to clinicians to perform a comprehensive patient examination.

- Patients who transferred into LAC from another CDCR institution with existing medication orders did not always receive their prescribed medication at the next dosing interval.

- Patients did not always receive their chronic care medications within required time frames, and several patients who returned to the institution from an outside community hospital did not receive their hospital discharge medications timely. In addition, the OIG inspectors noted several medication line locations at LAC did not have adequate controls over narcotic medications.

- Medical staff at LAC poorly monitored patients who were taking tuberculosis (TB) medications.

- LAC providers did not always conduct follow-up visits for patients who received high-priority specialty service appointments. In addition, patients who had specialty service appointments previously scheduled at another CDCR institution before transferring to LAC did not always receive their specialty services or received them late.

Recommendations

The OIG recommends training of all health care staff in how to use RIS-PACS to allow appropriate patient care, and to consider discipline, when appropriate, for staff who continue to miss timely report review in RIS-PACS.

The OIG recommends nursing administrators develop a process to implement the CCHCS policy requiring administrators evaluate nursing assessments and nursing documentation.

Population-Based Metrics

LAC performed fairly well as measured by population-based metrics. In comprehensive diabetes care, the institution outperformed Medi-Cal in all five diabetic measures. It trailed Kaiser, North and South regions, and the United States Department of Veterans Affairs in its performance of some of these measures, but LAC outperformed both Medicaid and commercial health plans in all five diabetic measures reviewed.

Regarding immunization measures, LAC's rates varied extensively compared to the other entities reporting data. In general, the institution's performance was more effective for its older population than for its younger, but results for both groups were skewed by patients' tendency to refuse vaccines entirely.

For colorectal cancer screening, LAC performed better when compared to commercial plans, but less well in comparison to the other health care plans reviewed. As with the immunization rate, however, patients' tendency to refuse this screening served to negatively affect the institution's score for this measure.

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.

California State Prison, Los Angeles County (LAC), was the sixth 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, and it does not factor in the overall rating for the institution.

ABOUT THE INSTITUTION

LAC houses more than 3,400 patients and is located in the city of Lancaster. The institution runs several medical clinics where staff members handle non-urgent requests for medical services. The institution also conducts patient screenings in its receiving and release (R&R) clinical area, treats patients who require urgent or immediate care in its triage and treatment area (TTA), and treats patients who require inpatient care in its correctional treatment center (CTC). The CTC is a state-licensed facility where patients receive professionally supervised health care beyond that normally provided in the community on an outpatient basis. LAC also serves as a medical hub for enhanced outpatient programming (EOP) and EOP administrative segregation levels of health care.

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.

In addition, on August 16, 2015, the institution received national accreditation from the Commission on Accreditation for Corrections. This accreditation program is a professional peer review process based on national standards set by the American Correctional Association.

Based on staffing data the OIG obtained from the institution, LAC's vacancy rate among medical managers, primary care providers, supervisors, and rank-and-file nurses was five percent in February 2017, with the highest vacancy percentages among nursing supervisors at 29 percent. At the time of the OIG's inspection, 14 health care staff members were on long-term medical leave, including one primary care provider, one nursing supervisor, and 12 nursing staff members. Lastly, the CEO reported that in February 2017, there were 15 medical staff members currently working at LAC who were under CDCR disciplinary review.

LAC Health Care Staffing Resources as of February 2017

	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff		Totals	
Description	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Authorized Positions	5	4%	11	9%	12.7	10%	97.7	77%	126.4	100%
Filled Positions	5	100%	10	91%	9	71%	95.6	98%	119.6	95%
Vacancies	0	0%	1	9%	3.7	29%	2.1	2%	6.8	5%
Recent Hires (within 12 months)	2	40%	5	50%	3	33%	39	41%	49	41%
Staff Utilized from Registry	0	0%	1	0%	0	0%	1	0%	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%	1	0%	1	11%	12	13%	14	12%

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

As of February 13, 2017, the Master Registry for LAC showed that the institution had a total population of 3,435. Within that total population, 7.0 percent was designated as high medical risk, Priority 1 (High 1), and 15.9 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.

LAC Master Registry Data as of February 13, 2017

Medical Risk Level	# of Patients	Percentage
High 1	240	7.0%
High 2	546	15.9%
Medium	1,609	46.8%
Low	1,040	30.3%
Total	**3,435**	**100%**

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. This report identifies these 15 indicators in the *LAC Executive Summary Table* on page *iv*.

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 rating or 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 was 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 is considered high-risk and accounts for more than half of the institution's pharmaceutical, specialty, community hospital, and emergency costs.

2. Selecting this target group for 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, adverse 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: LAC Sample Sets*, the OIG clinicians evaluated medical charts for 64 unique patients. *Appendix B, Table B-4: LAC Case Review Sample Summary* clarifies that both nurses and physicians reviewed charts for 15 of those patients, for 79 reviews in total.

Physicians performed detailed reviews of 25 charts, and nurses performed detailed reviews of 18 charts, totaling 43 detailed reviews. For detailed case reviews, physicians or nurses looked at all encounters occurring in approximately six months of medical care. Nurses also performed a limited or focused review of medical records for an additional 36 patients. These generated 1,305 clinical events for review (*Appendix B, Table B-3: LAC 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 six chronic care patient records, i.e., 3 diabetes patients and 3 anticoagulation patients (*Appendix B, Table B-1: LAC Sample Sets*), the 64 unique sampled patients included those with 275 chronic care diagnoses, including 18 additional patients with diabetes (for a total of 21) and one additional anticoagulation patient (for a total of 4) (*Appendix B, Table B-2: LAC 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 reanalyzed 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 will use a sample size of detailed physician-reviewed cases 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.

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 *proficient* (excellent), *adequate* (passing), or *inadequate* (failing). A separate confidential *LAC 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 March to May 2017, registered nurse inspectors obtained answers to 90 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 371 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 March 6, 2017, registered nurse field inspectors conducted a detailed onsite inspection of LAC's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,127 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 LAC'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 90 questions for the ten applicable indicators, the OIG derived a score for each quality indicator by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Based on those results, the OIG assigned a rating to each quality indicator of *proficient* (greater than 85 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 LAC, the OIG reviewed some of the compliance testing results, randomly sampled additional patients' records, and obtained LAC's 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 *LAC Executive Summary Table* on page *iv* of this report, 13 of the OIG's indicators were applicable to LAC. Of those 13 indicators, 7 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 scored by the compliance component alone. The *Administrative Operations* indicator is a secondary indicator, and, therefore, did not affect 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 LAC was ***inadequate***.

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

The OIG physicians rated the overall adequacy of care for each of the 25 detailed case reviews they conducted. Of these 25 cases, 17 were *adequate* and 8 were *inadequate*. In the 1,305 events reviewed, there were 253 deficiencies, of which 85 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 or have the potential to 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. There were no adverse events identified in the case reviews at LAC.

Summary of Compliance Results: The compliance component assessed 10 of the 13 indicators applicable to LAC. Of these ten indicators, OIG inspectors rated one *adequate* and nine *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 patients, 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:
Inadequate
Compliance Score:
Inadequate
(73.1%)

Overall Rating:
Inadequate

Case Review Results

The OIG clinicians reviewed 571 provider and nurse encounters, and identified 19 deficiencies relating to *Access to Care*. Of those 19 deficiencies, 10 were significant. The case review rating for *Access to Care* was *inadequate*.

Provider Follow-up Appointments

The institution performed poorly with provider-ordered follow-up appointments. These appointments are important elements of the *Access to Care* indicator. The OIG clinicians identified seven deficiencies related to such appointments not occurring either timely or at all, three of which were significant and that occurred in the following case:

- In case 25, the patient had poorly controlled diabetes. Three provider follow-up appointments did not occur. A nurse consulted with a provider for a critically high blood glucose level (445 mg/dL); the provider ordered one-time extra insulin and requested a follow-up appointment in three to five days, but the appointment did not occur. Seven days later, a provider also ordered extra insulin for a high blood glucose level (389 mg/dL) and requested a follow-up appointment in two days, but the appointment did not occur. One month later, a provider ordered extra insulin for a critically high blood glucose level (470 mg/dL) and requested a TTA follow-up appointment, but the appointment did not occur.

The OIG also identified deficiencies in the timeliness of follow-up visits:

- In case 2, a provider requested a patient follow-up visit in three to five days, but the appointment occurred in seven days.

- In case 25, a provider requested a patient follow-up in 30 days, but the appointment occurred in 40 days.

- In case 26, a provider requested a patient follow-up in 7 days, but the appointment occurred in 12 days.

- In case 64, a provider requested a patient follow-up in two to three weeks, but the appointment occurred in four weeks.

RN Sick Call Access

The sick call process at LAC was well-organized and provided patients with timely access to health care. However, there was one significant deficiency for RN sick call appointments:

- In case 41, the patient submitted a sick call request for knee pain, but was not assessed by a nurse until seven days later.

RN-to-Provider Referrals

Nurses assessed patients and were required to refer them to a provider if a situation needed a higher level of care. The OIG identified one minor deficiency:

- In case 58, a nurse evaluated the patient for heel numbness. The nurse requested a patient follow-up with a provider in 14 days, but the appointment occurred in 26 days.

RN Follow-up Appointments

The institution performed well in scheduling and completing RN appointments that were generated by providers or nurses. The OIG clinicians found one significant deficiency:

- In case 2, the patient had swelling and edema of the legs. The provider requested the patient follow up with a nurse in five days, but the appointment did not occur.

Intra-System Transfers

There were no nursing deficiencies related to this indicator during transfer either into or out of the facility.

Follow-up After Hospitalization

Provider follow-up appointments after hospitalization should occur in time frames ensuring both patient safety and optimal clinical outcomes, but in all cases, no later than five days from hospital discharge. The OIG clinicians identified two significant deficiencies for patient returns from hospitals:

- In case 13, the patient returned to LAC after hospitalization for pneumonia, but the provider follow-up appointment did not occur. Subsequently, the patient did not receive the recommended antibiotic, placing him at risk of harm.

- In case 20, the patient returned to the institution after hospitalization for chest pain. A provider requested a patient follow-up appointment with the TTA provider on the following day, but the appointment did not occur until three days later.

Specialized Medical Housing

The provider saw patients in the CTC timely, and performed history and physical examinations on all newly admitted patients. There were no nursing deficiencies related to follow-up encounters from the CTC.

Provider Follow-up After Specialty Service Visits

After specialty service visits, all patients should be evaluated by a provider within 14 days or earlier if indicated. These appointments are crucial in the delivery of care to patients as providers review and address specialists' recommendations. LAC performed poorly with these appointments as there were four significant deficiencies:

- In case 1, the patient was seen by a cardiologist with a provider-requested follow-up in five days to address the specialist's recommendations; the appointment did not occur.

- In case 7, the patient had an echocardiogram (heart imaging test), and a provider-requested follow-up in 10 to 14 days to address the result; the appointment did not occur.

- Also in case 7, the patient was seen by a cardiologist and had a provider-requested patient follow-up in 10 days to address the recommendations; the appointment did not occur.

- In case 17, the patient had a pelvic computerized tomography (CT) scan, which showed a new bladder tumor. The follow-up provider visit to review this did not occur. This error meant a delay in the cancer treatment plan.

Clinician Onsite Inspection

During the onsite visit, clinic nurses reported seeing 8 to 10 patients each day, and the providers saw 15 to 18 patients each day. Each clinic had a designated office technician (OT) who attended daily clinic huddles and coordinated with providers to ensure that all important follow-up appointments were scheduled. The OTs indicated that there were backlogs of provider appointments on all yards, from 50 patients to more than 200 patients.

The chief medical executive (CME) stated that the missed provider appointments resulted from inexperienced psychiatric technicians not appropriately scheduling the appointments, as well as a shortage of providers. The CME expressed that the recent hiring of three new providers would alleviate the appointment backlogs.

Case Review Conclusion

The institution performed poorly with regard to this indicator because numerous important provider appointments did not occur, which hindered patient care. The OIG clinicians rated this indicator *inadequate*.

Compliance Testing Results

The institution performed in the *inadequate* range in this indicator, with a compliance score of 73.1 percent. The following areas showed room for improvement:

- Only 8 of 24 sampled patients (33 percent) who received a high-priority or routine specialty service also received a timely follow-up appointment with a provider. Of those 16 patients who did not receive timely follow-up appointments, 6 patients' high-priority specialty service follow-up appointments were one to 11 days late, one was 153 days late, and 4 received no appointment at all. Two patients' routine specialty service follow-up appointments were 54 and 59 days late, and three received no appointment at all (MIT 1.008).

- Among 25 sampled patients who suffered from one or more chronic care conditions, only 9 (36 percent) timely received their provider-ordered follow-up appointments. The remaining 16 patients received one or more of their appointments late or not at all: six appointments were one to 16 days late; five appointments, 28 to 46 days late; one, 91 days late; one, 146 days late; and, finally, five appointments did not occur at all (MIT 1.001).

- Among 18 sampled Health Care Services Request forms (CDCR Form 7362) that nursing staff used to refer patients for provider appointments, ten patients (56 percent) received their appointments in a timely manner. Four patients received their appointments one to eight days late. Two patients received their appointments 23 and 31 days late, and two other patients received no provider visit at all (MIT 1.005).

- The OIG clinicians sampled 25 patients discharged from a community hospital to determine whether they had received provider follow-up appointments at LAC within five calendar days of their return to the institution, or earlier, if a TTA provider had ordered that the appointment occur sooner. Only 15 of the 25 patients (60 percent) received timely provider follow-up appointments. Of those remaining, nine received their appointments from one to nine days late, and for one patient, there was no evidence that his appointment had ever occurred (MIT 1.007).

The following test received a score of *adequate*:

- Among 25 sampled patients who transferred into LAC from other institutions and were referred to a provider based on nursing staff's initial health care screening, 19 (76 percent)

were seen timely, and 6 patients received their provider appointment from 4 to 16 days late (MIT 1.002).

All of the following tests received scores in the *proficient* range:

- The OIG clinicians sampled 35 health care services requests submitted by patients across all facility clinics. Nursing staff reviewed all service request forms on the same day they were received (MIT 1.003).

- Of the two sampled patients referred to and seen by a provider, and for whom the provider subsequently ordered follow-up appointments, both received those appointments timely (MIT 1.006).

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

- Nursing staff completed a timely face-to-face triage encounter for 34 of 35 sampled patients who had submitted Health Care Services Requests (97 percent) (MIT 1.004).

2 — *DIAGNOSTIC SERVICES*

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(58.5%)

Overall Rating:
Inadequate

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.

Case Review Results

The OIG clinicians reviewed 205 events in diagnostic services and identified 58 deficiencies. A total of 37 significant deficiencies were identified once in cases 1, 3, 6, 7, 9, 10, 13, 15, 16, 19, 23; twice each for cases 2, 4, 18, and 20; three times each in cases 14, 17, and 24; four times in case 22, and five times in case 21. The case review rating for this indicator was *inadequate*.

Test Completion

The OIG clinicians identified 23 significant deficiencies due to diagnostic tests not being performed as requested.

LAC had a warfarin clinic in which the provider adjusted the blood-thinning medication prescribed to prevent clots. While warfarin is effective in doing this, the medication is difficult to safely use as the specific dose for the patient needs to be initially determined, and then constantly adjusted to avoid undertreating the patient and the risk of additional blood clots, or overtreating and the risk of severe bleeding. This requires a laboratory test, the international normalized ratio (INR) readings. The OIG identified seven significant deficiencies indicating when these levels were not checked as requested by a physician:

- In case 20, a provider requested the INR to be done in three days, but the test was not performed.
- In case 21, on three occasions, the requested INR was not done. Specifically, a provider requested drawing the INR in four days, prior to the follow-up visit. This did not occur, which the provider noted at the follow-up visit.
- In case 22, on three occasions, the requested INR was not done.

The OIG clinicians identified six significant deficiencies in cases 7, 9, 13, 17, 19, and 21 for which a laboratory screening test for colon cancer was not done.

The OIG clinicians identified nine significant deficiencies as other laboratory tests were not done as requested in cases 2, 17, 22, 23, and the following:

- In case 4, a provider ordered urine toxicology to be done in four weeks, but it was done in seven weeks. Also in case 4, a provider requested laboratory tests including diabetes in two weeks, but they were done in six weeks.

- In case 14, the patient had prostate cancer. In this case, the provider was using a prostate-specific antigen (PSA) test as a monitor to see if the cancer was progressing, or not. The provider ordered the PSA test to be done in 21 days. However, it was done more than three months later. Also in case 14, the second order for the PSA test to be done in 14 days was done more than two and a half months later. Thus the specialist evaluated the patient without the requested test.

- In case 24, a provider requested tests, one of which was a diabetes test to be done in 10 weeks and prior to the provider appointment in 12 weeks. However, this test was done more than three months later, after the appointment.

The OIG clinicians identified one significant deficiency with a diagnostic procedure not done as requested:

- In case 10, a provider requested an abdominal CT scan to monitor the patient's transplanted liver, but it was not done.

Health Information Management

Health information management contributed to the *inadequate* rating of the indicator. There were 31 diagnostic reports not scanned into the eUHR. The OIG clinicians identified 14 significant deficiencies due to missing diagnostic reports.

There were three significant deficiencies due to missing pathology reports:

- In case 6, the patient had a colonoscopy (colon imaging test) with biopsy; a provider requested the biopsy report, but it was not retrieved or scanned into the electronic health record.

- In case 14, a provider requested the bone marrow biopsy report, but it was not retrieved or scanned into the electronic health record.

- In case 17, the patient had stomach cancer; a provider requested a biopsy report, but it was not retrieved or scanned into the electronic health record. Four months later, another provider requested the missing report, being the second request.

There were six significant deficiencies due to missing laboratory reports in cases 15, 16, 20 and the following:

- In case 2, the patient had a low sodium (salt) level; a provider requested an urgent chemistry panel, but the resulting laboratory report was not retrieved or scanned into the electronic health record.

- In case 21, an INR report was not retrieved or scanned into the electronic health record.

- In case 24, a laboratory report of an elevated diabetes test (HbA1c of 11.3) and a critically high blood fat level (triglyceride level of 1288 mg/dL) were not retrieved or scanned into the electronic health record. The provider failed to address this critically high triglyceride level.

There was one significant deficiency related to a missing X-ray report:

- In case 24, an X-ray of the hand was completed, but the patient was not informed of the X-ray result. Subsequently, two and a half months later, the patient inquired about the result; the provider stated the report was not available and requested it. The provider was unaware the report was located in a second separate electronic medical record repository, the radiology information system-picture archiving and communication system (RIS-PACS).

There were four significant deficiencies due to missing diagnostic procedure reports:

- In case 1, a kidney ultrasound report was not retrieved or scanned into the electronic medical record. Health care staff failed to retrieve the report from the other electronic record repository, RIS-PACS. Subsequently, the kidney specialist evaluated the patient without the benefit of the report.

- In case 3, a liver ultrasound report was not retrieved or scanned from RIS-PACS into the electronic health record. The provider evaluated the patient two weeks later, and failed to check RIS-PACS to be able to review the report.

- In case 18, there were two significant deficiencies. Two abdominal ultrasound scans were performed within one and a half months. Subsequently, two and a half months later, a provider ordered another abdominal ultrasound as the previous two ultrasound reports were not readily accessible; they were in RIS-PACS.

Clinician Onsite Inspection

Each of the four main clinics had an assigned staff member (a phlebotomist) for blood drawing, but the warfarin clinic and the TTA had no assigned phlebotomists. Thus, nursing staff performed most of the blood drawing at these two sites.

The chief physician and surgeon (CP&S) stated that X-ray, ultrasound, CT scan, MRI scan, and bone scan reports were in RIS-PACS and did not require scanning into the electronic health record.

Providers, however, expressed having difficulty in navigating this system to review diagnostic reports.

Case Review Conclusion

The numerous incomplete laboratory tests, and diagnostic reports scanned into the less frequently used electronic repository (RIS-PACS), had a negative impact on patient care, as the providers and specialists were seeing patients without reviewing the requested laboratory tests or diagnostic reports. Accordingly, the OIG clinicians rated the *Diagnostic Services* indicator *inadequate*.

Compliance Testing Results

The institution received an *inadequate* compliance score of 58.5 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

- While radiology services were timely performed for eight of ten sampled patients (80 percent), two sampled patients received their tests one day late (MIT 2.001). LAC providers did not complete timely reviews by initialing and dating any corresponding diagnostic services reports for any of these sampled patients and timely communicated test results to only four of the ten patients (40 percent). For the remaining patients, four received their results from one to 68 days late, and two never received their results at all (MIT 2.002, 2.003).

Laboratory Services

- Eight of ten sampled patients (80 percent) received their provider-ordered laboratory services timely; however, two of the ten services were provided one and eight days late (MIT 2.004). The institution's providers also reviewed five of the ten resulting laboratory services reports within the required time frame (50 percent), but four reports were reviewed one to 11 days late, and one report had no date to identify when it was reviewed (MIT 2.005). Finally, providers timely communicated the results to only five of the ten patients (50 percent); the other five patients received their results one to 11 days late (MIT 2.006).

Pathology Services

- The institution timely received six of the ten (60 percent) final pathology reports. Three diagnostic reports were received 2 to 13 days late, and one report was never received (MIT 2.007), reducing the applicable sample size to nine. Providers documented their review process by initialing and dating all nine sampled final pathology reports (MIT 2.008). Providers timely communicated pathology results to only six of these nine patients (67 percent). For three patients, the provider communicated the results 5 to 24 days late (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 43 urgent and emergent events and found 28 deficiencies with various aspects of emergency care. There were four significant deficiencies (cases 1, 4, 12, and 19). Case review rating for the *Emergency Services* indicator was *adequate.*

Cardiopulmonary Resuscitation Responses

In general, cardiopulmonary resuscitation (CPR) response was good at LAC.

Provider Performance

LAC provider performance was good in emergency care. There were three deficiencies, with one significant:

- In case 1, TTA staff consulted with a provider about a patient with a critically high INR (level was 11.5 for this blood test monitoring the effects of a blood thinner). The provider did not give the patient the recommended antidote treatment medication, vitamin K, to reverse the effects of warfarin. Without this, the patient was at a high risk of serious bleeding. Fortunately, no harm came to the patient because this occurred.

Nursing Performance

In general, nursing performance during emergency responses was good. An accumulation of less serious nursing deficiencies included incomplete documentation of nursing assessments and of the patient's status during emergent care. The OIG identified two significant deficiencies in nursing care:

- In case 4, there was a 20-minute delay of the nurse's arrival on scene to assess a patient who had fallen, hit his head, and was unconscious. Another 20 minutes elapsed before the patient was taken to the TTA. This was the patient's second fall, seizure, and loss of consciousness in 14 hours. The nurse's assessment did not include a check of either vital signs or blood sugar levels.

- In case 12, the nurse did not assess circulation, or the presence and quality of pulses in a patient with severe leg swelling and redness. A "now" order for ceftriaxone (an antibiotic) was given to the patient five and a half hours later.

Nursing Documentation

The OIG clinicians identified an accumulation of nursing documentation deficiencies, none of which were considered significant. However, case review findings indicated areas for staff education and quality improvement strategies. For example, nurses did not adequately document ongoing timelines for assessments and treatment interventions during emergent events, such as the times when emergency equipment including an automated external defibrillator (AED) or oxygen nasal cannula were initiated. Nursing staff who responded on scene to medical emergencies did not consistently document relevant information of the emergent event prior to the patient's arrival to the TTA.

External Emergency Medical Service Responses

Emergency ambulance services generally responded timely. However, there were three events when ambulance service was appropriately delayed, twice in case 4 and once in case 6, due higher-level 9-1-1 emergency calls for events occurring out in the local community.

Patient Care Environment

The TTA was generally well-stocked with medications and equipment. However, there was one significant deficiency:

- In case 19, a TTA provider evaluated a patient with eye pain likely resulting from a corneal abrasion. A corneal examination was not performed as LAC lacked a working ultraviolet Wood's lamp, which is used to diagnose injuries to the eye.

Emergency Medical Response Review Committee

The OIG reviewed ten unscheduled emergency response incidents. The Emergency Medical Response Review Committee (EMRRC) reviewed the incidents timely and thoroughly. The EMRRC identified training needs for various incidents reviewed, and the training had been completed before clinical onsite inspection.

Clinician Onsite Inspection

The TTA had two beds and was well staffed with nurses. A provider was assigned to the TTA during working hours, and an on-call provider was readily available during after-hours. The OIG clinicians interviewed the nursing administrators, and some of the training needs were acknowledged for the numerous newly hired nurses in LAC's TTA.

Case Review Conclusion

Nursing documentation during emergent events needed improvement and while there were some delays in CPR and nursing response in emergency situations, in general, LAC responded creditably to emergent events. Thus, the OIG clinicians rated the *Emergency Services* indicator *adequate*.

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4 — *HEALTH INFORMATION MANAGEMENT*

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(69.9%)

Overall Rating:
Inadequate

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.

During the OIG's testing period, LAC had not yet converted to the new Electronic Health Record System (EHRS); therefore, all testing occurred in the electronic Unit Health Record (eUHR) system. LAC is scheduled for conversion to EHRS in October 2017.

Case Review Results

The OIG clinicians reviewed 1,305 events and identified 56 deficiencies related to health information management. A total of 23 significant deficiencies were identified once in cases 2, 3, 6, 8, 14, 15, 17, 20, 21, and 22; twice each in cases 1, 16, and 24; three times in case 18, and four times in case 7. The *Health Information Management* indicator was rated *inadequate* due to numerous missing diagnostic and specialty reports.

Inter-Departmental Transmission

The OIG did not identify any problems in communication between the departments within the institution.

Hospital Records

The OIG clinicians reviewed 39 community hospital events including emergency department visits; the hospital records were timely retrieved, reviewed, and scanned into the medical record.

Specialty Services Reports

There were nine significant deficiencies related to missing specialty service reports that had hindered patient care. These deficiencies are also discussed in the *Specialty Services* indicator.

- In case 16, a patient with metastatic lung cancer had a bone scan, but the report was not retrieved or scanned from RIS-PACS into the electronic health record. Subsequently, on two follow-up visits, providers failed to check RIS-PACS, and repeatedly requested retrieval of the report.

- In case 18, an echocardiogram (heart imaging) test was scheduled, but not completed. Six weeks later, a provider requested the report, and 11 weeks later, another provider requested the report. The test was never completed at the facility as the report was not entered into RIS-PACS.

Missing Documents (Progress Notes and Forms)

Most of the nursing and provider progress notes and forms were scanned into the electronic medical record; however, five progress notes and three forms were missing.

- In case 4, TTA staff evaluated the patient for elevated blood pressure and headache. The nurse consulted with a provider who ordered blood pressure medications and transferred the patient to the community hospital. However, no provider progress note documented the emergent event.

Diagnostic Reports

There were 31 deficiencies related to diagnostic service reports. The OIG clinicians identified 14 significant deficiencies related to missing diagnostic reports that had negative impacts on patient care.

- In case 1, a kidney imaging ultrasound report was not retrieved or scanned into the electronic health record. While the report was available in RIS-PACS, these records were not made available for the offsite consulting nephrologist (kidney specialist). During the specialist visit, the nephrologist evaluated the patient without the report, documenting "no result of ultrasound to review."

- In case 6, the patient had a colonoscopy with biopsy; a provider requested the biopsy report, which had not been retrieved or scanned into the electronic health record. These deficiencies are also discussed in the *Diagnostic Services* indicator.

Scanning Performance

There were three minor deficiencies related to mislabeled documents.

- In case 3, a wound-care progress note was mislabeled as a nursing assessment protocol.

Legibility

Most provider and nursing progress notes were dictated or legibly handwritten.

Clinician Onsite Inspection

LAC had a central medical record office in which staff retrieved and scanned medical records. As noted in the *Diagnostic Services* indicator, the CP&S stated that X-ray, ultrasound, CT scan, MRI scan, and bone scan reports were in RIS-PACS and did not require scanning into the electronic

health record. Providers, however, expressed having difficulty in navigating this system to review diagnostic reports.

Case Review Conclusion

The OIG is aware of CCHCS policy regarding the decision to only store imaging reports in RIS-PACS, and not scan the reports into the electronic medical record. However, health care staff at LAC repeatedly failed to look in RIS-PACS for the radiology reports. The numerous missing diagnostic and specialty reports had a negative impact on patient care as the providers and specialists were seeing patients without knowledge of the radiology reports. Thus, the OIG clinicians rated the *Health Information Management* indicator *inadequate.*

Compliance Testing Results

The institution performed in the *inadequate* range in this indicator with a compliance score of 69.9 percent. The following areas showed room for improvement:

- LAC scored 29 percent in its labeling and filing of documents scanned into patients' electronic health records. For this test, the OIG bases its score on 24 mislabeled or misfiled documents. For this test, once the OIG identifies 24 mislabeled or misfiled documents, the maximum points are lost, and the resulting score is zero. For the LAC medical inspection, inspectors identified a total of 17 documents with scanning errors. The errors consisted of documents that were scanned under the wrong date, were missing from the electronic medical file, or were incorrectly labeled (MIT 4.006).

- Among 25 sampled patients admitted to a community hospital and then returned to the institution, LACs providers timely reviewed only 14 patients' corresponding hospital discharge reports within three calendar days of the patient's discharge (56 percent). For one sampled patient, the provider reviewed the discharge report one day late; and ten reports did not include the patients' discharge dates (MIT 4.007).

- For 12 of 20 specialty service consultant reports sampled (60 percent), LAC staff scanned the reports into the patient's health record file within five calendar days. However, two documents were each scanned five days late, and six other reports were found only in RIS-PACS and not in the eUHR, which is contrary to CCHCS policy (MIT 4.003).

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

- LAC's medical records staff timely scanned miscellaneous, non-dictated documents such as provider progress notes, nursing initial health screening forms, and patient requests for health care services. Specifically, 17 of the 20 sampled documents (85 percent) were timely scanned into the patient's electronic health record within three calendar days of the patient's encounter. For two patients, a provider's progress note was scanned one day and two days

late, and for a third patient, a Health Care Services Request form was scanned three days late (MIT 4.001).

In the following two tests, the institution scored in the *proficient* range:

- LAC's medical records staff timely scanned medication administration records (MARs) into the patients' electronic health records in 17 of 19 samples tested (89 percent). Two MARs were scanned one day and four days late (MIT 4.005).

- The OIG inspectors tested 20 patients' discharge records to determine whether staff timely scanned the records into the patient's electronic health record, and all 20 samples were compliant (MIT 4.004).

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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. This component's score is based entirely on compliance testing results from visual observations the OIG clinicians make at the institution during their onsite visit.

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

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 70.8 percent in the *Health Care Environment* indicator and showed room for improvement in 5 of 11 test areas, as described below:

- The non-clinic bulk medical supply storage areas did not meet the supply management process and did not support the medical health care program's needs. The OIG clinicians observed multiple medical supplies either improperly stored on the floor or with expiration dates that had passed as noted by manufacturer guidelines (MIT 5.106).

- The institution received a score of 29 percent based on results from inspectors' examining emergency response bags in seven applicable clinics to determine whether clinical staff inspected the bags daily and inventoried them monthly, and whether the bags contained all essential items. Three clinics were missing monthly inventory logs, and at each location, the bag's oxygen tanks were not properly pressurized; at two clinics, staff on each watch did not always conduct daily inspections of the location's bag (MIT 5.111).

- Only four of ten clinic locations (40 percent) met compliance requirements for essential core medical equipment and supplies. The remaining six clinics were missing one or more functional pieces of properly calibrated core equipment or other medical supplies necessary to conduct a comprehensive examination. Missing items included an examination table, a nebulization unit, sharps container, an oto-ophthalmoscope, tongue depressors, lubricating jelly, and hemoccult cards and developer. In addition, an oto-ophthalmoscope charger did not have a recent calibration sticker (MIT 5.108).

- Only six of ten clinic examination rooms observed (60 percent) had appropriate space, configuration, supplies, and equipment to allow clinicians to perform proper clinical examinations. Two clinics were lacking portable screens for visual privacy. In addition, two other clinics contained examination tables with ripped vinyl coverings that could harbor infectious agents if not adequately disinfected (*Figure 1*) (MIT 5.110).

Figure 1: Exam table with torn vinyl

- In seven of the ten clinics inspected, clinical health care staff ensured that reusable invasive and non-invasive medical equipment was properly sterilized or disinfected (70 percent). While all ten clinics generally employed adequate non-invasive medical equipment disinfection protocols, three did not have adequate sterilization safeguards for invasive medical equipment. All three of these clinics did not properly process, package, or store previously sterilized instruments (MIT 5.102).

The following tests all scored in the *proficient* range:

- Staff appropriately disinfected, cleaned, and sanitized all ten sampled clinics; floor and sink areas were clean, and institution staff maintained cleaning logs in the most recent 30-day period reviewed (MIT 5.101).

- LAC's ten clinics were inspected to verify adequate hygiene supplies were available and sinks were operable; all clinics were compliant (MIT 5.103).

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

- All ten clinic common areas had an environment adequately conducive to providing medical services, with sufficient auditory privacy and adequate clinician workspace and patient waiting areas (MIT 5.109).

- The OIG inspectors observed health care clinicians in each clinic to ensure they employed proper hand hygiene protocols. In nine of ten clinics tested, LAC clinicians adhered to universal hand-hygiene precautions, scoring (90 percent). In one clinic, the OIG inspectors did observe a clinician failing these handwashing and sanitizing protocols both before and after patient contact (MIT 5.104).

- In nine clinics, staff followed protocols for managing and storing bulk medical supplies, scoring 90 percent for this test. However, one clinic was found to have stored medical supplies whose expiration dates had passed as noted by manufacturer guidelines. In addition,

personal items belonging to nursing staff were observed stored together with medical supplies (MIT 5.107).

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. The OIG does not score this question. When OIG clinicians interviewed health care managers, the latter did not identify any significant concerns. At the time of the OIG's medical inspection, LAC had several significant infrastructure projects underway, which included increasing clinic space at the central medical services building. These projects were started during fall 2016, and the institution estimated they will be completed by the end of summer 2017 (MIT 5.999).

6 — *INTER- AND INTRA-SYSTEM TRANSFERS*

Case Review Rating:
Proficient
Compliance Score:
Inadequate
(74.9%)

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 facility, the OIG evaluates the ability of the institution to document transfer information that includes pre-existing health conditions, pending appointments, tests and requests for specialty services, medication transfer packages, and medication administration prior to transfer. The OIG clinicians also evaluate the care provided to patients returning to the institution from an outside hospital and check to ensure appropriate implementation of the hospital assessment and treatment plans.

For this indicator, the case review and compliance scores yielded different results, with case review providing a *proficient* rating and compliance testing resulting in an *inadequate* score. The OIG's internal review process considered the factors that led to both results. Although the case review found strong performance in most areas, the compliance testing found concerns with the timeliness of care provided, specifically, in medication administration for newly arrived patients and the completion of initial health care assessment forms. As a result, the medical inspection team determined the overall rating for this indicator was *adequate*.

Case Review Results

Clinicians reviewed 57 encounters relating to system transfers, including information from both the sending and receiving institutions. These included 39 hospitalization events, each of which resulted in a transfer back to the institution. In general, the inter- and intra-system transfer processes at LAC were *proficient,* with eight deficiencies noted, none of which were significant.

Transfers In

Thirteen transfer-in events were reviewed. Nurses provided adequate care for patients transferring into the facility. Patients were referred appropriately and seen timely. Patients received medications without lapses in continuity.

Transfers Out

Five patients being transferred out were reviewed. While there were no significant deficiencies, there were minor deficiencies when nurses did not document transfer information thoroughly or omitted patient information. None of the deficiencies resulted in patient harm.

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, they are at risk due to potential lapses in care that can occur during any transfer. There were no significant deficiencies related to the 41 hospitalizations when patients returned to the facility.

Clinician Onsite Inspection

During the onsite visit, both TTA nurses and receiving and release nurses were interviewed. The nurses were not new to their patient-care areas and were knowledgeable about their clinical roles. They reported there were no major barriers in communication with nursing supervisors, providers, or custody officers regarding patient care needs.

Case Review Conclusion

The LAC clinical nursing team performed well with regard to *Inter- and Intra-System Transfers,* and any deficiencies were rare and minor. Patients transferring into LAC received their medications timely and were seen by the providers and specialists as scheduled. Thus, the indicator rating was *proficient.*

Compliance Testing Results

The institution received an *inadequate* score of 74.9 percent in the *Inter- and Intra-System Transfers* indicator, with the following tests scoring in the *inadequate* range:

- Among 20 sampled patients who transferred out of LAC to other CDCR institutions, only 10 had their scheduled specialty service appointments properly included on the health care transfer form (50 percent) (MIT 6.004).

- Of 25 sampled patients who transferred into LAC, only 16 had an existing medication order; of those 16, only 9 patients (56 percent) received their medications without interruption. Seven patients incurred medication interruptions of one or more dosing periods upon arrival (MIT 6.003).

- The OIG tested 25 patients who transferred into LAC from another CDCR institution to determine whether they received a complete initial health screening assessment from nursing staff on their day of arrival. LAC received a score of 68 percent for this test because nursing staff only answered all applicable questions on the initial health care screening for 17

patients. For eight patients, nurses neglected to answer one or more of the screening form questions (MIT 6.001).

The institution scored within the *proficient* range in the following two tests:

- Nursing staff timely completed the assessment and disposition sections of the initial health screening assessment form for all 30 patients (MIT 6.002).

- The OIG inspected the transfer packages of nine patients who were transferring out of the facility to determine whether the packages included required medications and support documentation. All six transfer packages were compliant (MIT 6.101).

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7 — *PHARMACY AND MEDICATION MANAGEMENT*

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(72.3%)

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 prescriber, staff, and patient.

For this indicator, the case review and compliance testing yielded different results, with case review providing an *adequate* rating and compliance testing resulting in an *inadequate* score. The OIG internal review process considered the factors that led to both results 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 evaluate pharmacy and medication management as secondary processes as they relate to the quality of clinical care provided. Compliance testing, a more targeted approach, is heavily relied on for this indicator's overall rating. The OIG clinicians evaluated 66 events related to medication management and found 17 deficiencies, 3 of which were significant.

Medication Continuity

In general, LAC performed adequately to ensure medication continuity.

Medication Administration

Nurses at LAC provided accurate and timely medication administration.

Pharmacy Errors

The OIG clinicians observed three significant pharmacy errors in the sampled cases reviewed.

- In case 1, a provider increased the metolazone dose (a diuretic medication prescribed for the patient's congestive heart failure), but the pharmacy did not fill the order.

- In case 4, the provider increased the patient's daily insulin dose, but the order was not completed.

- In case 10, a provider prescribed vitamin D and decreased the tacrolimus dose (an immune suppressor) as recommended by the liver consultant for a patient with a liver transplant. However, the patient did not receive the medications.

Clinician Onsite Inspection

During the onsite visit, patient care teams communicated well. In morning huddles, issues with medications were discussed. The medication nurse reported no problems with medication issues. The provider was informed of the medications needing refills in the next three days or over the weekend. Medications were renewed at that time, or provider visits were scheduled for reevaluation for the continued need for a medication.

Case Review Conclusion

LAC patient care teams performed well with regard to *Pharmacy and Medication Management,* and the indicator rating was thus *adequate.*

Compliance Testing Results

The institution received a compliance score of 72.3 percent in the *Pharmacy and Medication Management* indicator. For the following discussion purposes, 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 average score of 62.8 percent, an *inadequate* score, and showed room for improvement in the following areas:

- LAC timely provided hospital discharge medications to 9 of 25 sampled patients (36 percent). For the other 16 patients, the institution demonstrated one or more of the following deficiencies: medication administration was one to three days late, medication was late by one dosing interval, or there was no evidence of medication having been made available or administered (MIT 7.003).

- Among 19 sampled patients, 11 (58 percent) timely received chronic care medications. One patient missed three consecutive doses and more than 50 percent of his direct observation therapy (DOT) medication and received no provider counseling. For four patients, the MAR was not completed for a particular day's medication dosing interval. Two patients did not receive their keep-on-person (KOP) medication timely, and one patient had MARs missing for part of a month, so timely administration could not be established (MIT 7.001).

- Nursing staff administered medications without interruption to six of ten patients who were en route from one institution to another and had a temporary layover at LAC (60 percent). For four patients, there was no medical record evidence that their medications were administered as ordered (MIT 7.006).

- LAC ensured that 18 of 25 sampled patients (72 percent) received their medications without interruption when they transferred from one housing unit to another, but the remaining 7 patients did not receive their medications at the proper dosing interval (MIT 7.005).

The institution scored in the *proficient* range in the following area:

- The OIG clinicians noted that 22 of 25 sampled patients (88 percent) received their newly ordered medications in a timely manner. Yet for three patients, there was no MAR found of their medications having been administered (MIT 7.002).

Observed Medication Practices and Storage Controls

In this sub-indicator, the institution received a score of 57.9 percent, an *inadequate* score, and showed a need for improvement in the following areas:

- The institution employed adequate security controls over narcotic medications in only two of the eight applicable clinic and medication line locations at which narcotics were stored (25 percent). At five clinics, the narcotics logbook lacked evidence on multiple dates that two licensed nursing staff had performed a controlled-substance inventory. Two clinics did not immediately update their respective narcotics logbooks after administering narcotic medication. At one clinic, the OIG clinician found a tallying discrepancy during a spontaneous physical count of narcotic medications (MIT 7.101).

- LAC properly stored non-narcotic medications not requiring refrigeration at three of the nine applicable clinic and medication line storage locations (33 percent). At six locations, one or more of the following deficiencies were observed: the medication area lacked a designated location for return-to-pharmacy medications; and external and internal medications were not properly separated when stored (MIT 7.102).

- Only three of six inspected medication preparation and administration areas demonstrated appropriate administrative controls and protocols (50 percent). At four medication line locations, patients waiting to receive their medications did not have sufficient outdoor cover to protect them from heat or inclement weather. The OIG clinicians observed LAC nurses at two different locations who did not always ensure that a patient had swallowed DOT medications (MIT 7.106).

- Non-narcotic refrigerated medications were properly stored at only five of the nine clinics and medication line storage locations (56 percent). At four locations, one or more of the following deficiencies were observed: the medication refrigerator lacked a designated area

for return-to-pharmacy medications; and the temperature logbook was missing multiple entries during the most recent 60-day period (MIT 7.103).

The institution scored in the *adequate* range in the following area:

- Nursing staff at five of the six sampled medication preparation and administration locations (83 percent) followed proper hand-hygiene contamination control protocols during medication preparation and administrative processes. At one location, nursing staff did not wash or sanitize their hands as or when required, such as before re-gloving during medication administration passes (MIT 7.104).

The institution scored in the *proficient* range in the following area:

- Nursing staff at all six 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 99 percent, composed of scores received at the institution's main pharmacy, resulting in a *proficient* score in the following areas:

- In its main pharmacy, the institution followed general security, organization, and cleanliness management protocols; properly stored and monitored non-narcotic medications requiring refrigeration and those that did not; and maintained adequate controls over and properly accounted for narcotic medications (MIT 7.107, 7.108, 7.109, 7.110).

- The institution's pharmacist-in-charge (PIC) followed required protocols for 24 of the 25 reports reviewed (96 percent) that track medication errors and monthly statistics. For one medication error report, the PIC completed corresponding medication error follow-up reports three days late (MIT 7.111).

Non-Scored Tests

- In addition to testing reported medication errors, the OIG inspectors followed up on any significant medication errors found during compliance testing to determine whether those errors were properly identified and reported. The OIG provides those results for information purposes only; at LAC, the OIG found no applicable medication errors (MIT 7.998).

- The OIG interviewed patients in isolation units to determine whether they had immediate access to their prescribed KOP asthma rescue inhalers and nitroglycerin medications, and determined that all ten sampled patients did (MIT 7.999).

8 — *PRENATAL AND POST-DELIVERY SERVICES*

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

Because LAC was a male-only institution, this indicator did not apply.

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:
Inadequate
(65.8%)

Overall Rating:
Inadequate

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 *inadequate* range in the *Preventive Services* indicator, with a compliance score of 65.8 percent. The following areas showed room for improvement:

- LAC scored poorly in monitoring patients on TB medications. For all eight sampled patients, the institution either failed to complete monitoring at all the required intervals or failed to scan the monitoring forms into the patient's medical record in a timely manner (MIT 9.002).

- The institution scored poorly in administering TB medications on time. The OIG examined the health care records of eight patients who were taking TB medications during the inspection period, and only five of them received all of their required medications (63 percent). More specifically, one patient did not receive medication on the provider-scheduled day (received Tuesday rather than the ordered Monday). One patient received additional medications on unscheduled dates, had no medication administration record (MAR) found for two dates indicating administration, had an incomplete MAR for a dosing interval, and had a dose given on a day other than the scheduled day. Another patient had a MAR that was not completed for multiple administration intervals (MIT 9.001).

- The OIG clinicians examined the records of 30 sampled patients to determine whether they had been screened for TB within the prior year. Of this sampled group, 13 patients were classified as Code 22 (requiring a TB skin test in addition to a signs and symptoms check), 10 were classified as Code 34 (subject only to an annual signs and symptoms check), and 7 were tested under the current policy that does not include code distinctions. Of the 30 sampled patients, the institution timely and appropriately conducted TB screenings for only 19 of them (63 percent). More specifically, nurses properly screened 4 of the 15 sampled patients classified as Code 22, 8 of the 15 sampled patients classified as Code 34, and all of

the sampled patients classified under the current policy, which is not coded. The OIG clinicians identified the following various deficiencies (MIT 9.003):

- For nine of the patients classified as Code 22, one or more of the following deficiencies were found: a licensed vocational nurse (LVN) or psychiatric technician read the test results rather than an RN, public health nurse, or primary care provider as required by CCHCS policy in place at the time of the OIG clinicians' review; the timeliness of the reading could not be established because of missing administered (start) or read (end) dates and times to evidence that the TB test was completed within the 48- to 72-hour time frame; the reading itself was not timely; or the patient refused, and protocols were not followed for a refusal.

- For two patients classified as Code 34, nursing staff did not properly complete the required history section of the Tuberculin Testing/Evaluation Report (CDCR Form 7331).

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

- The OIG noted that 19 of 25 sampled patients (76 percent) either had received a normal colonoscopy within the preceding decade or had been offered a colorectal cancer screening in the previous 12 months. However, six patients' medical records contained no evidence that either a normal colonoscopy was performed within the preceding decade or that they were offered a colorectal cancer screening within the previous 12 months (MIT 9.005).

The institution scored in the *proficient* range in the following two tests:

- All 30 sampled patients either had received or were timely offered influenza vaccinations during the most recent influenza season (MIT 9.004).

- The OIG clinicians tested whether patients suffering from a chronic care condition were offered vaccinations for influenza, pneumonia, and hepatitis. Among the 14 sampled patients with applicable chronic conditions, 13 patients (93 percent) were timely offered the vaccinations. For one patient, however, there was no record that the influenza immunization was administered or offered in the last year (MIT 9.008).

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 on site, 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 the CTC are reported in the *Specialized Medical Housing* indicator and nursing services 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

OIG nursing clinicians rated the *Quality of Nursing Performance* at LAC *adequate*. The OIG clinicians reviewed 368 nursing encounters, of which 174 were outpatient nursing encounters. Most outpatient nursing encounters were for sick call requests, walk-in visits, and nursing follow-up. Of the 93 identified deficiencies related to nursing care performance, 8 were significant (cases 1, 4, 12, 17, 23, 25, 60, and 64).

Nursing Assessment/Documentation

The OIG clinicians found the majority of nursing care deficiencies was minor. Almost half of them were for incomplete assessments, primarily by nurses in the CTC and in the outpatient clinics. Nurses either did not ask patients to describe the symptoms related to their complaints or did not complete a physical examination of the patient. The indicator for *Specialized Medical Housing* provides an additional description of inpatient deficiencies.

Nursing Intervention

Nursing interventions, based on appropriate nursing assessment, include nursing actions, treatments, and referrals to help patients reach their health care goals, and alleviate illness and injury conditions. In general, nursing interventions at LAC were good. However, there were patterns of minor deficiencies found in the cases reviewed that are appropriate for targeted quality improvement strategies. For example, TTA nurses delayed calling local 9-1-1 emergency medical services from one to two hours for Code 2 non-emergent ambulance transports to community hospital emergency departments for a higher level of care in three cases; and outpatient clinic nurses

missed completing interventions, such as blood pressure checks in four cases and wound-care dressing changes in three cases. The indicators for *Emergency Services* and *Specialty Services* provide additional details.

Nursing Documentation

In general, nursing documentation at LAC was adequate, and for outpatient care, it was comprehensive and addressed specific needs of the patient. However, several patterns of minor nursing deficiencies demonstrated the need for training and monitoring strategies to improve nursing documentation processes. For example, some nurses did not specify the times when assessments and interventions were carried out, had time frame lapses in which no patient care was documented, and did not note the presence of intravenous medical devices. In the CTC, some nursing documentation was repetitive, and it did not include a current physical assessment of the patient or of the nursing care provided to the patient.

Sick Call

The OIG clinicians reviewed 45 sick call nursing encounters. Generally, nurses triaged sick call requests promptly, assessed patients timely, and provided good care. Most deficiencies were not considered significant, but reflected a pattern of practice that did not adhere to the sick call access standard required by CCHCS that a patient with medical complaints be assessed by an RN on the next business day after the request is reviewed. For example, minor deficiencies were found in four cases when sick call nurses referred patients directly to a provider without providing a face-to-face nursing assessment of the patient's complaints, and in three cases when nurses did not address each complaint when the patient had multiple complaints.

Care Management

The role of the RN primary care manager includes assessing patients, initiating appropriate interventions to support goals in the patient's treatment plan, and monitoring patients with chronic health needs and those at increased risk for developing serious health complications. Some LAC nurse care managers did not ensure that provider orders for medical treatments and monitoring chronic health conditions were implemented.

- In case 17, the provider requested daily vital signs' checks to monitor for possible infection in a patient receiving chemotherapy for cancer treatment, but his vital signs were not checked.

- In case 64, the provider requested daily wound care, but the care was not provided during four consecutive weekends and on two other week days.

Urgent/Emergent

Nurses' performance in the TTA was good. Significant deficiencies in emergency care are discussed in the *Emergency Services* indicator.

After Hospital Returns

The OIG clinicians reviewed 40 instances when patients returned to the institution following community hospital visits and identified no nursing deficiencies. Nurses assessed patients in the TTA when they returned from a hospital admission. Often, providers were available onsite to perform an evaluation on returning patients. There were no nursing deficiencies identified. Performance in this area is also discussed in the *Inter- and Intra-System Transfers* indicator.

Out-to-Medical Return and Specialty Care

The OIG clinicians reviewed 21 nursing encounters when patients returned from specialty pre-scheduled appointments and hospital admissions. At LAC, nurses assessed these returning patients in the TTA, and a provider was also often present in the TTA and evaluated patients. When there was no provider present in the TTA, nurses appropriately contacted the on-call provider about hospital discharge and specialty consultation recommendations. Additional details are described in the *Specialty Services* indicator summary.

Specialized Medical Housing

A total of 206 CTC encounters were reviewed by the OIG, of which almost half were nursing encounters. Nursing care in the CTC was good with no significant deficiencies. As in other areas of nursing services, patterns of incomplete nursing assessment, documentation, and interventions were identified. Some nursing documentation was cloned (copied from previous documentation), repetitive, and not reflective of the patient's current status and medical treatment in three cases. The *Specialized Medical Housing* indicator summary provides additional information.

Transfers and Reception Center

The OIG clinicians reviewed 18 patient encounters for transfers into and out of LAC, noting care provided at LAC during this process was adequate. Deficiencies were largely related to nursing staff not fully documenting pertinent patient information. The *Inter- and Intra-System Transfers* indicator summary offers more on this topic.

Medication Administration

Nurses at LAC performed adequately in medication administration. In general, nurses at LAC administered the correct medications within acceptable time frames. However, some nurses did not document the reasons for missed medication doses, obtain signed patient refusals for medications, or notify providers when patients missed three consecutive days or at least 50 percent of scheduled doses of nurse-administered medication within a seven-day period. Additional information is presented in the *Pharmacy and Medication Management* indicator summary.

Clinician Onsite Inspection

Both the director of nursing (DON) services and the CME met with the OIG clinicians, and answered all questions related to patient care and nursing operations. The OIG clinicians also

interviewed nurses from utilization management (UM), specialty services, telemedicine, receiving and release, and nursing education services. All nurses interviewed were knowledgeable about their clinical positions and had undergone cross-training for various nursing positions. The nurse educator (NE) was enthusiastic about both teaching in-service classes, and conducting annual training and emergency response training. The NE was also the emergency medical response coordinator who reviewed and critiqued emergency responses for review and discussion by the EMRRC.

The nurses in outpatient clinic settings were active participants in the primary care team's morning huddles. Providers, sick call nurses, mental health staff, schedulers, and other care team members attended the morning huddles. Medication line nurses attended the huddle via conference call. During the huddles observed, the huddle content was comprehensive and allowed time for discussion. Schedulers reported add-on appointments to the day's clinic schedule, including patients for follow-up in clinics, and the utilization management nurse reported on patients returning after hospital discharge. All participants contributed to the discussion by providing short, factual reports related to their specific areas of responsibility.

The OIG clinicians also visited clinics in each yard. Nurse staffing was appropriate for the patient acuity (intensity of nursing care required by a patient). Some yard clinics had two registered nurses, while others had three, depending on the patient population. The CTC had 16 licensed beds in addition to a safety cell and restraint room. Four beds were for patients with medical conditions, with the remaining beds occupied by mental health patients. Staffing in the CTC included three RNs and one psychiatric technician on each watch, and an additional LVN on second watch. Nurses carried keys to the patient cells to ensure the timeliness of medical emergency responses. The CTC staff expressed a need for more medical beds due to the increasing acuity of the institution's patient population. Nursing staff indicated that there were no major barriers to initiating communication with nursing supervisors, providers, or custody officers regarding patient care needs. Nurses expressed enthusiasm over their assignments and working conditions.

Case Review Conclusion

The OIG clinicians rated LAC's *Quality of Nursing Performance* indicator *adequate*. The number of nursing deficiencies represented a small fraction of the total deficiencies. The outpatient nursing care team demonstrated timely, appropriate nurse triage. There are opportunities for improvement in the nursing services provided at LAC in the areas of nursing documentation and nursing assessment. In general, significant nursing deficiencies were isolated and did not display a pattern of poor nursing practices.

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 is associated with this quality indicator.

Case Review Rating:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

Case Review Results

The OIG clinicians reviewed 246 medical provider encounters and identified 32 deficiencies related to provider performance. Most of those 32 deficiencies were considered minor deficiencies; however, 12 were significant (cases 1, 4, 10, 13, 15, 20, and two each in cases 21, 24, and 25). In general, LAC provider performance was rated *adequate*.

Assessment and Decision-Making

In most cases, the institution's providers made appropriate assessments and created sound medical plans. There was one minor deficiency:

- In case 2, a provider evaluated the patient and reviewed laboratory results, but did not acknowledge an elevated potassium level (5.4 mmol/L).

Emergency Care

Providers generally made appropriate triage decisions when patients presented emergently to the TTA. In addition, providers generally were available to consult with the TTA nursing staff. However, there was one significant deficiency identified related to provider care quality in emergency services. The case below is also discussed in the *Emergency Services* indicator:

- In case 1, the patient was taking the anticoagulant warfarin and had a critically high INR (laboratory test showing an excess level of warfarin) of 11.5; the provider failed to order the antidote, vitamin K. This would have lowered the risk of serious bleeding. Fortunately, no harm came to the patient because this occurred.

Chronic Care

Chronic care performance was adequate as most providers demonstrated good care in regard to hypertension, asthma, hepatitis C infection, and cardiovascular disease. LAC providers' thorough documentation showed sound assessments and plans. There was one minor deficiency:

- In case 3, the patient had a hepatitis C infection complicated by esophageal varices (fragile blood vessels). These required a surgical procedure (banding) and medication to reduce the bleeding. During the provider's encounter, the patient's examination indicated he was on an inadequate dose of medication to protect against bleeding.

The management of diabetes was poor at the institution. The OIG clinicians identified five significant deficiencies in diabetic care:

- In case 4, a provider prescribed and increased the long-acting insulin without assessing fasting blood glucose levels. This placed the patient at risk of low blood sugar.

- In case 24, during a period of nine months, HbA1C (a blood test that indicates the average level of blood sugar over the past two to three months) levels were not at goal (8.2 percent to 11.3 percent). The providers made only three medication adjustments instead of having the patient follow up more frequently.

- Also in case 24, a provider evaluated the patient with poorly controlled diabetes (HbA1C of 10.5 percent). This was a level at which insulin should have been started. The provider failed to start the insulin and also ordered an inappropriately long three-month follow-up appointment.

- In case 25, a nurse consulted with a provider for critically high blood glucose level (over 400 mg/dL). The provider failed to make a progress note as well as failed to order a follow-up on the following day.

- Also in case 25, the patient had high blood glucose; a provider appropriately ordered insulin and one liter of intravenous fluid. However, the provider failed to record a progress note, and no patient follow-up was made with a provider the following day.

The following diabetic care deficiencies were also identified:

- In case 7, a provider evaluated a diabetic patient for dizziness, but the provider did not check a blood glucose level to exclude a low blood sugar as the cause.

- In case 25, the provider should have prescribed a dose of insulin before dinner as the patient had an elevated blood glucose level after dinner, indicating a need for this treatment.

Although one provider failed to appropriately manage the sole TTA patient on blood-thinning medication (case 1 described above), most LAC patients had effective management, as the institution had a warfarin clinic. The main provider in this clinic appropriately monitored INR levels via laboratory tests to observe and adjust medications as necessary. The OIG noted one significant deficiency:

- In case 21, a provider should have withheld warfarin for at least five days prior to an upper gastrointestinal imaging surgical procedure (esophagogastroduodenoscopy (EGD)) with possible biopsies and banding of the fragile blood vessels in the esophagus. Subsequently on the day of the procedures, the gastroenterologist could not perform the procedure.

Specialty Services

LAC providers generally referred patients appropriately and reviewed specialty reports timely. The reports were properly signed by providers, and specialists' recommendations were timely addressed; however, there were four significant deficiencies:

- In case 10, a provider evaluated the patient after a liver transplant specialist's visit, but failed to recognize the patient had not received vitamin D and a decreased dose of an immunosuppressive drug per the hepatologist's recommendation.

- In case 15, a provider evaluated the patient with sickle cell disease after a recent hematology visit, but did not address the specialist's recommendations to obtain an echocardiogram and ophthalmology evaluation.

- In case 20, a provider evaluated the patient after a specialty visit, but did not address the diagnosis of vitreous (internal eye gel) detachment with a recommendation that the patient return to ophthalmology immediately if visual symptoms recurred.

- In case 21, a provider evaluated the patient after a recent EGD and did not recognize that variceal bandings were not done due to warfarin not being withheld for five days. The provider also did not address recommendations to follow up with the gastroenterologist in two weeks and to repeat the EGD in two months.

The following minor deficiencies were also identified:

- In case 8, the cardiologist recommended that the patient have no caffeine 24 hours prior to a stress test, but the provider did not address this recommendation. Subsequently, ten days later, the stress test was cancelled because the patient had consumed coffee the morning of the test.

- In case 17, the oncologist recommended obtaining a cystoscopy to assess for a possible bladder lesion; the provider saw the patient on the same day after the consultation, acknowledged the recommendation, and requested that the patient follow up with a provider in 30 days. The provider did not address the oncologist's recommendation, however, and should have requested that the patient be followed up sooner than 30 days to be assessed for possible cancer.

Health Information Management

The providers generally documented outpatient and TTA encounters on the same day. Most progress notes were dictated and generally legible.

Clinician Onsite Inspection

At the time of the OIG's inspection, there was no provider vacancy as one physician and two mid-level providers had recently been hired. All LAC providers were enthusiastic about their work and generally satisfied with nursing and specialty services; however, the providers expressed having difficulty in navigating RIS-PACS to review diagnostic reports. Each provider was mainly assigned to one clinic to assure continuity of care. The four medical clinics observed had adequate space needed to provide patient care with auditory privacy, and clinics had good lighting. Morning huddles were productive, were led by providers, and were attended by nurses, care coordinator, custody staff, and an office technician. The TTA had two beds and adequate space for patient evaluation, with working areas for both nurses and providers. The TTA also had ample lighting and was well-stocked with medications and medical equipment, such as an AED and an emergency crash cart.

The CME stated that LAC medical staff had not had adequate time to make appropriate adjustments as the Cycle 4 report for LAC was published in January 2017, and the OIG clinicians returned to LAC for the Cycle 5 inspection in April 2017—less than three months later. Both the CME and the CP&S were committed to patient care and quality improvement. The providers were supportive of the CME and expressed broad job satisfaction with their positions, and in general, morale was good.

Case Review Conclusion

The *Quality of Provider Performance* indicator was rated *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.

Because LAC did not have a reception center, 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. LAC's only specialized medical housing unit is a CTC.

Case Review Rating:
Adequate
Compliance Score:
Adequate
(85.0%)

Overall Rating:
Adequate

Case Review Results

The CTC at LAC is licensed for 16 beds (not including a safety cell and a restraint room). There were only four medical beds, and the remaining beds were for mental health patients. The OIG clinicians reviewed 206 provider and nurse CTC encounters, identifying 19 deficiencies, with none considered significant enough to contribute to patient harm. The OIG reviewed only medical patients. The CTC provided 24-hour skilled nursing care for treatment and rehabilitation after surgery, pain management, administration of intravenous medications, and end-of-life care.

Provider Performance

The OIG clinicians reviewed 43 provider encounters in the CTC and did not find any deficiencies. The providers timely visited CTC patients, addressed the specialists' recommendations, and made appropriate medical decisions.

Nursing Performance

There were no significant deficiencies in nursing care. However, the OIG identified patterns of incomplete nursing assessment and documentation in the CTC. At times, nursing documentation did not describe the care and condition of the patient.

Typed notes were almost identical from one day to the next and often repeatedly communicated misinformation, such as medicating a patient for bilateral hip pain when he had knee pain. Nursing progress notes were illegible in two cases throughout the patient's stay. However, because these deficiencies were not likely to contribute to patient harm and due to the small number of deficiencies, nursing care in the CTC was deemed *adequate*.

Clinician Onsite Inspection

The CTC was adequately staffed during the onsite visit. There were three RNs and one psychiatric technician working on each of the two shifts. The day shift had an LVN to assist the RNs with patient care. The RNs carried patient cell keys to timely assess the patients in emergency responses.

LAC is an intermediate medical facility providing care for patients with complex medical conditions, and there were only four CTC medical beds. The medical and nursing administrators

expressed a need for more medical beds to accommodate the increased complexity and the growing number of patients at this institution requiring 24-hour skilled nursing care.

Case Review Conclusion

The OIG clinicians observed patterns of deficiencies in nursing assessments and documentation. However, most of these deficiencies were considered minor and not likely contributing to patient harm. Nursing and provider care in the *Specialized Medical Housing* is rated *adequate*.

Compliance Testing Results

LAC received an *adequate* score of 85.0 percent in compliance testing for this indicator. In two of the four tests, the institution scored in the *proficient* range:

- For all five sampled patients, nursing staff timely completed an initial health assessment on the day the patient was admitted to the CTC (MIT 13.001).

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

The following test was assigned an *adequate* score:

- Providers performed a history and physical examination on four of the five sampled patients within 24 hours of admission to the CTC (80 percent). One patient's examination, however, was performed four days late (MIT 13.002).

Only one test received an *inadequate* score in this indicator:

- When the OIG clinicians tested whether providers had completed their Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes at the required three-day intervals, providers had completed timely SOAPE notes for three of the five sampled patients (60 percent), but for the remaining two patients, provider notes were one and two days late (MIT 13.003).

14 — *SPECIALTY SERVICES*

This indicator focuses on specialist care from the time a request for services or physician's order for specialist care is completed to the 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 Rating:
Inadequate
Compliance Score:
Inadequate
(69.8%)

Overall Rating:
Inadequate

Case Review Results

The OIG clinicians reviewed 155 events related to *Specialty Services*, which included 134 specialty consultations and procedures, and 21 nursing encounters. There were 22 deficiencies found in this category, of which 19 were significant. The case review rating is *inadequate* for this indicator.

Access to Specialty Services

Specialty appointments are integral aspects of specialty services. The OIG identified five significant deficiencies in which specialty appointments did not occur within the requested time frame or did not occur at all, placing the patients at risk of harm:

- In case 1, the patient had chronic kidney disease with edema (fluid retention); the nephrologist adjusted his diuretic medications and requested a patient follow-up in one week. A provider requested a nephrology follow-up in one week, but the appointment did not occur. Subsequently, one and a half months later, the patient was transferred to community hospital for severe edema and had multi-organ failure.

- Also in case 1, a provider requested a patient follow-up with nephrology in one to two weeks, but the appointment occurred one month later.

- In case 8, the patient had hemorrhoid surgery; a provider requested a gastroenterology follow-up in two weeks as recommended by the gastroenterologist, but the appointment occurred seven weeks later.

- In case 11, the patient had an exacerbation of ulcerative colitis (an inflammatory bowel disease); the gastroenterologist adjusted the patient's medications and recommended a follow-up appointment in 12 weeks for reassessment. A provider requested a patient follow-up with gastroenterology in 12 weeks, but the appointment did not occur.

- In case 21, the patient returned from hospitalization for severe anemia, requiring blood transfusion. The patient underwent an endoscopy (imaging of the digestive tract) with a recommended 14-day follow-up with the gastroenterologist, but the appointment did not occur.

Nursing Performance

Nursing care was good in assessments on patient return from offsite appointments, interventions, and documentation. However, there was one significant deficiency related to telemedicine nursing performance:

- In case 1, the telemedicine nursing staff did not provide the urinalysis and kidney ultrasound (imaging) results for the nephrologist to review. Thus the nephrologist requested to have the patient return in seven to ten days with the results.

Provider Performance

Case review showed that patients were generally referred to specialists appropriately by the providers. The providers addressed most of the specialists' recommendations, except on six occasions, and four of these six deficiencies were considered significant. These episodes are discussed further in the *Quality of Provider Performance* indicator.

Health Information Management

Health information management contributed to *Specialty Services* inadequacy because numerous specialty reports were not retrieved or scanned into the electronic medical record. Most of the radiology report deficiencies were due to the providers not seeking the reports in the appropriate electronic record repository, RIS-PACS. This is discussed in the *Diagnostic Services* indicator. The OIG clinicians identified nine significant deficiencies:

- In case 1, a kidney ultrasound was completed. A consulting nephrologist (kidney specialist) needed this ultrasound report. The health care staff facilitating the specialist appointment were unaware the report was available in the secondary electronic radiology health record, RIS-PACS. Health care staff therefore failed to retrieve the report to send it to the nephrologist. As a result, the ultrasound report was unavailable to the consulting nephrologist at the appointment.

- In case 7, the ophthalmologist performed a cataract extraction with lens implant, but the procedural note was not retrieved or scanned into the electronic health record.

- Also in case 7, the cardiology consultation and the pacemaker assessment reports were not retrieved or scanned into the electronic health record.

- In case 8, a cardiac nuclear stress test report was not retrieved or scanned into the electronic health record.

- In case 16, the patient with metastatic (spread) lung cancer had a bone scan. The provider saw the patient to review this test result. However, on the follow-up appointments, the provider was unaware the reports were available, and kept only in RIS-PACS. As a result, the provider twice re-scheduled the patient's follow-up appointment s, and the provider requested the results before each of the re-scheduled appointments.

- In case 18, an echocardiogram was performed, but the report was not completed. Subsequently, 6 weeks later, a provider requested the report, and 11 weeks later, another provider requested the report. The test was apparently never completed, as there was no RIS-PACS report.

- In case 22, an echocardiogram was performed, but the report was not retrieved or scanned from RIS-PACS into the electronic health record.

- There was one minor deficiency in case 12 due to a mislabeled specialty report.

Clinician Onsite Inspection

At the time of the OIG inspection, there were specialty service staff assigned to offsite, onsite, and telemedicine specialty services. They scheduled specialty appointments and made necessary orders and referrals. A tracking process was established to ensure that patients received their appointments. Most of the missed appointments were due to TTA and clinic staff not placing appropriate requests for specialty appointments.

Case Review Conclusion

The OIG clinicians rated this indicator *inadequate* because the numerous missed and delayed specialty appointments, and providers not reviewing specialty reports, hindered patient care.

Compliance Testing Results

The institution received an *inadequate* compliance score of 69.8 percent in the *Specialty Services* indicator.

In the following three areas, the institution received *inadequate* scores:

- 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 4 of the 20 sampled patients who transferred to LAC with an approved specialty service (20 percent) received their appointments within the required time frame. Of the remaining 16 sampled patients, 9 did not timely receive their previously approved services. The appointments ranged from 2 to 124 days late. Seven patients did not receive their appointments at all (MIT 14.005).

- When LAC ordered specialty services for patients, providers did not always review the specialists' reports within three business days after the service was performed. For high-priority specialty services, LAC providers timely reviewed specialists' reports for only 8 of the 14 applicable sampled patients (57 percent). For two patients, the reports were reviewed 9 and 11 days late, while another was 16 days late and reviewed by only the specialist. One other report showed no evidence of review, and another two reports were not found at all (MIT 14.002).

- Among 19 sampled patients, for whom LAC's health care management denied a specialty service, 12 patients (63 percent) received a timely notification of the denied service, including the provider meeting with the patient within 30 days to discuss alternate treatment strategies. For three patients, the provider's follow-up visit occurred 6 to 33 days late, and one other provider visit or notification occurred 129 days late. For three patients, no provider follow-up appointment occurred at all to discuss the denial (MIT 14.007).

In the following area, the institution received an *adequate* score:

- The institution timely denied providers' specialty service requests for 17 of 20 sampled patients (85 percent). The remaining three specialty services requests were denied from two to eight days late (MIT 14.006).

- For routine specialty services, providers timely reviewed specialists' reports for only 10 of 13 sampled patients (77 percent). Three patients' reports were reviewed one to nine days late (MIT 14.004).

The institution received a *proficient* score in the following two areas:

- For all 15 sampled patients, high-priority specialty service appointments occurred within 14 calendar days of the provider's order. In addition, for 15 different sampled patients, 13 (87 percent) received their routine specialty services appointments within 90 calendar days of the provider's order. For two patients, their routine specialty service appointments were two days late (MIT 14.001, 14.003).

15 — *ADMINISTRATIVE OPERATIONS (SECONDARY)*

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(62.6%)

Overall Rating:
Inadequate

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. The OIG clinicians also verify that the institution follows reporting requirements for adverse/sentinel events and patient deaths. The OIG verifies that the Emergency Medical Response Review Committee (EMRRC) performs required reviews and that staff perform required emergency response drills. The OIG clinicians also assess whether the Quality Management Committee (QMC) meets regularly and adequately addresses program performance. For those institutions with licensed facilities, the OIG clinicians 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 *inadequate* score for the *Internal Monitoring, Quality Improvement, and Administrative Operations* indicator, with a compliance score of 62.6 percent. The institution showed room for improvement in the following seven areas:

- The OIG reviewed the only reported adverse/sentinel event (ASE) that occurred at LAC during the prior six-month period, which required a root cause analysis and four monthly status reports per the plan of action. The event report was submitted to the ASE Committee of CCHCS three days late. As a result, LAC received a score of zero on this test (MIT 15.002).

- The institution did not take adequate steps to ensure the accuracy of its Dashboard data and did not provide substantial evidence of a discussion of the methodologies used to conduct periodic data validation, the results of that data validation testing, or the methodologies used to train staff who collected Dashboard data. Therefore, LAC received a score of zero (MIT 15.004).

- LAC's local governing body met quarterly during the four-quarter period ending January 2017, but none of the meeting minutes evidenced discussion of general management and planning processes consistent with CCHCS policies and other directives. Additionally, one month's minutes were approved five days late. These deficiencies resulted in a score of zero (MIT 15.006).

- LAC hired seven nurses within the last 12 months. Of these, five nurses received their orientation 23 days late based on the allowable time frame (MIT 15.111).

- The OIG clinicians inspected records from January 2017 for five nurses to determine whether their nursing supervisors had properly completed monthly performance reviews. The following deficiencies were identified in this group's monthly nursing reviews (20 percent) (MIT 15.104):

    - The supervisor did not complete the required number of reviews for four nurses;

    - The supervisor's review did not summarize aspects that were well done for two nurses.

- The institution did not meet the emergency response drill requirements for the most recent quarter for two of its three watches, resulting in a score of 33 percent. More specifically, the institution's second and third watch drill packages did not contain a Medical Report of Injury or Unusual Occurrence (CDCR Form 7219) as required by CCHCS policy (MIT 15.101).

- The OIG reviewed data received from the institution to determine whether LAC timely processed at least 95 percent of its monthly patient medical appeals during the most recent 12-month period. LAC timely processed only 6 of the 12 months' appeals reviewed (50 percent). Of the six months that showed more than 5 percent of medical appeals in an overdue status, percentages ranged from 8 percent to 18 percent (MIT 15.001).

In the following two areas, LAC received *adequate* scores:

- Medical staff reviewed and timely submitted the Initial Inmate Death Report (CDCR Form 7229A or CDCR Form 7229B) to the Death Review Unit of CCHCS for eight of ten cases tested, resulting in a score of 80 percent. In two cases, LAC did not submit a completed CDCR Form 7229B as required for suicide deaths (MIT 15.103).

- Eight of the ten nurses sampled (80 percent) were current on their clinical competency validations. Two nurses did not receive a clinical competency validation within the required time frame (MIT 15.105).

In the following eight areas, LAC scored in the *proficient* range:

- The institution's QMC met monthly, evaluated program performance, and took action when management identified areas for improvement opportunities (MIT 15.003).

- The OIG inspected incident package documentation for 12 emergency medical responses reviewed by LAC's EMRRC during the prior six-month period; all 12 of the 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).

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

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

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

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

Non-Scored Results

- The OIG gathered non-scored data regarding the completion of death review reports by the Death Review Committee (DRC) of CCHCS. Ten deaths occurred during the OIG's review period. The DRC is required to complete death review summaries within 30 or 60 days of death, depending on whether the death was expected or unexpected, and then notify the institution's CEO of the review results within 7 days so that any corrective action may be promptly pursued. However, the DRC completed its report for the 10 deaths reviewed from 3 to 148 days late (50 to 208 days after the death) and submitted it to LAC's CEO from 8 to 156 days later (75 to 223 days after the death) (MIT 15.998).

- The OIG discusses the institution's health care staffing resources in the *About the Institution* section on page *1* (MIT 15.999).

RECOMMENDATIONS

The OIG recommends training of all health care staff in how to use RIS-PACS to allow appropriate patient care, and to consider discipline, when appropriate, for staff who continue to miss timely report review in RIS-PACS.

The OIG recommends nursing administrators develop a process to implement the CCHCS policy requiring administrators evaluate nursing assessments and nursing documentation.

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. More than 90 percent of the nation's health plans as well as many leading employers and regulators use this dataset. 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. HEDIS 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 eUHR, the Master Registry (maintained by CCHCS), as well as a random sample of patient records analyzed and abstracted by trained personnel. Data obtained from the CCHCS Master Registry and Diabetic Registry was not independently validated by the OIG and is presumed to be accurate. For some measures, the OIG used the entire population rather than statistically random samples. While the OIG is not a certified HEDIS compliance auditor, the OIG uses similar methods to ensure that measures are comparable to those published by other organizations.

Comparison of Population-Based Metrics

For California State Prison, Los Angeles County, nine HEDIS measures were selected for comparison; these are listed in the following table, *LAC Results Compared to State and National HEDIS Scores*. Multiple health plans publish their HEDIS performance measures at the state and national levels. The OIG has provided selected results for several health plans in both categories for comparative purposes.

Results of Population-Based Metric Comparison

Comprehensive Diabetes Care

For chronic care management, the OIG chose measures related to the management of diabetes. Diabetes is the most complex common chronic disease requiring a high level of intervention on the part of the health care system in order to produce optimal results. LAC's management of diabetes was comparable to the other state and national health care plans.

When compared statewide, LAC outperformed Medi-Cal in all five diabetic measures. LAC outperformed Kaiser North in two of the five diabetic measures, but was less effective in measuring for diabetes under good control, blood pressure control, and eye exams. The institution performed better than Kaiser South in three of the five diabetic measures, but worse for blood pressure control and eye exams.

Nationally, LAC outperformed Medicaid and commercial health plans in all five of the diabetic measures reviewed. When compared to Medicare and the United States Department of Veterans Affairs (VA), the institution performed better or matched both health plans in four of the five diabetic measures, but the institution performed less well for eye exams when compared to both Medicare and the VA.

Immunizations

Comparative data for immunizations was fully available for only the VA and partially available for Kaiser, commercial plans, Medicaid, and Medicare. With respect to administering influenza vaccinations to younger adults, LAC performed worse than Kaiser, commercial plans, and the VA, but outperformed Medicaid. However, the 47-percent patient refusal rate for vaccinations negatively affected the institution's score for this measure. When administering influenza vaccinations to older adults, LAC outperformed Medicare and matched the VA. With regard to administering pneumococcal vaccines to older adults, the institution scored better than Medicare, but performed less well when compared to the VA.

Cancer Screening

With respect to colorectal cancer screening, LAC was outperformed when compared to Kaiser, Medicare, and the VA, but performed better than commercial plans. However, the 27-percent patient refusal rate negatively affected the institution's score for this measure.

Summary

LAC's population-based metrics performance was generally adequate when compared to the two statewide and four national health plans. The institution's scores would be higher, compared to the other statewide and national health plans, if patient refusals for vaccinations and cancer screenings had been lower. The institution can improve its score through patient education concerning the benefits of these preventive services.

LAC Results Compared to State and National HEDIS Scores

Clinical Measures	California				National			
	LAC 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]	**19%**	39%	20%	23%	45%	34%	27%	19%
HbA1c Control (<8.0%)[6]	**68%**	49%	70%	63%	46%	55%	63%	-
Blood Pressure Control (<140/90)	**76%**	63%	83%	83%	59%	60%	62%	74%
Eye Exams	**62%**	53%	68%	81%	53%	54%	69%	89%
Immunizations								
Influenza Shots - Adults (18–64)	**44%**	-	56%	57%	39%	48%	-	55%
Influenza Shots - Adults (65+)	**76%**	-	-	-	-	-	72%	76%
Immunizations: Pneumococcal	**88%**	-	-	-	-	-	71%	93%
Cancer Screening								
Colorectal Cancer Screening	**66%**	-	79%	82%	-	63%	67%	82%

1. Unless otherwise stated, data was collected in March 2017 by reviewing medical records from a sample of LAC'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 2016 reports for the Northern and Southern California regions.

4. National HEDIS data for Medicaid, commercial plans, and Medicare was obtained from the 2016 *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 LAC population was tested.

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

APPENDIX A — COMPLIANCE TEST RESULTS

California State Prison, Los Angeles County Range of Summary Scores: 58.52% – 85.00%	
Indicator	**Compliance Score (Yes %)**
1 – ***Access to Care***	73.11%
2 – ***Diagnostic Services***	58.52%
3 – ***Emergency Services***	Not Applicable
4 – ***Health Information Management (Medical Records)***	69.94%
5 – ***Health Care Environment***	70.78%
6 – ***Inter- and Intra-System Transfers***	74.85%
7 – ***Pharmacy and Medication Management***	72.32%
8 – ***Prenatal and Post-Delivery Services***	Not Applicable
9 – ***Preventive Services***	65.78%
10 – ***Quality of Nursing Performance***	Not Applicable
11 – ***Quality of Provider Performance***	Not Applicable
12 – ***Reception Center Arrivals***	Not Applicable
13 – ***Specialized Medical Housing***	85.00%
14 – ***Specialty Services***	69.84%
15 – ***Administrative Operations***	62.55%

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?	9	16	25	36.00%	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?	19	6	25	76.00%	0
1.003	Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received?	35	0	35	100%	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?	10	8	18	55.56%	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?	2	0	2	100%	33
1.007	Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame?	15	10	25	60.00%	0
1.008	Specialty service follow-up appointments: Do specialty service primary care physician follow-up visits occur within required time frames?	8	16	24	33.33%	6
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:					**73.11%**	

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?	8	2	10	80.00%	0
2.002	Radiology: Did the primary care provider review and initial the diagnostic report within specified time frames?	0	10	10	0.00%	0
2.003	Radiology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	4	6	10	40.00%	0
2.004	Laboratory: Was the laboratory service provided within the time frame specified in the provider's order?	8	2	10	80.00%	0
2.005	Laboratory: Did the primary care provider review and initial the diagnostic report within specified time frames?	5	5	10	50.00%	0
2.006	Laboratory: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	5	5	10	50.00%	0
2.007	Pathology: Did the institution receive the final diagnostic report within the required time frames?	6	4	10	60.00%	0
2.008	Pathology: Did the primary care provider review and initial the diagnostic report within specified time frames?	9	0	9	100%	1
2.009	Pathology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	6	3	9	66.67%	1
Overall percentage:					**58.52%**	

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?	17	3	20	85.00%	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?	12	8	20	60.00%	0
4.004	Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge?	20	0	20	100%	5
4.005	Are medication administration records (MARs) scanned into the patient's electronic health record within the required time frames?	17	2	19	89.47%	6
4.006	During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files?	7	17	24	29.17%	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?	14	11	25	56.00%	0
Overall percentage:					**69.94%**	

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?	10	0	10	100%	0
5.102	Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	7	3	10	70.00%	0
5.103	Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	10	0	10	100%	0
5.104	Does clinical health care staff adhere to universal hand hygiene precautions?	9	1	10	90.00%	0
5.105	Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	10	0	10	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?	9	1	10	90.00%	0
5.108	Do clinic common areas and exam rooms have essential core medical equipment and supplies?	4	6	10	40.00%	0
5.109	Do clinic common areas have an adequate environment conducive to providing medical services?	10	0	10	100%	0
5.110	Do clinic exam rooms have an adequate environment conducive to providing medical services?	6	4	10	60.00%	0
5.111	Emergency response bags: Are TTA and clinic emergency medical response bags inspected daily and inventoried monthly, and do they contain essential items?	2	5	7	28.57%	3
Overall percentage:					**70.78%**	

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?	17	8	25	68.00%	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?	24	0	24	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?	9	7	16	56.25%	9
6.004	For patients transferred out of the facility: Were scheduled specialty service appointments identified on the patient's health care transfer information form?	10	10	20	50.00%	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	0	6	100%	2
Overall percentage:					**74.85%**	

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?	11	8	19	57.89%	6
7.002	Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames?	22	3	25	88.00%	0
7.003	Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames?	9	16	25	36.00%	0
7.004	For patients received from a county jail: Were all medications ordered by the institution's reception center provider administered, made available, or delivered to the patient within the required time frames?	Not Applicable				
7.005	Upon the patient's transfer from one housing unit to another: Were medications continued without interruption?	18	7	25	72.00%	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?	6	4	10	60.00%	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%	2
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?	3	6	9	33.33%	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?	5	4	9	55.56%	1
7.104	Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes?	5	1	6	83.33%	4
7.105	Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients?	6	0	6	100%	4
7.106	Medication preparation and administration areas: Does the Institution employ appropriate administrative controls and protocols when distributing medications to patients?	3	3	6	50.00%	4
7.107	Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and satellite pharmacies?	1	0	1	100%	0

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?	1	0	1	100%	0
7.109	Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications?	1	0	1	100%	0
7.110	Pharmacy: Does the institution's pharmacy properly account for narcotic medications?	1	0	1	100%	0
7.111	Does the institution follow key medication error reporting protocols?	24	1	25	96.00%	0
Overall percentage:					**72.32%**	

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?	5	3	8	62.5%	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?	0	8	8	0.00%	0
9.003	Annual TB Screening: Was the patient screened for TB within the last year?	19	11	30	63.33%	0
9.004	Were all patients offered an influenza vaccination for the most recent influenza season?	25	0	25	100%	0
9.005	All patients from the age of 50 - 75: Was the patient offered colorectal cancer screening?	19	6	25	76.00%	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?	Not Applicable				
9.007	Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy?	Not Applicable				
9.008	Are required immunizations being offered for chronic care patients?	13	1	14	92.86%	11
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:					**65.78%**	

10 – *Quality of Nursing Performance*

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

11 – *Quality of Provider Performance*

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

12 – *Reception Center Arrivals*

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

Reference Number	13 – *Specialized Medical Housing*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient on the day of admission, or within eight hours of admission to CMF's Hospice?	5	0	5	100%	0
13.002	For CTC and SNF only: Was a written history and physical examination completed within the required time frame?	4	1	5	80.00%	0
13.003	For OHU, CTC, SNF, and Hospice: Did the primary care provider complete the Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes on the patient at the minimum intervals required for the type of facility where the patient was treated?	3	2	5	60.00%	0
13.101	For OHU and CTC Only: Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter patient's cells?	1	0	1	100%	0
Overall percentage:					**85.00%**	

Reference Number	14 – *Specialty Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	Did the patient receive the high priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service?	15	0	15	100%	0
14.002	Did the primary care provider review the high priority specialty service consultant report within the required time frame?	8	6	14	57.14%	1
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?	13	2	15	86.67%	0
14.004	Did the primary care provider review the routine specialty service consultant report within the required time frame?	10	3	13	76.92%	2
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?	4	16	20	20.00%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	17	3	20	85.00%	0
14.007	Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame?	12	7	19	63.16%	0
Overall percentage:					**69.84%**	

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?	6	6	12	50.00%	0
15.002	Does the institution follow adverse / sentinel event reporting requirements?	0	1	1	0.00%	0
15.003	Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified?	6	0	6	100%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	0	1	1	0.00%	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?	0	4	4	0.00%	0
15.101	Did the institution complete a medical emergency response drill for each watch and include participation of health care and custody staff during the most recent full quarter?	1	2	3	33.33%	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?	8	2	10	80.00%	0
15.104	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	1	4	5	20.00%	0
15.105	Are nursing staff who administer medications current on their clinical competency validation?	8	2	10	80.00%	0
15.106	Are structured clinical performance appraisals completed timely?	9	0	9	100%	0
15.107	Do all providers maintain a current medical license?	13	0	13	100%	2
15.108	Are staff current with required medical emergency response certifications?	2	0	2	100%	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?	7	0	7	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?	1	0	1	100%	0
15.111	Are nursing staff current with required new employee orientation?	0	1	1	0.00%	0
Overall percentage:					**62.55%**	

APPENDIX B — CLINICAL DATA

Table B-1: LAC Sample Sets

Sample Set	Total
Anticoagulation	3
CTC/OHU	4
Death Review/Sentinel Events	3
Diabetes	3
Emergency Services – CPR	5
Emergency Services – Non-CPR	3
High Risk	5
Hospitalization	4
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	24
Specialty Services	4
	64

Table B-2: LAC Chronic Care Diagnoses

Diagnosis	Total
Anemia	7
Anticoagulation	4
Arthritis/Degenerative Joint Disease	7
Asthma	13
COPD	9
Cancer	12
Cardiovascular Disease	18
Chronic Kidney Disease	6
Chronic Pain	28
Cirrhosis/End-Stage Liver Disease	13
Deep Venous Thrombosis/Pulmonary Embolism	2
Diabetes	21
Gastroesophageal Reflux Disease	20
Gastrointestinal Bleed	3
Hepatitis C	24
HIV	4
Hyperlipidemia	25
Hypertension	33
Mental Health	16
Seizure Disorder	8
Thyroid Disease	2
	275

Table B-3: LAC Event — Program

Program	Total
Diagnostic Services	224
Emergency Care	68
Hospitalization	71
Intra-System Transfers in	13
Intra-System Transfers out	5
Not Specified	1
Outpatient Care	501
Specialized Medical Housing	205
Specialty Services	217
	1,305

Table B-4: LAC Review Sample Summary

	Total
MD Reviews, Detailed	25
MD Reviews, Focused	0
RN Reviews, Detailed	18
RN Reviews, Focused	36
Total Reviews	79
Total Unique Cases	64
Overlapping Reviews (MD & RN)	15

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

California State Prison, Los Angeles County (LAC)

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 (20)	OIG Qs: 1.001, 1.002, & 1.004	• Non-dictated documents • 1st 10 IPs MIT 1.001, 1st 5 IPs MITs 1.002, 1.004
MIT 4.002	(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	(19)	OIG Q: 7.001	• MARs • First 20 IPs selected
MIT 4.006	(17)	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.007	Returns From Community Hospital (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 (10)	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 (20)	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 (10)	SOMS	• Date of transfer (2–8 months) • Sending institution (another CDCR facility) • **Randomize** • NA/DOT meds
MITs 7.101–103	Medication Storage Areas (varies by test)	OIG inspector onsite review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–106	Medication Preparation and Administration Areas (varies by test)	OIG inspector onsite review	• Identify and inspect onsite clinical areas that prepare and administer medications
MITs 7.107–110	Pharmacy (1)	OIG inspector onsite review	• Identify & inspect all onsite pharmacies
MIT 7.111	Medication Error Reporting (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 (10)	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 Codes, Annual Screening (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Codes • **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 (5)	CADDIS	• Admit date (1–6 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • **Randomize**
MIT 13.101	Call Buttons CTC (all)	OIG inspector onsite review	• Review by location
Specialty Services			
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 (9)	InterQual	• Review date (3–9 months) • **Randomize**
	(11)	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 (1)	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 (4)	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 (10)	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 (9)	Onsite provider evaluation files	• All required performance evaluation documents
MIT 15.107	Provider licenses (13)	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 (10)	OIG summary log - deaths	• Between 35 business days & 12 months prior • CCHCS death reviews

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

September 5, 2017

Roy Wesley, Inspector General (A)
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 California State Prison, Los Angeles County (LAC) conducted from March 2017 to May 2017. California Correctional Health Care Services (CCHCS) acknowledges all OIG findings.

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

Sincerely,

Janet Lewis

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

cc: Clark Kelso, Receiver
Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Richard Kirkland, Chief Deputy Receiver
Ryan Baer, Senior Deputy Inspector General, OIG
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