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Inspector General

Office of the Inspector General

Mule Creek State Prison
Medical Inspection Results
Cycle 4

May 2016

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

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EXECUTIVE SUMMARY

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

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

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

The OIG performed its Cycle 4 medical inspection at MCSP from December 2015 to February 2016. The inspection included in-depth reviews of 65 inmate-patient files conducted by clinicians, as well as reviews of documents from 402 inmate-patient files, covering 92 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 MCSP using 14 health care quality indicators applicable to the institution, made up of 12 primary clinical indicators and two secondary administrative indicators. To conduct clinical case reviews, the OIG employs a clinician team consisting of a physician and a registered nurse consultant, while compliance testing is done by a team of deputy inspectors general trained in monitoring medical compliance. Of the 12 primary indicators, seven were rated by both case review clinicians and compliance inspectors, three were rated by case review clinicians only, and two were rated by compliance inspectors only; both secondary indicators were rated by compliance inspectors only. See the *Health Care Quality Indicators* table on page ii. Based on that analysis, OIG experts made a considered and measured overall opinion that the quality of health care at MCSP was *inadequate*.

Health Care Quality Indicators

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

Overall Assessment: Inadequate

Overall Assessment Rating:

Inadequate

Based on the clinical case reviews and compliance testing, the OIG's overall assessment rating for MCSP was *inadequate*. Of the 12 primary (clinical) quality indicators applicable to MCSP, the OIG found one *adequate* and 11 *inadequate*. Of the two secondary (administrative) quality indicators, the OIG found both *inadequate*. To determine the overall assessment for MCSP, the OIG considered individual clinical ratings and individual compliance question scores within each of the indicator categories, putting emphasis on the primary indicators. Based on that analysis, OIG experts made a considered and measured overall opinion about the quality of health care observed at MCSP.

Clinical Case Review and OIG Clinician Inspection Results

The clinicians' case reviews sampled patients with high medical needs and included a review of more than 1,016 patient care events.[1] Of the 12 primary indicators applicable to MCSP, ten were evaluated by clinician case review; none was *proficient*, one was *adequate*, and nine 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, for MCSP, the adequate provider performance could not overcome the many serious systemic inadequacies.

Program Strengths — Clinical

Hepatitis C management was proficient at MCSP. MCSP had designated two providers to deliver coordinated specialty care for hepatitis C and HIV patients. With severe provider shortages elsewhere in the institution, the management decision to dedicate two providers to specialty services was questionable. However, the resultant care for hepatitis C patients was very good.

Program Weaknesses — Clinical

MCSP demonstrated markedly *inadequate* access to care.

- MCSP could not meet the population's demand for the medical services, as evidenced by severe problems with access to care in nearly all aspects reviewed. Provider follow-ups regularly occurred late or did not occur at all. RN sick call access was inadequate. MCSP could not provide timely access to care for patients transferring into the institution, or provide reliable follow-up care for those patients who had abnormal diagnostic test results. At the onsite inspection, the presence of severe backlogs on the provider schedules and even intermittent backlogs on the sick call nursing schedules corroborated the case review findings.

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

- MCSP had a severe shortage of physicians. Despite efforts, the institution was unable to hire and retain qualified physicians throughout 2015. MCSP had two physician vacancies the institution could not adequately fill throughout most of 2015, as well as five additional physician vacancies for the infill expansion that started in February 2016. The chief physician and surgeon (CP&S) had recently hired a nurse practitioner due to the inability to hire qualified physicians. In addition to actual physician vacancies, MCSP had some functional vacancies among its existing providers. One provider was given excessive time off out of concern that the provider would choose to retire if the time off was not granted. Another provider was on intermittent medical leave throughout the case review period.

- At the OIG clinician onsite inspection in February 2016, MCSP nurse managers explained that nursing staff vacancies were high during the review period. The managers estimated that through much of 2015, MCSP had a vacancy rate of over 40 percent among line nursing staff. Nursing managers told the OIG clinicians that they had some recent success in hiring nurses, and that the vacancy rate had significantly decreased.

- At the OIG clinician onsite inspection, multiple MCSP health care managers remarked that many of MCSP's existing challenges were attributable to the opening of the California Health Care Facility (CHCF) in Stockton in 2013. The MCSP CEO agreed with that assessment, and informed the OIG clinicians that approximately 25 percent of its entire health care staff had transferred to CHCF in 2013.

MCSP lacked critical health care leadership and demonstrated inadequate supervision of existing health care staff.

- The OIG case review period was from July through December 2015; for half of that period, MCSP's chief medical executive (CME) position was vacant. MCSP did not appoint a physician executive as acting CME until February 2016, when the OIG clinicians conducted their onsite inspection.

- During most of the OIG case review period, MCSP's chief nurse executive (CNE) position experienced frequent turnover. At the time of the OIG clinician onsite inspection, MCSP had no permanent CNE, and the acting CNE did not plan to remain at MCSP for an extended period.

- At the OIG clinician onsite inspection, MCSP nurse managers estimated that the nurse manager and supervisory vacancy rate was approximately 45 percent throughout most of 2015.

- The OIG clinicians attributed the widespread inadequate nursing performance to inadequate nursing supervision. Sick call nurses regularly failed to triage requests appropriately and often failed to assess patients face to face when clinically indicated. In addition, nurses failed to recognize the need for same-day nursing assessments or provider evaluations for

those patients with serious requests. Nurses made numerous errors in administering warfarin, a critical blood-thinning medication that prevents blood clots. Nurses performed superficial assessments and made errors with patients returning from outside specialty services or community hospitals. Wound care documentation was so poor that in some cases, it was impossible for the OIG clinicians to determine that any wound care occurred at all. Although nurse training files showed that staff were current and up to date, individual interviews with nursing staff revealed that nurses felt that they had not received adequate training specific to their responsibilities in their assigned areas. Up-to-date nurse performance evaluations were missing in four out of ten nurse supervisory files reviewed.

- Provider supervision was also inadequate. Out of ten provider files examined, only one contained an up-to-date annual performance appraisal. Review of the provider annual clinical appraisals showed that those performed by MCSP on its own providers were superficial. During the onsite inspection, some providers voiced complaints about the lack of monitoring and supervision.

- MCSP health care staff exhibited low morale. Nurses attributed their low morale to staffing shortages, which resulted in redirections and mandatory overtime. Physicians attributed their low morale to the excessive workload, with perpetual scheduling backlogs that only seemed to get worse. Physicians also complained of burnout and a lack of leadership. During the onsite inspection, even custody officers stopped the OIG clinicians to express their concern for the low morale of the health care staff.

Compliance Testing Results

Of the 14 total health care indicators applicable to MCSP, 11 were evaluated by compliance inspectors.[2] There were 92 individual compliance questions within those 11 indicators, generating 1,235 data points, testing MCSP's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[3] Those 92 questions are detailed in *Appendix A — Compliance Test Results*. The institution's inspection scores for the 11 applicable indicators ranged from 51.1 percent to 84.4 percent, with the secondary (administrative) indicator *Internal Monitoring, Quality Improvement, and Administrative Operations* receiving the lowest score, and the primary (clinical) indicator *Diagnostic Services* receiving the highest. Of the nine primary indicators applicable to compliance testing, the OIG rated none *proficient*, three *adequate*, and six *inadequate.* Of the two secondary indicators, which involve administrative functions, both were rated *inadequate*.

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

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

Program Strengths — Compliance

As the *MCSP Executive Summary Table* on page viii indicates, none of the institution's compliance ratings were *proficient*, scoring above 85 percent, in any of the indicators. However, the following are some of MCSP's strengths based on its compliance scores on individual questions in both the primary and secondary health care indicators:

- All patients sampled timely received their radiology services, and providers timely reviewed the diagnostic reports and communicated the results to patients.

- The institution offered timely influenza vaccinations and colorectal cancer screenings to applicable patients.

Program Weaknesses — Compliance

The institution received ratings of *inadequate*, scoring below 75 percent, in the following six primary indicators: *Access to Care*, *Health Information Management, Health Care Environment*, *Pharmacy and Medication Management*, *Preventive Services*, and *Specialty Services*. The institution also received *inadequate* scores in both secondary indicators, *Internal Monitoring, Quality Improvement, and Administrative Operations*; and *Job Performance, Training, Licensing, and Certifications*. The following are some of the weaknesses identified by MCSP's compliance scores on individual questions in all the primary health care indicators:

- Providers did not conduct timely appointments with most of the patients the OIG sampled. This included patients who required a PCP follow-up visit for chronic care conditions; patients who required a follow-up visit after receiving a specialty service; and patients who had been referred to a PCP by nursing staff due to the patient's request for service, or upon the patient's transfer to MCSP from another institution.

- Health records staff did not always properly label or file documents into patients' electronic health records, and clinicians' signatures on health care records were often illegible.

- Daily cleaning logs for most clinics showed lapses in scheduled cleaning; some clinics' exam room floors were dirty. Also, monthly inventory logs were not maintained for clinics' emergency response bags.

- Clinical staff did not always utilize universal hand hygiene precautions before or after patient encounters, or practice proper hand hygiene contamination protocols during medication preparation and administration processes.

- In most clinics, essential equipment and supplies were missing in exam rooms and common areas.

- Clinician exam rooms lacked visual privacy for patients, and clinic common areas where blood draws and patient triage services were provided lacked auditory privacy for patients.

- For many patients sampled, nursing staff did not timely deliver or administer prescribed medications, failed to timely adjust the dosage of medications when ordered, and failed to discontinue or re-start medications when ordered. This included sampled patients who were randomly selected, those who suffered with chronic care conditions, those who returned to the institution from a community hospital, and those who transferred into MCSP from other CDCR institutions.

- Clinical staff did not employ strong security controls over narcotic medications assigned to clinical areas and did not follow proper protocols for storing non-narcotic medications.

- Nursing staff did not follow required protocols for administering and reading inmate-patients' annual tuberculosis skin tests, and did not properly administer anti-tuberculosis medications to those who tested positive for tuberculosis.

- Providers did not timely review patients' high-priority and routine specialty services reports.

- The institution did not timely deny providers' specialty service requests, and providers did not timely communicate those denials to the patients.

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

- Emergency Medical Response Review Committee incident review packages and emergency response drill packages lacked required documentation.

- Clinical supervisors did not complete structured performance appraisals of providers and appropriate periodic reviews of nursing staff.

- Nursing staff did not always receive new employee orientation training within 60 days of being hired.

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

MCSP Executive Summary Table

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

The *Prenatal and Post-Delivery Services* and *Reception Center Arrivals* indicators did not apply to this institution.

Secondary Indicators (Administrative)		Compliance Rating	Overall Indicator Rating
Internal Monitoring, Quality Improvement, and Administrative Operations	Not applicable	Inadequate	Inadequate
Job Performance, Training, Licensing, and Certifications	Not applicable	Inadequate	Inadequate

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

Population-Based Metrics

In general, MCSP performed adequately as measured by population-based metrics. In four of the five comprehensive diabetes care measures, MCSP outperformed or performed similarly to other State and national organizations. This included Medi-Cal as well as Kaiser Permanente (typically one of the highest-scoring health organizations in California), and Medicaid, Medicare, commercial entities (based on data obtained from health maintenance organizations), and the United States Department of Veterans Affairs (VA). For the fifth diabetic measure, patient dilated eye exams, MCSP scored lower than two of the other entities.

With regard to immunization measures, MCSP's rates were adequate, scoring higher than the other entities that reported data for administering influenza vaccinations, but lower than the VA in administering pneumococcal vaccinations. The institution's rates for colorectal cancer screening were average, with higher scores than commercial health plans and Medicare, but lower scores than Kaiser and the VA. MCSP routinely offered patients their required immunizations but many of them refused the offers, which negatively impacted the institution's scores.

Overall, MCSP's performance demonstrated by population-based metrics indicated that comprehensive diabetes care, immunizations, and cancer screening were adequate in comparison to other State and national health care organizations.

INTRODUCTION

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

Mule Creek State Prison (MCSP) was the 16th medical inspection of Cycle 4. During the inspection process, the OIG assessed the delivery of medical care to patients for 12 primary clinical health care indicators and two secondary administrative health care indicators applicable to the institution. It is important to note that while the primary quality indicators represent the clinical care being provided by the institution at the time of the inspection, the secondary quality indicators are purely administrative and are not reflective of the actual clinical care provided.

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

ABOUT THE INSTITUTION

Mule Creek State Prison is located in Northern California's Amador County and maintains three sensitive needs yards and a minimum support facility. MCSP is committed to protecting public safety, ensuring the safety of CDCR personnel, and providing proper care and supervision of all offenders under its jurisdiction while assisting with inmates' reentry into society.

The institution operates six clinics where staff members handle non-urgent requests for medical services, including five facility clinics and a specialty clinic. MCSP also conducts screenings in its receiving and release clinical area, treats inmate-patients who need urgent or emergency care in its triage and treatment area (TTA), and treats those requiring inpatient health services in its correctional treatment center (CTC). MCSP has been designated as an "intermediate" care institution; these institutions are predominantly located in or near urban areas, close to tertiary care centers and specialty care providers, for the most cost-effective care.

In August 2013, MCSP received accreditation from the Commission on Accreditation for Corrections, a professional peer review process based on national standards set by the American Correctional Association. As of March 2016, the institution was in the process of undergoing a review for re-accreditation.

According to information provided by the institution, MCSP's overall vacancy rate among medical managers, primary care providers (PCPs), supervisors, and non-supervisory nurses was 26 percent in November 2015. As indicated in the table below, the highest vacancy percentage was among non-supervisory nursing staff; MCSP was using 14 registry staff to address some of the vacancies. Also, four of its non-supervisory nursing staff were on long-term medical leave.

MCSP Health Care Staffing Resources as of November 2015

	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff		Totals	
Description	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Authorized Positions	5	4%	11	9%	11.5	10%	90.9	77%	118.4	100%
Filled Positions	4	80%	9	82%	11	96%	64	70%	88	74%
Vacancies	1	20%	2	18%	0.5	4%	26.9	30%	30.4	26%
Recent Hires (within 12 months)	1	25%	2	22%	0	0%	11	17%	14	16%
Staff Utilized from Registry	0	0%	0	0%	0	0%	14	22%	14	16%
Redirected Staff (to Non-Patient- Care Areas)	0	0%	0	0%	0	0%	0	0%	0	0%
Staff on Long-Term Medical Leave	0	0%	0	0%	0	0%	4	6%	4	5%

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

As of November 23, 2015, the Master Registry for MCSP showed that the institution had 2,828 inmate-patients. Within that total population, 15.1 percent were designated High-Risk, Priority 1 (High 1), and 22.4 percent were designated High-Risk, Priority 2 (High 2). Patients' assigned risk levels are based on the complexity of their required medical care related to their specific diagnoses, frequency of higher levels of care, age, and abnormal labs and procedures. High 1 has at least two high-risk conditions; High 2 has only one. High-risk patients are more susceptible to poor health outcomes than medium- or low-risk patients. High-risk patients 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.

MCSP Master Registry Data as of November 23, 2015

Medical Risk Level	# of Inmate-Patients	Percentage
High 1	427	15.1%
High 2	633	22.4%
Medium	1,313	46.4%
Low	455	16.1%
Total	**2,828**	**100.0%**

Commonly Used Abbreviations

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

OBJECTIVES, SCOPE, AND METHODOLOGY

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

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

The OIG rates each of the quality indicators applicable to the institution under inspection based on case reviews conducted by OIG clinicians and compliance tests conducted by OIG deputy inspectors general. The ratings may be derived from the case review results alone, the compliance test results alone, or a combination of both these information sources. For example, the ratings for the primary quality indicators *Quality of Nursing Performance* and *Quality of Provider Performance* are derived entirely from the case review results, while the ratings for the primary quality indicators *Health Care Environment* and *Preventive Services* are derived entirely from compliance test results. As another example, primary quality indicators such as *Diagnostic Services* and *Specialty Services* receive ratings derived from both sources. At MCSP, 14 of the quality indicators were applicable, consisting of 12 primary clinical indicators and two secondary administrative indicators. Of the 12 primary indicators, seven were rated by both case review clinicians and compliance inspectors, three were rated by case review clinicians only, and two were rated by compliance inspectors only; both secondary indicators were rated by compliance inspectors only.

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

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

CASE REVIEWS

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

PATIENT SELECTION FOR RETROSPECTIVE CASE REVIEWS

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

1. The goal of retrospective chart review is to evaluate all aspects of the health care system. Statewide, high-risk and high-utilization patients consume medical services at a disproportionate rate; 11 percent of the total patient population are considered high-risk and

account for more than half of the institution's pharmaceutical, specialty, community hospital, and emergency costs.

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

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

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

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

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

BENEFITS AND LIMITATIONS OF TARGETED SUBPOPULATION REVIEW

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

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

Nonetheless, the health care system's response to this subpopulation can be accurately evaluated and yields valuable systems information. In the above example, if the health care system is providing appropriate diabetic monitoring, medication therapy, and specialty referrals for the high-risk patients reviewed, then it can be reasonably inferred that the health care system is also providing appropriate diabetic services to the entire diabetic subpopulation. However, if these same high-risk patients needing monitoring, medications, and referrals are generally not getting those services, it is likely that the health care system is not providing appropriate diabetic services to the greater diabetic subpopulation.

CASE REVIEWS SAMPLED

As indicated in *Appendix B, Table B–1, MCSP Sample Sets*, the OIG clinicians evaluated medical charts for 65 unique inmate-patients. *Appendix B, Table B–4, MCSP Case Review Sample Summary*, clarifies that both nurses and physicians reviewed charts for 20 of those patients, for 85 reviews in total. Physicians performed detailed reviews of 24 charts, and nurses performed detailed reviews of 19 charts, totaling 43 detailed reviews. For detailed case reviews, physicians or nurses looked at all encounters occurring in approximately six months of medical care. Physicians performed three additional limited or focused reviews of medical records. Nurses also performed a limited or focused review of medical records for an additional 39 inmate-patients. These generated 1,016 clinical events for review (*Appendix B, Table B-3, MCSP Event/Program*). The reporting format 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 five chronic care patient records, i.e., two diabetes patients and three anticoagulation patients (*Appendix B, Table B–1, MCSP Sample Sets*), the 65 unique inmate-patients sampled included patients with 200 chronic care diagnoses, including nine additional patients with diabetes, for a total of 11, and two additional anticoagulation patients, for a total of five (*Appendix B, Table B–2, MCSP Chronic Care Diagnoses*). The OIG's sample selection tool evaluated many chronic care programs because the complex and high-risk patients selected from the different categories often had multiple medical problems. While the OIG did not evaluate every chronic disease or health care staff member, the overall operation of the institution's system and staff were assessed for adequacy. The OIG's case review methodology and sample size matched other qualitative research. The empirical findings, supported by expert statistical consultants, showed adequate conclusions after 10 to 15 charts had undergone full clinician review. In qualitative statistics, this phenomenon is known as "saturation." The OIG asserts that the sample size of over 30 detailed reviews certainly far exceeds the saturation point necessary for an adequate qualitative review. For MCSP, the OIG physicians did not perform detailed reviews of the typical 30 charts because case review saturation occurred much earlier than usual. After only five to eight charts, an overabundance of data found in each chart saturated the physicians' findings. Nevertheless, physicians went on to perform 24 detailed reviews to ensure that the findings were accurate. 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 the case review sample size was adequate to assess the quality of services provided.

Based on the collective results of clinicians' case reviews, the OIG rated each quality indicator as either *proficient* (excellent), *adequate* (passing), *inadequate* (failing), or *not applicable*. A separate confidential *MCSP 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 December 2015 to February 2016, deputy inspectors general attained answers to 92 objective medical inspection test (MIT) questions designed to assess the institution's compliance with critical policies and procedures applicable to the delivery of medical care. To conduct most tests, inspectors randomly selected samples of inmate-patients for whom the testing objectives were applicable and reviewed their electronic unit health records. In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed health records of 402 individual inmate-patients and analyzed specific transactions within their records for evidence that critical events occurred. Inspectors also reviewed management reports and meeting minutes to assess certain administrative operations. In addition, during the week of December 7, 2015, field inspectors conducted a detailed onsite inspection of MCSP's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,235 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 MCSP's plant infrastructure, protocols for tracking medical appeals and local operating procedures, and staffing resources.

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

SCORING OF COMPLIANCE TESTING RESULTS

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

- Primary indicators: *Access to Care, Diagnostic Services, Health Information Management (Medical Records), Health Care Environment, Inter- and Intra-System Transfers, Pharmacy and Medication Management, Preventive Services, Specialized Medical Housing (OHU, CTC, SNF, Hospice),* and *Specialty Services*.

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

After compiling the answers to the 92 questions, the OIG derived a score for each primary and secondary quality indicator identified above by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Based on those results, the OIG assigned a rating to each quality indicator of *proficient* (greater than 85 percent), *adequate* (between 75 percent and 85 percent), or *inadequate* (less than 75 percent).

CCHCS DASHBOARD COMPARISON

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

OVERALL QUALITY INDICATOR RATING FOR CASE REVIEWS AND COMPLIANCE TESTING

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

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

POPULATION-BASED METRICS

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

MEDICAL INSPECTION RESULTS

PRIMARY (CLINICAL) QUALITY INDICATORS OF HEALTH CARE

The primary quality indicators assess the clinical aspects of health care. As shown on the *Health Care Quality Indicators* table on page ii of this report, 12 of the OIG's primary indicators were applicable to MCSP. Of those 12 indicators, seven were rated by both the case review and compliance components of the inspection, three were rated by the case review component alone, and two were rated by the compliance component alone.

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

Summary of Case Review Results: The clinical case review component assessed 10 of the 12 primary (clinical) indicators applicable to MCSP. Of these ten indicators, OIG clinicians rated none *proficient*, one *adequate*, and nine *inadequate*.

The OIG physicians rated the overall adequacy of care for each of the 24 detailed case reviews they conducted. Of these 24 cases, 7 were *adequate*, and 17 were *inadequate*. In the 1,016 events reviewed, there were 638 deficiencies, of which 216 were considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

Adverse Events Identified During Case Review: Medical care is a complex dynamic process with many moving parts, subject to human error even within the best health care organizations. Adverse events are typically identified and tracked by all major health care organizations for the purpose of quality improvement. They are not generally representative of medical care delivered by the organization. The OIG identified adverse events for the dual purposes of quality improvement and the illustration of problematic patterns of practice found during the inspection. Because of the anecdotal description of these events, the OIG cautions against drawing inappropriate conclusions regarding the institution based solely on adverse events. However, at MCSP, these events were reflective of the poor system processes and inadequate supervision evident throughout the cases reviewed.

There were four case reviews at MCSP with adverse sentinel events identified:

- In case 7, the patient underwent an MRI of the elbow that showed a complete tear of his bicep tendon. The provider reviewed the test the next day, and ordered a follow-up appointment to occur in exactly three days. MCSP never scheduled the follow-up appointment, resulting in a lapse in care. By the end of the review period, MCSP health care staff still had not addressed the condition.

- In case 27, the patient was taking adalimumab (brand name Humira), a medication used to decrease inflammation caused by rheumatoid arthritis. Adalimumab interacts with the immune system and in some cases can cause serious and potentially life-threatening

infections. The patient submitted a sick call form complaining of serious side effects from the medication. However, the nurse failed to evaluate the patient and failed to process the sick call form. MCSP health care staff never addressed the symptoms, and the incomplete sick call form was scanned into the medical record three months later. Fortunately, the patient began to refuse the medication, and an offsite specialist later discontinued it.

- In cases 29 and 30, the providers prescribed the patient warfarin, a commonly used blood thinner for the treatment and prevention of blood clots. Providers typically monitor this medication level tightly because both low and high levels can lead to very serious or even lethal complications. The medication administration records (MARs) showed numerous and severe administration errors. MCSP nurses repeatedly administered large warfarin doses on days the provider had not ordered it. MCSP nursing and pharmacy staff failed to report any of the errors. In the middle of the inspection process, the OIG notified MCSP of these critical problems so that the institution could take corrective action immediately. Fortunately, the evidence suggested that these errors did not result in any permanent harm.

Summary of Compliance Results: The compliance component assessed 9 of the 12 primary (clinical) indicators applicable to MCSP. Of these nine indicators, OIG inspectors rated none *proficient*, three *adequate*, and six *inadequate*. The results of those assessments are summarized within this section of the report. The test questions used to assess compliance for each indicator are detailed in *Appendix A.*

ACCESS TO CARE

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

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(67.9%)

Overall Rating:
Inadequate

Case Review Results

The OIG clinicians reviewed 325 provider, nursing, specialty, and outside hospital encounters for which a follow-up needed to be scheduled. The clinicians found 148 deficiencies relating to *Access to Care*. Eighty-eight of the 148 deficiencies were likely to cause patient harm if MCSP staff continued to allow the deficiencies to persist. Poor health care access affected nearly every aspect of health care delivery at MCSP, which is further discussed in each applicable indicator. Due to both the large number and the severity of the deficiencies identified, *Access to Care* at MCSP was *inadequate*.

Provider-to-Provider Follow-up Appointments

MCSP performed extremely poorly with provider-ordered follow-up appointments. These are among the most important aspects of the *Access to Care* indicator. Failure to accommodate provider-ordered appointments can often result in lapses in care or in patients being lost to follow-up. The problem was severe and widespread at MCSP. The provider-ordered appointments deficiency was evident in the vast majority of cases reviewed (cases 4, 5, 7, 8, 24, 25, 26, 27, 28, 29, 30, 32, 33, 35, 36, 58, 59, 62, 63, 65, and 69), often several times per case. In many cases, follow-up appointments were not just late, but dropped altogether. The following are four examples among 14 significant deficiencies identified during case review for provider-ordered follow-up appointments:

- In case 26, the provider ordered a biopsy of a potentially cancerous skin lesion. The biopsy never occurred.

- Also in case 26, the institution scheduled a chronic care evaluation for the patient, which the provider did not conduct during the examination. Instead, the provider focused only on a post-operative wound. The provider failed to address the patient's nine chronic care illnesses, including COPD, sleep apnea, coronary artery disease, and hypertension, which the provider did not manage for six months. Despite lack of chronic care on this encounter,

the scheduler marked that the patient received a chronic care appointment. The institution did not schedule a chronic care follow-up appointment.

- In case 33, the patient had elevated blood pressure. The provider ordered labs and a follow-up in five to six weeks, but the appointment did not occur. This contributed to a lapse in care.

- The final example was an MCSP patient not included in the case review sample set. An OIG physician reviewed the patient's care after the OIG compliance staff identified a lengthy absence of chronic care for one of the sampled patients. This patient had multiple chronic illnesses, including diabetes, hypertension, seizure disorder, asthma, and hypertension. His diabetes was poorly controlled with a high three-month average blood sugar level (HemA1c of 9.5%). The evidence suggested the patient was lost to follow-up, as there were no chronic care visits for over 18 months.

RN Sick Call Access

MCSP did not perform adequately with RN sick call access. As the primary initial method of access to the prison health care system, adequate RN sick call access is a critical component of *Access to Care*. MCSP received as many as 50 sick call requests per yard, per day. MCSP had neither the nursing staff nor the space to process the number of sick call requests it received. This situation created backlogs in nursing appointments, which contributed to delays in sick call processing. The OIG clinicians reviewed 159 sick call encounters and found delays in processing sick call forms in cases 23, 24, 57, 62, and the following:

- In case 7, the patient submitted a sick call form for severe pain with a deformed and swollen finger. MCSP nursing did not triage or review the sick call form for three days. After reviewing the form, the nurse did not perform a face-to-face evaluation. Fortunately, the patient's symptoms did not require urgent care.

RN-to-Provider Referrals

A properly functioning health care system must allow nurses to refer a patient for a provider evaluation if the patient's medical needs are beyond the nurse's scope of practice. MCSP performed very poorly with RN-to-provider appointments, with widespread, often severe, deficiencies. The institution often dropped the referrals altogether, leaving the patients' medical concerns unaddressed. Deficiencies in RN-to-provider referrals existed in cases 4, 5, 8, 13, 16, 21, 23, 24, 27, 31, 42, 44, 45, 47, 48, 54, 55, 56, 58, and the following:

- In case 7, the patient complained to the nurse that he had not seen a doctor for over ten weeks and that his medications were running out. He had seen a specialist recently and he wanted to have the specialist's recommendations addressed. The nurse ordered a one-week follow-up with the PCP, but the appointment did not occur. This contributed to a significant delay in care.

RN-to-RN Follow-up Appointments

MCSP nurses rarely referred patients for nursing follow-up appointments in the cases reviewed, instead opting to refer the patient to a provider. However, even in the few instances where a nurse ordered a nursing follow-up appointment, MCSP had difficulty keeping those appointments. The OIG clinicians identified this problem in cases 4 and 22.

Provider Follow-up After Specialty Service

MCSP did not consistently provide patients with a provider follow-up after specialty services. The OIG clinicians reviewed 93 diagnostic and consultative specialty services and found many instances when the provider follow-up did not occur or was delayed. This pattern markedly increased the risk of lapses or delays in care. The OIG clinicians identified these deficiencies in cases 7, 8, 18, 24, 27, 28, 29, 31, 35, and 36.

- In case 35, the patient completed his second regimen of chemotherapy for non-Hodgkin's lymphoma. The specialist recommended that the institution send the patient to a bone marrow transplant center for evaluation. The PCP did not see the patient for nearly six weeks. This delay in care lowered his chances for a successful transplant and, ultimately, for successful cancer treatment.

Intra-System Transfers

Nurses assessed newly transferred patients and usually referred them to a provider. The OIG clinicians reviewed 12 transfer-in patients and found three cases (4, 9, and 30) deficient in this area. In each of those cases, the patient experienced significant delays in seeing a provider after transferring into MCSP.

Follow-up After Hospitalization

MCSP performed better at ensuring that providers followed up with their patients after return from an outside hospital or an emergency department, but there were still some problems with this area. In the 31 hospitalization and outside emergency events reviewed, there were delays in provider follow-up three times: cases 7, 8, and 25.

Follow-up After Urgent/Emergent Care

MCSP had significant difficulty ensuring that a PCP followed up on patients after their return from the triage and treatment area (TTA). The OIG clinicians reviewed 65 urgent/emergent encounters, 28 of which required a PCP follow-up. Provider follow-up appointments did not occur, or the institution delayed the follow-up, in cases 15, 20, 25, 35, 36, and 69.

Specialized Medical Housing

MCSP did not perform adequately with provider access during and after patients' admission to the correctional treatment center (CTC). Providers did not always see the CTC patients at appropriate intervals. The OIG clinicians reviewed six CTC admissions with 30 CTC provider encounters. The most concerning problem was the lack of provider continuity, which contributed to other problems in care. Provider continuity is further discussed in the *Specialized Medical Housing* indicator.

Specialty Access

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

Diagnostic Results Follow-up

MCSP performed very poorly providing patient follow-ups after the institution obtained abnormal diagnostic tests. After reviewing diagnostic results, a provider indicated whether the patient required a follow-up appointment on the CDCR Form 7393. MCSP had great difficulty processing those forms, often scanning them into the medical record without scheduling any appointments. This oversight greatly increased the risk of medical staff ignoring and not acting on abnormal diagnostic results, which correspondingly increased the risk of harm.

- In case 7, an MRI of the right elbow showed a complete bicep tendon rupture. The reviewing provider (not the PCP) ordered a three-to-five-day follow-up on the CDCR Form 7393, but the appointment did not occur. This contributed to a significant lapse in care, as the PCP was seemingly unaware of the abnormal MRI report and never adequately addressed the condition.

- In case 36, a CT scan showed the possibility of liver cancer. A provider ordered a follow-up to occur within a week, but the appointment did not occur. The hepatitis C specialist discovered this lapse a month later, then arranged appropriate care.

Clinician Onsite Inspection

At the onsite inspection, the OIG clinicians discussed the widespread problems with *Access to Care*. There were multiple reasons for the problems. MCSP had created a local workgroup tasked with identifying health care access problems. The most significant problem MCSP management identified was provider vacancies (further discussed in the *Quality of Provider Performance* indicator). Another was underperforming scheduling staff. Within the most recent year, MCSP had assigned new scheduling staff to perform provider and nurse scheduling functions. In addition, until October 2015, MCSP did not "bundle" appointments for the providers, or combine multiple medical concerns into one appointment. Prior to bundling, if a patient had hypertension as well as foot pain, MCSP would have had to create two separate appointments, one for each condition.

The demand for medical services at MCSP far outweighed the available supply of resources, demonstrated by the exceedingly high number of sick call requests received on a daily basis as well

as the backlogs for nursing appointments. At the time of the onsite inspection, each provider line on Yard A was approximately 325 appointments behind. Scheduling staff pointed out that the chief physician and surgeon (CP&S) did not publish provider schedules far enough in advance for effective scheduling. MCSP nursing staff remarked that only recently had the institution begun to fill vacant nursing positions. However, even if the institution filled all nursing vacancies, there would be insufficient clinical space for those nurses to work, and those nurses would be effectively unable to alleviate the nursing shortage. MCSP had two vacant physician openings for most of 2015, and the CP&S as well as the CEO described tremendous challenges in the recruitment and retention of well-qualified physicians. In addition, provider vacancies increased to five by the time of the OIG clinicians' inspection in February 2016 because of the future increase in inmate population with new housing for an additional 1,584 inmates.

Clinician Summary

MCSP demonstrated a profound inability to provide patients with adequate *Access to Care*. There were problems in virtually all areas. Severe problems were identified with provider follow-ups, nurse-to-provider referrals, diagnostic test follow-ups, specialty consultation follow-ups, and TTA follow-ups. MCSP offered several reasons for its poor performance in this indicator. Of critical importance was MCSP's lack of provider availability and extreme difficulty with recruitment and retention of qualified physicians. Nursing vacancies also contributed significantly to the poor performance during the period of review. At the time of the onsite inspection, MCSP did not have adequate clinical space to meet the demand for medical services. However, MCSP anticipates that an ongoing CCHCS Health Care Facilities Improvement Project (HCFIP) expansion to existing facilities should help with that problem.

In addition to staffing and space limitations, there were apparently significant problems with other processes. The OIG identified many *Access to Care* deficiencies that involved appointments that were never scheduled. While inadequate provider and nursing staffing could explain the non-completion of scheduled appointments, it would not account for appointments that the institution never scheduled in the first place. In an attempt to correct some of the process problems, MCSP had replaced all of the schedulers with new staff. However, because the problems were widespread, varied, and extensive, MCSP needed major process revision and optimization.

Compliance Testing Results

The institution received an *inadequate* compliance score of 67.9 percent in the *Access to Care* indicator, scoring in the *inadequate* range in the following four tests:

- Among 20 health care service requests sampled on which nursing staff referred the patient for a PCP appointment, only five of the patients (25 percent) received a timely appointment. Eleven patients received their appointment from one to 69 days late; four other patients did not receive an appointment at all (MIT 1.005).

- Among the 40 sampled patients who suffered from one or more chronic care conditions, only 16 (40 percent) received timely PCP follow-up appointments. Nine patients received chronic care follow-up appointments from one to 26 days late; eight patients received appointments from one to five months late; and one patient, who had several chronic care conditions, received his follow-up appointment over 16 months late. For the remaining six patients, there was no evidence in the eUHR that the patients had been seen (MIT 1.001).

- Among 13 patients sampled who had transferred into MCSP from other institutions and been referred to a PCP based on nursing staff's initial health care screening, only six (46 percent) were seen timely. Six patients received their PCP appointment from 18 to 61 days late, and one other patient never received his appointment at all (MIT 1.002).

- Only 14 of 27 sampled patients who received a high-priority or routine specialty service (52 percent) received a timely follow-up appointment with a PCP. Nine patients' high-priority specialty service follow-up appointments were from one to 26 days late. Two patients' routine specialty service follow-up appointments were 5 and 11 days late; the two other patients' routine specialty service follow-up appointments did not occur at all (MIT 1.008).

MCSP performed in the *adequate* range in the following tests:

- Twenty-five of 30 sampled patients who were discharged from a community hospital (83 percent) received a timely PCP follow-up appointment upon their return to MCSP. Five patients received their follow-up appointments one or two days late (MIT 1.007).

- Of the four patients sampled whom nursing staff referred to a PCP and for whom the PCP subsequently ordered a follow-up appointment, three (75 percent) received their follow-up appointments timely. For one patient, the appointment did not occur at all (MIT 1.006).

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

- Inspectors sampled 30 Health Care Services Request forms (CDCR Form 7362) submitted by inmate-patients across all facility clinics. Nursing staff reviewed 28 of the 30 patients' request forms on the same day they were received (93 percent). One patient's request form lacked nursing initials and the date reviewed; another patient's request was reviewed one day late (MIT 1.003). Also, nursing staff timely completed a face-to-face triage encounter for 29 of those 30 patients (97 percent). The nurse encounter for one patient's visit occurred two days late (MIT 1.004).

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

Recommendations

No specific recommendations.

DIAGNOSTIC SERVICES

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

Overall Rating:
Inadequate

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

In this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *inadequate* rating and the compliance review resulting in an *adequate* score. The OIG's internal review process considered those factors that led to both scores and ultimately rated this indicator *inadequate.* The key factors were that the OIG's case review showed that medical staff did not perform urgent laboratory orders within the time frame the provider ordered. The institution also stopped scanning radiology reports in late 2015, which could have affected the quality of patient care. The deficiencies identified in the case reviews were significant enough to outweigh the compliance results and reach the overall *inadequate* rating.

Case Review Results

The OIG clinicians reviewed 124 diagnostic events and found 29 deficiencies. Of those, 22 related to health information management, and seven related to the non-completion of ordered tests.

MCSP performed the majority of diagnostic services in a timely manner. However, failure to complete diagnostic tests was a serious system deficiency that potentially could have led to significant delays or even lapses in care. MCSP staff's failure to complete diagnostic tests as ordered was uncommon, but was more likely to occur when providers ordered tests with short processing time frames. The following examples demonstrate areas for quality improvement:

- In case 24, the provider ordered labs to be performed the next day out of concern that the patient may have developed a problem with a shunt (a tube to prevent excessive fluid buildup) implanted in the patient's brain. MCSP did not draw the lab the very next day as ordered, but took two days to perform the test.

- In case 29, the patient had a high warfarin (blood thinner) level, so the provider ordered a repeat test to be performed in five days. The test was not performed.

- In case 30, the patient had a high warfarin level, so the provider ordered a repeat test to be performed the very next day. The test was not performed.

Starting in late 2015, the OIG case review identified poor performance in MCSP's retrieval of radiology reports from the radiology information system and scanning them into the separate electronic data repository, the eUHR. At the onsite inspection, MCSP leadership explained that they had stopped scanning radiology reports into the eUHR based on a directive from CCHCS headquarters. This new process, however, increased the risk of patient harm due to the chance of a lapse in care because of a provider being unaware of the report. Even if the ordering provider were initially notified of the report and reviewed it in the radiology information system, the report would still not be readily available to any subsequent medical staff. Any nurse or provider caring for the patient in the coming months or years would face a tremendous barrier, as the main information base used for patient care, the eUHR, would lack a scanned copy of the report.

OIG clinicians identified MCSP's failure to retrieve and scan radiology reports into the eUHR in cases 7, 8, 24, 28, 31, 32, and 36. The following case illustrates how the medical staff were unaware of the CT scan report because the nurse only reviewed the eUHR when searching for the report:

- Case 36: The patient underwent a liver CT scan that showed masses indicative of potential liver cancer. The ordering provider reviewed the results in the radiology information system and requested a one-week follow-up, which did not occur. Eight days later, the patient was found on the ground, outside of the clinic, complaining of dizziness. He was brought into the clinic and evaluated by a nurse. The nurse looked for the CT scan report in the eUHR, but the report was not available since MCSP had stopped scanning the reports into the medical record by that time. Without readily available information, the patient's care was delayed another week. Fortunately the report was retrieved by an exceptionally diligent provider who would be thorough enough to check a completely different information system for the radiology report. Continued delays or lapses in care could have potentially continued in this case due to this critical and ongoing deficiency.

In addition to radiology reports, MCSP did not retrieve, scan, or correctly process a few laboratory reports. The following examples illustrated inadequacies in diagnostic services:

- In case 30, institutional staff did not retrieve, review, or scan a warfarin level test report into the eUHR.

- In case 69, institution staff did not retrieve, review, or scan a critically important lab report into the eUHR for a patient who ultimately required hospitalization for sepsis and endocarditis. MCSP providers did not consistently review diagnostic test results in a timely manner. OIG clinicians identified delays in test review in cases 8, 17, 24, 29, 30, and 69.

- MCSP providers did not consistently complete patient notification forms (CDCR Form 7393) relaying the results of diagnostic tests. This deficiency occurred in cases 8, 29, 30, and 69.

- When MCSP providers reviewed the diagnostic test reports, they did not consistently date or initial the reports. OIG clinicians identified this deficiency in cases 25, 29, 30, and 69.

Clinician Summary

MCSP staff completed radiology and laboratory tests in a timely manner, with only rare occurrences of test non-completion. However, retrieval of radiology test results was highly problematic, especially since late 2015, when MCSP stopped scanning radiology reports into the eUHR. Failure to place radiology reports into the main medical record presented a significant and ongoing risk of harm to patient care. MCSP providers did not consistently review diagnostic test results in a timely manner and did not always complete patient notification forms.

Compliance Testing Results

The institution received an *adequate* compliance score of 84.4 percent in the *Diagnostic Services* indicator, which encompasses radiology, laboratory, and pathology services. For clarity, each type of diagnostic service is discussed separately below:

Radiology Services

- For all ten of the sampled radiology services, the patients' services were timely performed. For nine of the ten patients (90 percent), providers both timely reviewed the diagnostic services report and timely communicated the results to patients. For one patient, the provider reviewed and communicated the diagnostic results three days late (MIT 2.001, 2.002, 2.003).

Laboratory Services

- For eight of the ten sampled laboratory services (80 percent), the patients' ordered diagnostic services were timely received; two patients' labs were received one and three days late (MIT 2.004). Providers initialed and dated the laboratory reports for only seven of those ten patients (70 percent); providers reviewed two reports 7 and 20 days late; for the remaining patient, the provider did not identify the date the laboratory report was reviewed (MIT 2.005). Providers timely communicated the laboratory report results to eight of the ten patients (80 percent), communicating the results 7 and 20 days late to the same two patients whose results were reviewed late (MIT 2.006).

Pathology Services

- The institution timely received the final pathology report for eight of ten patients sampled (80 percent). For two patients, the institution received the reports 4 and 72 days late (MIT 2.007). Providers documented evidence that they timely reviewed the report results for eight of those ten patients (80 percent). For one patient, the PCP reviewed the report 56 days late; for another patient, the provider failed to initial and date the report evidencing review

of the results (MIT 2.008). Providers communicated the final pathology results to nine of the ten applicable patients (90 percent). The provider met with the remaining patient and discussed the procedure, but did not discuss the pathology results (MIT 2.009).

Recommendation for CCHCS

The OIG recommends that, to avoid risk of patient harm, CCHCS review the current process of not scanning radiology reports into the eUHR and develop a better process for staff to access radiology reports.

Recommendations for MCSP

No specific recommendations.

EMERGENCY SERVICES

Case Review Rating:
Inadequate
Compliance Score:
Not Applicable

Overall Rating:
Inadequate

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 56 urgent/emergent events and found 77 deficiencies in a variety of areas. In general, MCSP performed adequately with BLS care. However, several problems with unreliable 9-1-1 call activation times, poor emergency preparedness, and questionable nursing performance contributed to the *inadequate* rating in this indicator.

Emergency Preparedness and Response

MCSP staff was not adequately prepared to provide emergency response. Onsite inspection found full, partially used, and empty oxygen canisters stored together in the TTA with no clear method to determine the status of each canister. Case review corroborated the danger of this finding.

- In case 1, the nurse documented on the first medical responder form that the oxygen tank was empty. Evidently, nursing staff had not checked to ensure availability and readiness of emergency medical supplies and equipment. Fortunately, the patient suffered no harm from this deficiency and made a full recovery.

Staff handled most emergency responses in a timely manner. However, the following cases demonstrated delayed emergency responses:

- In case 1, there was a delay of 32 minutes from the time the patient was found unresponsive to the time of activating 9-1-1.

- In case 8, the patient had a seizure in the yard. It took 20 minutes for MCSP TTA staff to transfer the patient from the yard to the TTA. Ultimately, the delay resulted in no harm, as the hospital neurologist diagnosed the seizures with a less serious, non-epileptic cause.

Nursing Performance

Emergency services nursing deficiencies often related to inadequate documentation. The OIG clinicians found the TTA nursing documentation incomplete, disorganized, and, at times, illegible, with little evidence that nursing staff provided adequate care.

- In case 1, the nurse responded to a medical emergency in the yard and found the patient unresponsive and not breathing. Staff initiated CPR, but the nurse noted that the oxygen tank was empty. The patient regained consciousness prior to arrival in the TTA, where the physician examined him. The nurse noted that the patient was not breathing, but did have a steady pulse. Therefore, it was not clear why the nurse started chest compression instead of rescue breathing per BLS protocol. The first responders did not document their interventions during the CPR process, such as assessment for airway obstruction, signs of effective circulation, or the number of CPR cycles done. The TTA RN did not document the time emergency medical services (EMS) personnel arrived and the medical care responsibility was handed off.

- In case 5, medical staff evaluated the patient in the TTA for chest pain. There was a delay in care due to the slow ambulance response time. The TTA RN did not document the assessment and care provided to the patient for the 38 minutes prior to leaving the TTA for a higher level of care at a community hospital. There was no pain assessment noted after administration of three nitroglycerin tablets for chest pain. The RN did not document when EMS personnel arrived or when the transfer of care was made.

- In case 8, as described above, the patient was found seizing in the yard and was brought to the TTA. In addition to the delayed emergency response, the first medical responder did not document the emergency care provided to the patient during the first 20 minutes after arriving on the scene. The TTA RN did not document a detailed assessment of the patient's condition and the time when EMS personnel arrived and transfer of care was done.

- In case 25, the patient was seen in the TTA 13 times for chest pain during the review period. In ten of these nursing encounters, the TTA RN failed to adequately assess and document the care provided in the TTA. No harm occurred as the patient was eventually determined to have benign, non-cardiac chest pain.

Insufficient or inadequate first medical responder documentation was identified in cases 1, 3, 8, 14, 23, 25, and 28.

There was inadequate assessment and documentation by the TTA RNs in cases 5, 7, 8, 15, 21, 23, 25, 26, and 28.

There were discrepancies or omissions in documenting the time when TTA staff responded on scene or when the PCP or EMS was notified in cases 1, 2, 3, 8, 14, 21, and 28.

Provider Performance

Provider performance in the TTA was adequate, further discussed in the *Quality of Provider Performance* indicator. Providers did demonstrate a pattern of the on-call physician routinely failing to document telephone encounters.

Clinician Summary

While TTA providers largely made appropriate triage decisions, problems with unreliable emergency response times, poor preparedness, and inadequate assessment and documentation by first medical responders and TTA nurses resulted in an *inadequate* rating for this indicator.

Recommendations

The OIG recommends that the MCSP nursing leadership implement strategies to:

- Audit the frequency and quality of nursing assessments, interventions, and documentation.
- Ensure that nurses review TTA documentation for accuracy and legibility. Nursing notes must contain complete assessments, status reassessments, all medical interventions, patient responses to interventions, and contacts made on behalf of the patient, including the times these were performed. Patients must be regularly assessed and their care documented up to their departure, including recording the times of custody and ambulance notifications, arrivals, and departures.
- Develop TTA-specific nursing performance expectations and ensure all nurses are trained and monitored.

HEALTH INFORMATION MANAGEMENT (MEDICAL RECORDS)

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(68.9%)

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

Case Review Results

Inter-Departmental Transmission

The OIG clinicians identified a recurring pattern of providers' orders not being processed nor even noted by a nurse. MCSP medical staff ignored orders in cases 19, 20, 26, and 30. While these occurrences were infrequent, they represented a serious risk of harm when they occurred.

MCSP had severe problems with missing documents across all areas of the institution. Missing documents included clinic provider notes, emergency first responder notes, TTA nursing notes, CTC flow sheets, and medical administration records. Cases 4, 8, 10, 12, 19, 20, 21, 31, 54, 59, 65, 67, and 69 all had missing documents.

Dictated Progress Notes

In cases 24 and 28, when providers used dictation, there were transcription delays, but most providers usually used handwritten or typed progress notes.

Hospital Records

MCSP did very well with the retrieval of emergency department (ED) physician reports and hospital discharge summaries. Of seven reviewed outside ED events and 24 community hospital events, the institution retrieved and scanned all in a timely manner, with one exception: case 69, a hospital discharge summary.

MCSP performed poorly with ensuring that a provider reviewed and initialed the ED physician report or the hospital discharge summary. Initials were missing on outside hospital reports in cases 4, 5, 7, 8, 25, 26, 27, 28, 69, and 70.

Specialty Services

There were significant problems in the retrieval and review of specialty reports. The findings are discussed in detail in the *Specialty Services* indicator.

Diagnostic Reports

MCSP demonstrated poor performance in retrieval of diagnostic reports, specifically radiological reports. These findings are discussed in detail in the *Diagnostic Services* indicator.

Urgent/Emergent Records

MCSP nurses sometimes did not properly document their urgent/emergent encounters. Nursing documentation was missing in cases 4, 12, 20, and 69.

MCSP providers, when they were on call, failed to document their telephone encounters in every case with such an encounter.

Scanning Performance

Mistakes in the document scanning process consisted of either mislabeled or misfiled documents. Mislabeled documents were common and widespread. The OIG clinicians found mislabeled documents in the eUHR in cases 8, 15, 20, 23, 25, 36, 58, and 67. Only case 67 had misfiled documents (filed in the wrong chart).

Scanning times for all documents were generally good.

Legibility

Often, providers did not utilize name stamps, which created repeated legibility problems.

Clinician Onsite Inspection

The OIG clinicians observed clinical information transmission during the daily morning huddles and interviewed various health care staff regarding how they handled information, especially if clinical care occurred outside of the clinic and after hours. MCSP did not demonstrate a process by which the respective care teams distributed important after-hours clinical information. Patients requiring after-hours or weekend care were often evaluated in the TTA and managed by the TTA RN and the on-call provider. There was no standardized process for the on-call provider or TTA RN to summarize and transmit information about those weekend or after-hours events to other care teams. While each clinic utilized a standardized huddle report agenda every morning, the huddles lacked substantive discussion regarding those patients who required after-hours care. Huddle discussion was superficial and only touched upon each patient's chief complaint and whether the patient needed a follow-up appointment. OIG clinicians observed no discussion of the results of the after-hours assessment nor whether any interventions were required.

Clinician Summary

MCSP did well with the retrieval of outside ED reports and hospital discharge summaries. Scanning time frames were acceptable. However, the institution had significant difficulty with many aspects of this indicator. Missing documents were common throughout all clinical areas. There was a pattern of unprocessed orders presenting a serious risk to patient safety. MCSP had significant difficulty having outside ED and hospital discharge summaries initialed or properly signed by a provider. There were also significant problems with the handling of specialty and radiology reports. Mislabeled documents in the eUHR were common. MCSP providers often failed to document their telephone encounters when they were on call. MCSP had no effective method of transmitting important clinical events that occurred after hours to the responsible primary care teams. The OIG clinicians rated this indicator *inadequate*.

Compliance Testing Results

The institution received an *inadequate* compliance score of 68.9 percent in the *Health Information Management (Medical Records)* indicator and received *inadequate* scores in the following three areas:

- The institution scored zero in its labeling and filing of documents scanned into patients' electronic unit health records; most documents were mislabeled, such as Health Care Services Request forms (CDCR Form 7362), which are used by patients to see a nurse, scanned and labeled as providers' Interdisciplinary Progress Notes (CDCR Form 7230). Other errors included documents labeled with the wrong date or misfiled under the wrong document category. For this test, once the OIG identifies 12 mislabeled or misfiled documents, the maximum points are lost and the resulting score is zero. During the MCSP medical inspection, inspectors identified a total of 28 documents with filing errors, 16 more than the maximum allowable errors (MIT 4.006).

- Inspectors tested six PCP-dictated progress notes to determine if medical records staff scanned the documents within five calendar days of the patient encounter date and found only three documents (50 percent) were timely scanned. Three progress notes were scanned eight days late (MIT 4.002).

- Among 32 samples of various medical documents, such as hospital discharge reports, initial health screening forms, certain medication administration records, and specialty service reports, clinical staff legibly documented their names on only 18 (56 percent) (MIT 4.007).

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

- MCSP medical records staff timely scanned medication administration records (MARs) into the patients' eUHRs in 15 of 20 samples tested (75 percent). Four MARs were scanned one day late; one other MAR was scanned four days late (MIT 4.005).

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

- Staff timely scanned 19 of 20 sampled miscellaneous non-dictated documents (95 percent). These documents included patients' initial health screening forms (CDCR Form 7277), patients' requests for health care services, and providers' progress notes. The only exception was a health screening form scanned four days late (MIT 4.001).

- The institution's medical records staff scanned specialty service consultant reports into patients' eUHR files within five calendar days for 19 of the 20 documents reviewed (95 percent). One consultant's report was scanned five days late (MIT 4.003).

- Among 30 sampled hospital discharge records for patients whom the institution sent to the hospital for a higher level of care, 27 (90 percent) were complete and reviewed by a MCSP provider within three days of the patient's discharge. For two patients, providers reviewed the discharge reports one and three days late; for another patient, the provider did not document that the report was reviewed at all (MIT 4.008).

- The OIG also tested 20 of the patients' discharge records to determine if staff timely scanned the records into the patient's eUHR. Eighteen of the 20 samples (90 percent) were compliant. Two records were each scanned one day late (MIT 4.004).

Recommendations

No specific recommendations.

HEALTH CARE ENVIRONMENT

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

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(61.1%)

Overall Rating:
Inadequate

Compliance Testing Results

The institution received an *inadequate* compliance score of 61.1 percent in the *Health Care Environment* indicator; 6 of the 11 test areas scored in the *inadequate* range, as described below:

- The institution scored zero when inspectors examined emergency response bags in six applicable clinics to determine if clinical staff inspected the bags daily and inventoried them monthly, and whether the bags contained all essential items. None of the clinics had monthly inventory logs; also, at three clinics, staff on each watch did not always conduct daily inspections of the bag; and at two clinics, the bag's oxygen tank was not properly pressurized or the valve key to turn on the oxygen was missing (MIT 5.111).

- OIG inspectors observed clinicians' encounters with inmate-patients in seven of the institution's clinics. Clinicians followed good hand hygiene practices in only two clinics (29 percent). In five clinics, observed providers or nurses did not sanitize their hands before or after patient contact, before putting on gloves, or after administering an injection (MIT 5.104).

- Only three of the nine clinic common areas and exam rooms (33 percent) had all essential core medical equipment and supplies; the remaining six clinics had one or more deficiencies. Three clinics lacked a Snellen eye chart or an established distance line on the floor for the chart; two clinics had nebulization units not timely calibrated and another clinic lacked a nebulization unit; and the oto-ophthalmoscope in the CTC did not work. Also, in both the receiving and release (R&R) clinical area and the administrative segregation unit (ASU) nurse exam area, there was no exam table and no oto-ophthalmoscope. The R&R clinic also lacked a bio-hazard waste receptacle or bags (MIT 5.108).

- Inspectors examined nine clinics to determine if they had appropriate space, configuration, supplies, and equipment to allow clinicians to perform a proper exam, and found only three clinics (33 percent) were in compliance. Four clinics' RN and PCP exam rooms lacked patient privacy because there were no privacy screens available. In the ASU clinic, the PCP

exam area was next to the clinic's inmate-patient holding cell, which compromised auditory privacy during patient encounters; the exam room cabinet countertop was damaged and the exam table had a vinyl cover with cracks in it that staff could not adequately disinfect and that could harbor infectious agents. The R&R clinic had confidential medical records designated for shredding that were easily accessible to be viewed by inmate porters (MIT 5.110).

- Only four of the nine clinics examined (44 percent) were appropriately disinfected, cleaned, and sanitary. Five of the clinics displayed incomplete cleaning logs; two of those five clinics had dirty floors in exam rooms (Figure 1) (MIT 5.101).

- Clinic common areas at only five of nine clinics (56 percent) had an environment conducive to providing medical services. The location of triage and blood draw stations in four clinics compromised patients' auditory privacy (MIT 5.109).

Figure 1: Dirt on exam room floor

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

- In all nine of MCSP's clinics, proper protocols were followed to mitigate exposure to blood-borne pathogens and contaminated waste (MIT 5.105).

- Based on OIG's inspection of the institution's non-clinic storage areas for bulk medical supplies, and responses received from the warehouse manager and the CEO, the medical supply management process supported the needs of the medical health care program. As a result, the institution scored 100 percent on this test (MIT 5.106).

- Inspectors found that all nine clinics followed adequate medical supply storage and management protocols (MIT 5.107).

- Eight of the nine clinics (89 percent) had operable sinks and sufficient quantities of hand hygiene supplies. The inmate-patient restroom in one clinic lacked disposable paper towels (MIT 5.103).

- Clinical health care staff at seven of eight applicable clinics (88 percent) ensured that reusable invasive and non-invasive medical equipment was properly sterilized or disinfected. An equipment item in one clinic was designated as sterilized and ready for use, but based on the packaging label color coding, the item was not fully sterilized (MIT 5.102).

Other Information Obtained from Non-Scored Results

The OIG gathered information to determine if the institution's physical infrastructure was maintained in a manner that supported health care management's ability to provide adequate health care. The OIG did not score this question. When OIG inspectors interviewed health care management, they did not identify any concerns. MCSP had a number of significant infrastructure projects underway. Those projects and their anticipated completion dates are listed below (MIT 5.999).

- Central health services addition, including renovations of TTA and specialty clinic, support staff space, and CTC floor (June 2016 through March 2017)
- Facilities A, B, and C primary care clinic renovations, including new clothing exchange build-out (May through July 2016)
- New administrative segregation unit primary care clinic, dental clinic, and enhanced outpatient programming (EOP) mental health clinic (July 2016)
- New pharmacy and laboratory building (June 2016)
- Health care administration building renovation (May 2016)
- New EOP medication rooms (September 2016)

Recommendation for CCHCS

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

Recommendations for MCSP

The OIG recommends that MCSP develop local operating procedures that ensure the following:

- All clinical areas maintain a full complement of core medical equipment that includes a Snellen vision chart with a permanent distance marker, oto-ophthalmoscope, and a nebulization unit; and each exam room has an exam table in the immediate area and a biohazard waste receptacle.
- Staff regularly monitor medical equipment items to ensure applicable equipment is in working order and currently calibrated, torn areas on vinyl-covered exam tables are repaired or the tables are replaced, and cracked countertops are repaired.
- Staff verify that reusable invasive medical equipment is properly sterilized.

- Auditory and visual privacy is provided to patients being examined in clinicians' exam rooms; auditory privacy is provided to patients at triage and blood draw stations in clinic common areas; patients' confidential medical records are shredded or secured so they are inaccessible to other inmates and non-health-care staff.

- Clinics are cleaned each day they are operational; all floor surfaces are regularly cleaned; all clinic restrooms are stocked with disposable paper towels.

- Clinicians are aware of proper hand sanitation protocols when examining patients.

INTER- AND INTRA-SYSTEM TRANSFERS

Case Review Rating:
Inadequate
Compliance Score:
Adequate
(82.7%)

Overall Rating:
Inadequate

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

In this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *inadequate* rating and the compliance testing resulting in an *adequate* score. The OIG's internal review process considered the factors leading to both scores and ultimately rated this indicator *inadequate.* The key factors were that the OIG's case review showed poor documentation of chronic care conditions for patients transferring into the institution, poor documentation of pending chronic care appointments, and patients not always receiving their medication timely. These case review findings correlated to low compliance scores for nurses' completion of patients' Initial Health Screening form (CDCR Form 7277) and continuity of administering medication to patients who transferred in, ultimately tipping the balance toward the *inadequate* rating.

Case Review Results

The OIG clinicians reviewed 53 encounters related to *Inter- and Intra-System Transfers*, including information from both the sending and receiving institutions. Clinicians reviewed 12 encounters for inmates transferring into MCSP from other institutions, and ten encounters for inmates transferring out of MCSP to other institutions. The OIG also reviewed 31 events related to patients returning to MCSP from a community hospital or emergency department. In general, the transfer-out process was marginally adequate, but there were significant problems with the handling of transfers in. These deficiencies reflected a systemic problem that placed the patients at significant risk of harm. Despite the risk, the patients discussed below were not harmed, fortunately.

Transfers In

MCSP demonstrated significant problems with access to a provider for patients transferring into MCSP from other CDCR institutions. This finding is also discussed in the *Access to Care* indicator. Since MCSP's population had a high proportion of high-risk patients, the inability to provide new-arrival patients with timely access to a provider was a significant risk.

MCSP was also not able to ensure continuity of medication administration for newly arrived patients.

- In case 4, the patient's new-arrival chronic care medications expired without renewal.
- In case 30, the patient arrived taking daily warfarin (a blood thinner), but the medication was not administered continuously upon his arrival at MCSP.
- In case 15, the patient arrived at MCSP with prescriptions for twice-daily medications. He was administered the morning doses of the medications at the sending institution. However, upon arrival to MCSP, the nurse did not administer or ensure administration of the evening doses.

Nursing performance for patients transferring into MCSP was poor.

- In case 15, the receiving nurse did not recheck the patient's elevated blood pressure reading before his leaving the R&R clinic to return to his housing unit, nor did the nurse ensure that the patient had taken his prescribed blood pressure medications.
- In case 18, the receiving nurse did not obtain a history of medical conditions or assess the patient's vital signs upon his arrival at MCSP. On the health screening form, the nurse noted that the patient did not have any medical conditions requiring him to be under a doctor's care. However, the patient had asthma, gastroesophageal reflux disease (GERD), and hyperlipidemia, and was taking prescribed medications for these conditions. Furthermore, on the new arrival orders, the nurse noted that the patient was enrolled in the chronic care program (CCP) but failed to note when the next CCP appointment was due.

Transfers Out

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

- In case 8, the nurse did not document that the patient was undergoing telemedicine specialty follow-up for seizures.
- In case 13, the nurse did not document the patient's medication allergies on the form.

- In case 18, the nurse did not document the patient's hyperlipidemia and GERD.

- In case 12, a community hospital discharged the patient and MCSP transferred him directly to another institution, but there was no evidence that MCSP transmitted his health care information to the receiving facility.

Hospitalizations

Patients returning from hospitalizations or from outside emergency departments (EDs) are some of the highest-risk encounters due to two factors: these patients are of higher acuity, since, in most cases, they have just been hospitalized for a severe illness; and they are at risk due to the potential lapses that can occur during any transfer of care.

Upon return from an outside hospital, MCSP TTA nurses demonstrated inconsistent performance.

- In case 4, the RN did not review the patient's medication upon the patient's return from the hospital for evaluation of chest pain. The RN noted that there were no new medication orders; however, the discharging ED physician recommended that the patient start high doses of famotidine and sucralfate (antiulcer medications). The RN should have obtained orders for these recommended discharge medications from the on-call provider.

- In case 7, the RN did not assess the status of the various puncture wounds to the patient's hand, back, and chest, nor notify the on-call provider of the patient's return from the hospital.

- In case 8, the RN did not review the recommended medication changes upon the patient's hospital discharge. The discharging hospitalist recommended that the patient discontinue the prescription of oxcarbazepine (anticonvulsant), but the RN failed to notify the on-call physician of the recommendations.

- In case 26, the RN performed a minimal assessment of the patient's right finger surgical wound area and failed to inform the PCP that the patient was allergic to codeine when the PCP ordered acetaminophen with codeine.

Medication continuity for patients returning from the hospital was also problematic.

- In case 27, a hospital prescribed the patient antibiotics due to a serious infection. While the TTA nurse administered the first dose of the antibiotic in the TTA, the patient did not receive the dose the following day. MCSP staff failed to administer two other less critical medications until the third day after the patient's return from the hospital.

- In case 8, the patient had been prescribed several twice-daily direct observation therapy (DOT) medications. Upon the patient's return from the hospital, nursing staff did not administer the evening doses of those DOT medications.

Of lesser significance, MCSP did not ensure that a provider properly signed or initialed hospital discharge summaries and outside emergency reports. Institution staff scanned nearly all such reports with no evidence of provider review. This was only a minor finding because MCSP performed well in retrieving those specific reports and to ensure those patients had timely follow-up appointments with a provider.

Systemwide Transfer Challenges

In reviewing *Inter- and Intra-System Transfers*, the OIG acknowledges systemwide challenges common to all institutions. Nurses are responsible for accurately communicating pertinent information, identifying health care conditions that need treatment and monitoring, and facilitating continuity of care during the transfer process. While this is sufficient for most CDCR inmate-patients, it has not been adequate for patients with complex medical conditions or patients referred for complex specialty care. Often, nurses who are either not familiar with the patient's care or not part of the primary care team initiate the transfer forms. In addition, providers are often left out of the transfer process altogether, and patients are transferred without the provider's knowledge. Without a sending and receiving provider, the risk for lapses in care increases significantly. These problems were prevalent at MCSP, which housed a large percentage of high-risk patients. The OIG understands CCHCS is currently working to revise the transfer policy with its Patient Management Care Coordination Initiative, and looks forward to reviewing that new policy.

Compliance Testing Results

The institution obtained an *adequate* compliance score of 82.7 percent in the *Inter- and Intra-System Transfers* indicator. MCSP performed in the *proficient* range in the three tests below:

- The transfer packages for all three inmate-patients tested who transferred out of the institution during the onsite inspection included required medications and related documentation (MIT 6.101).

- For 29 of 30 sampled patients who transferred into the institution (97 percent), RNs timely completed the assessment and disposition sections of the Initial Health Screening form (CDCR Form 7277) on the same day they performed the patients' initial health screenings. The only exception was one patient whom the RN did not refer to the TTA after the patient showed signs and symptoms of tuberculosis (MIT 6.002).

- Inspectors sampled 20 patients who transferred out of MCSP to another CDCR institution to determine whether the institution listed their scheduled specialty service appointments on the Health Care Transfer Information form (CDCR form 7371). MCSP nursing staff documented the previously approved and still pending specialty service appointments for 18 patients (90 percent), but failed to do so for two others (MIT 6.004).

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

- For 23 of 30 sampled patients who transferred into the institution (77 percent), nursing staff completed a health screening assessment on the same day the patient arrived. On seven patients' Initial Health Screening assessment forms (CDCR Form 7277), nursing staff either failed to answer one or more questions, did not complete a question, or answered a question incorrectly (MIT 6.001).

The institution has an opportunity to improve in the following area:

- Out of 30 sampled patients who transferred into the institution, 22 had an existing medication order upon arrival. When inspectors tested those patients' records to determine if they received their medications without interruption, only 11 (50 percent) were in compliance. For ten patients, MCSP nursing staff did not administer the next required dosing interval of one or more medications; for another patient, nursing staff failed to administer the next required weekly injection of a medication (MIT 6.003).

Recommendations

No specific recommendations.

PHARMACY AND MEDICATION MANAGEMENT

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(58.3%)

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 the PCP prescriber, staff, and patient.

Case Review Results

The OIG clinicians evaluate pharmacy and medication management as secondary processes as they relate to the quality of clinical care provided. Significant problems with unreliable medication administration, warfarin administration errors, and breaks in medication continuity for patients transferring into MCSP resulted in an *inadequate* rating for this indicator.

Nursing Medication Administration

MCSP demonstrated an inconsistent ability to properly administer medications. Missed medication doses in the CTC in cases 66 and 67, as well as the following specific examples, demonstrated this common deficiency:

- In case 20, nursing staff did not administer a prescribed dose of terazosin (medication for enlarged prostate) nor document any explanation for not doing so. Subsequently, the prescription expired. A few weeks later, the patient requested refills of the expired medications. The RN did not accurately review the patient's medications, and mistakenly wrote back to the patient that his prescriptions had not yet expired. At a later time, a physician ordered skin cream for precancerous skin lesions, but there was no evidence that MCSP administered that medication. Further, despite orders to stop aspirin prior to surgery, this patient was given aspirin on the stop date. When the patient developed a wound infection, a physician ordered antibiotics, but there was no evidence nursing staff administered the medication. When the physician ordered intramuscular antibiotics for the continued infection, there was a delay of two days before administration. This one case demonstrated severe and repetitive problems with medication continuity and administration at MCSP, possibly contributing to some of the patient's repeated infections.

- In case 27, MCSP failed to administer a scheduled dose of adalimumab (Humira) for rheumatoid arthritis.

- In case 32, a provider ordered vitamin B12 injections to treat a vitamin deficiency. There was no evidence that the prescription was processed or administered for four months.

- In case 33, a provider increased the dose of an important heart medication. However, the medication administration record (MAR) showed that it took nearly a month for nurses to administer the correct dose.

- In case 4, newly ordered medications took three and five days to be administered to the patient.

Warfarin Administration

In case 29, there were numerous medication errors in warfarin administration found, which continued for several months. The following medication errors were not identified and reported by MCSP nursing or pharmacy:

- The MAR showed that the patient received extra doses of warfarin numerous times.

- Nursing staff administered warfarin medications on days they were not scheduled to be given.

- The medication nurse initialed that warfarin was administered, then crossed out the initial without explanation as to whether the medication was actually given.

- When the provider ordered staggered dosing of warfarin, the nurse did not properly transcribe the discontinued order on the MAR and mistakenly administered extra doses of warfarin. When the provider ordered the warfarin dose be held, the patient still received the medication.

In case 30, there were also numerous critical medication errors in warfarin administration, which were not identified and reported by MCSP nursing or pharmacy. Because of the potentially life-threatening severity of the errors, the OIG immediately notified MCSP and CCHCS of the errors upon discovering them. MCSP responded promptly and quickly implemented a comprehensive corrective action plan.

- The MAR showed that the patient received extra doses of warfarin numerous times.

- Although the physician ordered the patient to receive warfarin medication once daily, the MAR showed two different administration times (morning and bedtime) during the month of October.

- The physician changed the warfarin dosage twice, but the nurse continued to administer the previous dosage.

- The medication nurse initialed administration of the warfarin dose for several days, and then crossed out the initials without any explanation of any error. It was unclear whether the nurse administered the dose. More importantly, the nurse recognized the dose was only to be administered on a specific day, but did not report the medication errors that occurred. By failing to report the critical medication errors, the nurse placed the patient at significant risk of harm.

Medication Management

In addition to nursing administration, nursing performance regarding medication management was also problematic.

Nurses regularly neglected to notify the provider when a patient was non-compliant with his medications. OIG clinicians identified this deficiency numerous times in each of the cases 4, 6, and 27.

- In case 4, the patient had a stent (device to keep a blood vessel unblocked) placed in a heart artery less than a year prior. It was important for him to take the medication clopidogrel, which lowered the risk of a stent blockage, which can lead to a heart attack. When the patient began to refuse the medication, nurses did not appropriately refer the patient to the provider, and the patient was not counseled on the importance of taking the medication. Fortunately, no apparent harm resulted from this oversight.

Pharmacy Errors

The OIG clinicians could not clearly determine the extent of responsibility of pharmacy services in the errors and delays identified in medication administration through case reviews. However, ambiguous warfarin dosing instructions certainly contributed to the frequency of warfarin administration errors.

Medication Continuity

There were problems with medication continuity for patients who returned to the institution from a hospitalization, those who transferred into the institution from another CDCR facility, and those who had recently been prescribed chronic medications. These errors occurred in cases 4, 8, 27, and 30.

Breaks in medication continuity for hospital or intra-system transfers are further discussed in the *Inter- and Intra-System Transfers* indicator.

MCSP performed better in maintaining medication continuity for patients simply prescribed chronic medications, but breaks were still identified in cases 4, 20, 26, 27.

Compliance Testing Results

The institution received an *inadequate* compliance score of 58.3 percent in the *Pharmacy and Medication Management* indicator. For discussion purposes below, this indicator is divided into three sub-indicators: Medication Administration, Medication Preparation and Administration Controls, and Pharmacy Protocols.

Medication Administration

For this sub-indicator, the institution received an average score of 68 percent, which fell into the *inadequate* range. The institution needs to improve in the following three areas:

- Clinical staff timely provided new and previously prescribed medications to only 15 of 30 patients sampled upon their return to the institution from a community hospital (50 percent). Thirteen patients received one or more of their KOP or DOT medications from one to three days late. One other patient, whose DOT medication was reordered timely when the patient returned to MCSP, never received his medication; instead, the provider canceled the prescription three days after the order date. The remaining patient received a supply of medication as KOP dosing seven days after the provider ordered the medication to be administered as DOT dosing, and did not receive two other KOP medications at all (MIT 7.003).

- The institution timely dispensed chronic care medications to 27 of 40 patients sampled, (68 percent). Inspectors found the following deficiencies (MIT 7.001):

    - Five patients who missed or refused doses of their DOT medications did not receive a nurse referral for provider counseling, or the provider counseling was untimely or did not occur at all;

    - Another patient who refused to pick up his KOP medications received counseling 11 days late;

    - Four patients received their KOP medications from 2 to 53 days late, or did not receive them at all during the OIG's three-month testing period;

    - One patient received his DOT medication two days late;

    - Another patient continued to receive a DOT medication for 12 days after it was discontinued;

    - Nursing staff failed to restart one patient's DOT medication for seven weeks after the PCP ordered the medication be held for only a few days due to a medical procedure.

- The institution timely administered or delivered new medication orders to only 29 of the 40 patients sampled (73 percent). Six patients continued to receive a previously prescribed dosage of their medications from one to seven days, even though their provider had changed the prescribed dosage. Four other patients received their KOP medications from one to five days late, or not at all; another patient received his DOT medication one day late (MIT 7.002).

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

- Of the 30 sampled patients at MCSP who had transferred from one housing unit to another, 25 (83 percent) received their prescribed DOT medications without interruption. Five patients did not receive one or more doses of their medications at the next dosing interval after the transfer occurred (MIT 7.005).

Observed Medication Practices and Storage Controls

For this sub-indicator, the institution received an average score of 51 percent, scoring within the *inadequate* range in the following five tests:

- The OIG interviewed nursing staff and inspected narcotics storage areas at the eight clinic and medication line locations that stored narcotics to assess whether strong security controls existed. At all eight locations, inspectors found one or more of the following exceptions (MIT 7.101):

    - At seven locations, the narcotics logbook was not counter-signed by two nursing staff at every shift change;

    - In the TTA, narcotics stored in a medication cart were not separately locked up in a narcotics lock box within the cart;

    - At another location, nursing staff did not update the narcotics logbook when removing patients' medications from the narcotics locker and instead updated the logbook after the entire medication pass was completed.

- Nursing staff at only three of seven inspected medication preparation and administration locations (43 percent), followed proper hand hygiene contamination control protocols during the medication preparation and administration processes. At four locations, nursing staff did not re-sanitize their hands after changing gloves (MIT 7.104).

- Nursing staff followed appropriate administrative controls when distributing medications to patients at only three of seven applicable medication preparation and administrative locations, resulting in a score of 43 percent for this test. At three pill lines, there was no overhang or shade protection to shield patients from extreme heat or inclement weather; at one of those three pill lines, nursing staff failed to document the administration of a narcotic

medication on the patient's MAR. At the ASU, nursing staff did not verify the identification of two patients who were brought to the medication room to receive insulin and did not observe whether another patient had swallowed his medication after the nurse administered it (MIT 7.106).

- The institution properly stored non-narcotic, non-refrigerated medications at 10 of the 16 applicable clinics and medication line storage locations (63 percent). One or more of the following deficiencies emerged at the other six locations: Five clinics' medication storage cabinets or carts had oral and topical medications stored together. Two clinics' medication storage cabinets had personal food stored in them (Figure 2). In one clinic's medication cabinet, there was an open bottle of topical medication with no documentation as to when it was opened or would expire, as well as a bag of IV fluid removed from its outer cover with the same lack of documentation. Also, that clinic had no system in place for returning medications to the pharmacy on weekends. Finally, at one other clinic, staff failed on one occasion to document the daily logbook for the crash cart, evidencing that the cart's security lock was checked (MIT 7.102).

Figure 2: Food stored in medication area

- Non-narcotic refrigerated medications were properly stored at seven of ten clinics and medication line storage locations (70 percent). At two locations, exceptions were found related to refrigerator temperatures not being kept within the acceptable range or the temperature logbook not being completed. At a third location, the refrigerator contained an open vial of insulin without any documentation as to when it was opened or would expire (MIT 7.103).

MCSP scored in the *proficient* range in the following test:

- MCSP nursing staff at six of seven sampled locations (86 percent) employed appropriate administrative controls and protocols when preparing patients' medications. A nurse that worked second watch at one location assisted the third watch nurse by preparing medications in advance for the next medication pill line. Policy requires that the same nurse who prepares medications in advance should also administer the medications to patients (MIT 7.105).

Pharmacy Protocols

For this sub-indicator, the institution received a total score of 59 percent, and scored a zero percent in the following two tests:

- In its main pharmacy, MCSP did not properly store non-refrigerated medication. Inspectors found medication boxes on the floor of the pharmacy, expired medications, and a personal beverage item stored next to medication (MIT 7.108).

- Similarly, the main pharmacy did not properly store refrigerated or frozen medications. The refrigerator log showed temperatures that exceeded the acceptable range on several days during the prior 30-day period (MIT 7.109).

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

- In its main pharmacy, the institution followed general security, organization, and cleanliness management protocols (7.107).

- The institution's Pharmacist-in-charge (PIC) properly accounted for narcotic medications stored in MCSP's pharmacy and reviewed monthly inventories of controlled substances in the institution's clinical and medication line storage locations (MIT 7.110).

- The institution's PIC properly processed 29 of 30 medication error reports that the OIG sampled (97 percent). One medication error report was submitted two days late (MIT 7.111).

Non-Scored Tests

- In addition to testing reported medication errors, OIG inspectors follow up on any significant medication errors that were found during the case reviews or compliance testing to determine whether the institution properly identified and reported errors. At MCSP, the OIG did not find any applicable medication errors subject to this test (MIT 7.998).

- The OIG tested inmate-patients in isolation units to determine if they had immediate access to their prescribed KOP rescue inhalers and nitroglycerin medications. Fourteen of the 19 applicable patients had possession of their rescue medication. Medical staff immediately issued or returned rescue medication to the five inmates that did not have their medication in their possession (MIT 7.999).

Recommendation

The OIG recommends that nursing staff receive training in the use of proper hand hygiene protocols when administering medication.

PREVENTIVE SERVICES

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

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(66.5%)

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 66.5 percent. The institution showed room for improvement in the following areas:

- The institution scored 33 percent for timely administering anti-tuberculosis medications (INH) to patients with tuberculosis. Of the nine patients sampled, only three received all required doses of their medication during the three-month test period. Inspectors identified one or more of the following exceptions for the six remaining patients (MIT 9.001):
    - Patients were given or offered daily doses of INH medication on days when it was not prescribed;
    - Patients missed one or more bi-weekly doses of INH, or did not receive medication at all for 18 or 24 days;
    - Some patients who missed doses and were referred for provider counseling never received it;
    - Some patients who missed doses of INH were never referred for counseling.
- Of those nine patients sampled who were prescribed INH, the institution completed required monthly tuberculosis monitoring for only five of them (56 percent). Four patients did not receive required monthly monitoring for one or more months during the three-month test period (MIT 9.002).
- OIG inspectors sampled 30 patients to test whether they received an annual tuberculosis (TB) screening within the last year. Fifteen of the sampled patients were classified as code 34 (subject only to an annual signs and symptoms check), and 15 were classified as code 22

(requiring a TB skin test in addition to a signs and symptoms check). The institution scored only 50 percent for its ability to timely conduct these annual TB screenings. Inspectors identified the following deficiencies for patients designated as code 34 or 22 for TB screening (MIT 9.003):

  - For three code 34 patients, nursing staff failed to complete the history section of the patients' Tuberculin Testing/Evaluation Report (CDCR Form 7331) regarding their prior history of TB disease;
  - Nursing staff did not sign or date the Form 7331 for one code 34 patient;
  - For five code 22 patients, nurses did not document when they administered the test, which prohibited inspectors from determining if the nurse timely read the test;
  - For four code 22 patients, nursing staff failed to document a signs and symptoms check;
  - For three code 22 patients, an LVN, rather than an RN, public health nurse, or primary care provider, read the test results;
  - The TB test was not read within the required 48-to-72-hour time frame for one code 22 patient;
  - One code 22 patient did not receive a tuberculosis test within the last 12 months.

- The OIG tests whether the institution offered vaccinations for influenza, pneumonia, and hepatitis to patients who suffered from a chronic care condition. At MCSP, 14 of 20 patients sampled (70 percent) received all recommended vaccinations at the required interval. Two patients had no record that they received, or that the institution offered, the recommended pneumonia and hepatitis A and B vaccinations; three patients were not offered or did not receive just the pneumonia vaccination, and one patient was not offered or did not receive a hepatitis A vaccination (MIT 9.008).

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

- The institution timely offered an influenza vaccination to 29 of 30 sampled patients, scoring 97 percent for this test. One patient was never offered the vaccine during the most recent influenza season (MIT 9.004).
- Twenty-eight of 30 patients sampled (93 percent) either had a normal colonoscopy within the last ten years or were offered a colorectal cancer screening within the previous 12 months. Two patients neither received a normal colonoscopy within ten years nor were offered the cancer screening in the prior 12 months (MIT 9.005).

Recommendations

No specific recommendations.

QUALITY OF NURSING PERFORMANCE

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

Overall Rating:
Inadequate

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

Case Review Results

The *Quality of Nursing Performance* at MCSP was *inadequate*. OIG clinicians reviewed 382 nursing encounters, finding 160 nursing deficiencies, 43 of which were significant. Deficiencies generally fell into four broad categories: nursing triage, assessment, documentation, and referral to a provider.

Nursing Sick Call

CCHCS policy requires an RN to review every sick call request on the day it is received to identify symptoms that may result in patient harm if not addressed on a same-day, urgent/emergent basis, and to schedule all other patients for RN assessments on the next business day. Serious deficiencies occurred with nurses reviewing sick call requests and failing to recognize the need for same-day RN assessments or provider evaluations. The OIG clinicians reviewed 159 RN sick call encounters. The following are examples of deficiencies:

Nursing Triage Deficiencies

- In cases 20 and 24, the RN did not assess the patient face to face one business day after the sick call request was reviewed.

- In case 23, two sick call requests (CDCR Form 7362) were not completed until four months later. The nurse noted on the form that the PCP saw the patient, but the PCP did not address the patient's medical concerns during the appointment. There were also two other sick call requests not reviewed on the day they were received.

Failure to Identify Urgent/Emergent Conditions

- In case 7, the patient submitted a sick call request for severe pain and hand swelling, but he was not assessed by the RN. The patient also submitted a sick call request two months later for persistent pain on his right fourth finger, but the RN did not perform a face-to-face assessment.

- In case 15, the patient submitted a request for an evaluation of severe neck pain with finger numbness and spasms, radiating to the shoulders and back. The RN did not see the patient the same day the CDCR Form 7362 was reviewed.

- In case 20, the patient submitted two requests for an evaluation of facial swelling and difficulty swallowing and breathing. The RN did not immediately see the patient.

- In case 24, the patient submitted a request for an evaluation of constant shoulder pain. The RN noted the patient was already scheduled to see the PCP in a couple of days regarding this concern, and instructed the patient to wait for his appointment notification. The RN did not see the patient face-to-face and assess for a possibly urgent PCP referral. This was the patient's third request.

- In case 27, the patient submitted a request for an evaluation of symptoms that were potentially life-threatening side effects of the adalimumab (Humira) medication. The RN reviewed the request, but failed to perform an assessment. The RN failed to address the patient's symptoms or to refer the patient to the provider. The sick call request was not completed until three months later.

- In case 30, the patient submitted a sick call request on two occasions stating that he was a high-risk patient taking warfarin (blood thinner) and that he had not seen the doctor or had a blood test since he arrived nearly a month previously. The patient also wrote that his warfarin medications were crushed and he was concerned if he was receiving the correct dosage. The RN did not perform a nursing assessment or medication review to determine whether the patient was receiving the correct dosage or having any adverse side effects from the high-risk medication.

- In case 40, the RN did not see a patient with fatigue, dizziness, and incontinence. The RN noted that the patient was scheduled for a PCP visit in two days.

- In case 41, the patient submitted a request stating that he was attacked by an inmate, was injured, and could not use his right shoulder due to pain. The RN did not assess the patient face-to-face but wrote that the patient had a primary care provider appointment for the same concern. The OIG checked the schedule, which did not show an appointment scheduled with the provider.

- In case 53, the RN did not assess the patient with testicular pain on the same day the sick call request was reviewed.

- In case 58, over the course of one month, the patient submitted three sick call requests for neck and back pain. The RN did not see the patient for face-to-face assessment for any of these requests.

- In case 59, the LVN provided a 24-hour note to rest in housing to a patient with nausea, vomiting, diarrhea, and fever, but did not refer him to the RN or PCP on the same day. When the patient saw the RN the next day, the nursing assessment indicated signs and symptoms of leg infection, but the nurse did not refer the patient to the PCP on the same day.

- In case 69, the RN failed to see a patient with fever, chills, and night sweats on the same day the sick call request was reviewed.

Inadequate Nursing Assessment

The majority of nursing encounters demonstrated inadequate assessment. In many cases, the OIG clinicians could not determine if the nurse asked important questions, examined pertinent areas of the body, or performed necessary measurements. Nurses also failed to document the presence or absence of common accompanying signs and symptoms. These deficiencies were found in cases 7, 13, 15, 20, 21, 27, 28, 45, 48, 58, 60, and the following specific examples:

- In case 8, the patient saw the RN for severe knee and hand pain. The RN did not obtain a history regarding the cause, onset, or duration of the knee pain, and failed to adequately assess the knee.

- In case 23, the patient saw the sick call RN ten times. Each time, the RN failed to perform an adequate assessment. The RN did not obtain a history or perform a focused assessment of the patient's complaints.

Failure to Refer to the Provider

- In case 15, the RN did not refer the patient to the provider on the same day for severe neck and back pain with spasms and numbness of the fingers.

- In case 20, the RN did not notify the PCP about the change in color of wound drainage and elevated temperature, which could have indicated infection.

- In case 23, the RN did not refer the patient with signs and symptoms of wound infection to the provider on the same day. When the provider saw the patient in the TTA two days later, the wound was infected and required antibiotics.

- In case 59, the RN did not forward the service request form or refer the patient to dental services for painful mouth sores. A dentist did not see the patient until after the patient submitted his fourth sick call request. The RN also failed to refer the patient with signs and symptoms of a leg infection to the provider on the same day.

- In case 69, the RN saw the patient for fever and chills. The patient was seen in the TTA five days previously with a provider follow-up visit ordered in one to two days. The RN failed to note that the PCP follow-up did not occur, and should have referred this patient with persistent fever to the provider on the same day. The patient with a history of a blood infection and heart valve replacement was subsequently admitted to the hospital for septicemia (bacteria in the blood).

Failure to Follow Provider Orders

- In case 6, daily blood pressure checks ordered for seven days were not completed.

- In case 20, the RN noted that the provider ordered immediate blood draws, but the RN did not perform the tests immediately.

- In case 30, the provider ordered the holding of one dose of warfarin, but the medication nurse gave the patient the dose. The provider also ordered the warfarin dose decreased and a repeat of a laboratory test. The nurses failed to carry out these orders.

Nursing Documentation

The OIG found minor deficiencies in documentation as required by CCHCS nursing policy and protocols. These are part of the institutional nursing education and training orientation.

- In cases 21, 24, 25, and 27, the time the TB skin test was administered and read was not documented.

- In cases 25 and 64, the RN did not document the date and time of receipt and review of the CDCR Form 7362.

- In case 6, nursing staff did not complete a refusal form when the patient refused his nurse appointment.

- In cases 4, 16, 18, 19, and 60, the nurse failed to document the patients' vital signs.
- In case 23, the nurse did not document the patient's vital signs, tetanus immunization status, or wound care instructions. The nurse also failed to sign the progress note.
- In cases 19 and 20, there were inadequate descriptions of wounds.
- In case 26, the nurse's handwriting was illegible. In cases 16, 17, 19, 22, 24, 25, 59, and 60, either the nurse did not sign the progress note or the signature was illegible.

Offsite Specialty Services Returns

Among 48 nursing encounters reviewed for patients returning from an offsite specialist consultation, there were 17 deficiencies. At MCSP, the R&R clinic processed patients returning from offsite specialty appointments. The nurses generally spent minimal time assessing the patient, which often resulted in inadequate nursing assessment. Nurses rarely obtained vital signs, and documentation was often incomplete or illegible. There was no education or instruction provided to each patient who underwent procedures. These findings are also discussed in the *Specialty Services* indicator.

Wound Care Documentation

Inadequate wound care documentation, including documentation not scanned into the eUHR, was another significant deficiency. During the OIG's onsite inspection, nursing staff were interviewed about the process of wound care in the outpatient clinics. The clinic scheduler generated a list daily for the treatment nurse, and the patients were provided passes to come to the clinic for dressing changes. Each patient presented his pass to the treatment nurse, who then retrieved the wound care form from the treatment binder and performed the dressing change. Some of the wound care forms in the binder were over three months old and were never scanned into the eUHR. There were also numerous incomplete or blank wound care forms. Nursing staff explained that the binder was not regularly reviewed to check which patients did not present at the clinic for dressing changes, and there was no mechanism for following up with these patients.

- In cases 5, 12, and 26, there was no evidence that nurses performed wound care as ordered.

Specialized Medical Housing

The nursing care in the CTC was inadequate. See the *Specialized Medical Housing* indicator for specific findings.

Medication Administration

There were significant problems in medication administration, placing patients at risk of serious harm. There were critical medication errors that were not reported by nursing and pharmacy. During the onsite visit, the medication LVNs did not participate in the morning huddles where information

about new or changed medication orders should have been discussed. See the *Pharmacy and Medication Management* indicator for specific findings.

Inter- and Intra-System Transfers

Nursing services in the inter- and intra-system transfer process were inadequate. There were significant deficiencies with transfers-in related to delay in primary care provider referrals and scheduling of specialty appointments, lack of medication continuity, and inadequate nurse screening. The deficiencies with transfers-out were generally related to nurses' failure to include significant medical information on the transfer form. See the *Inter- and Intra-System Transfers* indicator for specific examples.

Onsite Visit

The OIG clinicians attended the morning huddles in the outpatient clinics. The office technician facilitated the huddles, with the primary care RN, care management RN, supervising RN, primary care provider, LVN for the clinic provider, and a mental health clinician present. Custody officers attended only on an as-needed basis. The huddle topics included custody issues, TTA visits, hospital admissions and discharges, transfers in and out, new chronic care program patients, significant diagnostic reports, and staffing or supplies issues. However, there were no meaningful reports provided from nursing on the sick call and case management line status, or other clinical nursing issues. The medication LVNs did not attend the morning huddles, thus medication issues, such as medication non-compliance and new orders, were not consistently discussed in all clinics.

The nurses interviewed stated that they received an average of 50 sick call requests and saw 15 to 20 patients per day. At the time of the OIG visit, there were backlogs in the nursing sick call in some of the clinics. They reported generally having no problems communicating with the PCP throughout the day. RNs were aware of the nursing sick call performance monitoring conducted by nursing supervisors monthly, but stated that they rarely received feedback. Nurses were generally unclear about any other nursing performance monitoring strategies in progress and unaware of specific performance improvement efforts underway at MCSP.

The OIG clinicians visited various clinical areas and spoke with nursing staff during walking rounds, including nurses in specialty services, telemedicine, utilization management, TTA, CTC, outpatient clinics, and administrative segregation units. Nursing staff were knowledgeable about the general duties and the patient populations within their assigned clinical areas. However, nursing staff voiced that they were not familiar with their specific job responsibilities. The care management RNs, in particular, were not aware of their job responsibilities, and as such, were underutilized in the outpatient clinics. In addition, the outpatient clinics did not have adequate workspace for the care management RNs to see patients. Some of the nurses interviewed were also new to their assigned areas and felt that they did not receive adequate orientation or that they needed more time to familiarize themselves in their assigned area. None of the nurses interviewed received a written job description or training on the local operating procedure specific to the area to which they were assigned.

The nursing education program at MCSP provided staff with the required annual mandated training, policy update reviews, and skills improvement. Examples of these are medication administration competency, nursing protocols, and effective communication trainings. Although the nursing training files showed that nurses were current with the required trainings, nursing staff interviewed felt that they did not receive adequate training specific to the TTA, CTC, specialty services, or telemedicine. The OIG clinicians also reviewed ten supervisory files and found four lacking the most recent performance evaluation. There were no staff performance issues identified in these files.

A majority of the nurses interviewed expressed low morale among staff due to staffing shortages resulting in redirections and mandated overtime. The nurses also felt that nursing leadership was not visible and available enough to address nursing issues. The nursing leadership confirmed that there was a 40 percent vacancy rate recently, but that the vacancies were slowly being filled. MCSP had recently hired registry staff, and there were newly hired nurses in orientation during the OIG visit.

Recommendations

The OIG recommends that MCSP:

- Standardize the morning huddles and include a discussion of sick call requests received that day.

- Review and improve the current process of evaluating nursing competency to glean an accurate assessment of a nurse's knowledge and performance.

- Provide nurses additional training to ensure that they recognize cases requiring same-day assessment. Also, provide training to appropriately prioritize sick call requests to help reduce the backlog of patient appointments.

QUALITY OF PROVIDER PERFORMANCE

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

Case Review Rating:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

Case Review Results

The OIG clinicians reviewed 152 medical provider encounters and identified 93 deficiencies related to provider performance at MCSP, 23 of which were significant. As a whole, the OIG clinicians rated MCSP provider performance *adequate.*

Assessment and Decision-Making

MCSP providers demonstrated adequate assessment and decision-making for the patients' primary medical concerns in the majority of cases reviewed. Most deficiencies in this category related to providers failing to assess or address issues that were not of immediate importance. A complex patient with multiple medical concerns often saw his issues worsen while waiting to see a provider. Since MCSP had tremendous difficulty in providing patients with adequate follow-up appointments, providers occasionally overlooked some of the outstanding issues. By the time a provider actually saw a patient, there was often insufficient time to address all of the patient's medical concerns.

Provider errors in assessment were widespread, identified in cases 4, 5, 6, 16, 26, 28, 30, 32, 35, 36, and 69. The following examples illustrate how otherwise well-performing MCSP providers overlooked important medical concerns because they were not the most pressing issues at the time of the visit:

- In case 6, the patient had poorly controlled diabetes and was refusing his diabetic and blood pressure medications. He was also insistent that the provider start a specific pain medication for nerve damage. The provider proficiently counseled the patient regarding his diabetes and blood pressure and ordered repeat labs and a new nerve test. However, the provider overlooked the patient's history of coccidioidomycosis infection and the infectious disease consultation that had occurred two weeks earlier. The consultation was adequately addressed three weeks later, but the patient continued to refuse further tests and medications. He was subsequently admitted to an outside hospital with severe disseminated coccidioidomycosis infection and respiratory distress.

- In case 35, the provider saw the patient for follow-up of an oncology specialty consultation that had occurred six weeks prior. The oncologist recommended that the patient be sent to a

bone marrow transplant center for evaluation. The provider adequately reviewed the consultation and placed the appropriate referral. However, the provider overlooked the patient's newly diagnosed diabetes and his elevated blood pressure level. By the end of the review period, the patient had still not been evaluated for a bone marrow transplant, and the providers had not adequately addressed the patient's diabetes and hypertension. The OIG requested MCSP re-evaluate this patient's case.

The examples above were illustrative of errors that commonly occur in medical practices with high patient complexity. Providers typically mitigate the risks of these errors by having patients return frequently for close follow-up and re-evaluation. However, since MCSP had significant difficulty in providing follow-up appointments, the providers' oversights took on greater significance in this institution.

Examples of high-quality, comprehensive provider care were found commonly throughout the case reviews:

- In case 24, the patient had a history of congenital hydrocephalus, a buildup of excess cerebrospinal fluid, which can lead to increased pressure and brain damage. The patient had a shunt device placed to relieve the pressure. Despite at least two patient refusals, the provider consistently referred the patient to the neurosurgeon for continued follow-up of the shunt to ensure that it was functioning correctly. The provider also closely monitored the patient's lab studies and hormone levels, as the patient was also being treated for gender dysphoria. When the patient developed evidence of a serious infection, the provider diligently evaluated the patient and sent him to a hospital for further treatment.

Provider-Ordered Follow-up Intervals

A strong pattern emerged (cases 25, 26, 28, 29, 32, 35, 36, 59, and 69) in which providers did not order appropriate follow-up intervals for their patients. This pattern was evidence of providers trying to minimize the generation of appointments given the excess demand for provider appointments.

Review of Records

MCSP providers demonstrated frequent cursory review of records. This deficiency was identified in cases 4, 6, 24, 25, 26, 30, 31, 32, 35, and the following case:

- In case 27, the patient had been hospitalized due to a serious infection. The discharging hospital diagnosed him with enlargement of the prostate and urinary retention and started him on antibiotics and prostate medication. Due to a combination of patient refusal and MCSP scheduling difficulty, a provider did not see him for follow-up after the hospitalization. Five weeks later, during a chronic care visit, the provider addressed the patient's chronic conditions, but did not review the hospital records and was seemingly unaware that the patient had been started on prostate medication.

While no harm came from this oversight, the OIG clinicians consider it risky for primary care providers to care for patients seemingly unaware of the important events, such as hospitalizations.

Emergency Care

MCSP emergency care provider performance was adequate. TTA and on-call providers generally made accurate assessments and triage decisions. Those patients requiring higher level of care were "sent out" appropriately. Of the 56 TTA encounters reviewed, only three errors in this category were attributable to providers. One of these uncommon errors is described in the following example, which is provided for quality improvement purposes only:

- In case 69, the patient had endocarditis (heart valve infection) in the past that required an aortic valve replacement. He presented to the clinic with three weeks of fever, body aches, and weight loss. Blood tests showed evidence of an infection. The physician did not perform an evaluation in the clinic, but sent the patient to the TTA, which was staffed by a mid-level provider. Because of the medical complexity of the case, the mid-level provider had a telephone consultation with the initial clinic physician. They discussed the case, but did not review the labs. The patient was inappropriately kept in the institution instead of sent out to a higher level of care. The patient returned to the TTA the following day, where another provider reviewed the labs and sent him out to the hospital appropriately. This example illustrated MCSP's seemingly overwhelming clinic demand, where the clinic provider apparently did not have time to assess the acutely ill patient. Instead, he referred the patient to a less qualified provider for further evaluation.

Chronic Care

MCSP patients were of high medical complexity. While chronic care performance at MCSP was considered inadequate due to various system problems, provider chronic care performance was adequate.

MCSP's anticoagulation patients in 2015 were initially managed in an anticoagulation clinic, which had been canceled by the time of the OIG's inspection. By autumn 2015, MCSP's anticoagulation patients were managed by individual PCPs in their respective outpatient clinics. Providers generally made sound assessments and appropriate interventions. Some providers failed to closely follow CCHCS warfarin management guidelines, leading to some minor delays in care. While providers performed adequately in this regard, MCSP's anticoagulation management was generally poor, primarily due to severe errors in warfarin administration. Those findings are discussed separately in the *Quality of Nursing Performance* and *Pharmacy and Medication Management* indicators.

Hepatitis C management at MCSP was proficient. MCSP designated one primary care physician and one nurse practitioner as hepatitis C and HIV "champions." These providers followed patients with hepatitis C and HIV closely and, in consultation with other specialists, delivered excellent coordinated care.

- In case 5, the patient had a history of possible liver cancer that seemingly resolved spontaneously. The patient also had hepatitis C and end-stage liver disease. The hepatitis C provider expertly coordinated care between the medical oncologist and the CCHCS treatment authorization team for this rare and unique case, and was able to successfully start hepatitis C treatment for the patient during the period of review.

MCSP providers accurately assessed most diabetic cases at the time of the patient's visit. Providers appropriately ordered lab monitoring, reviewed the tests, ordered follow-up appointments, and initiated appropriate interventions. Providers sometimes ordered suboptimal follow-up intervals for patients needing adjustments of their insulin. Patients undergoing basal insulin adjustment should have their fingerstick glucose tests reviewed and adjusted every three to seven days. In case 32, the provider ordered follow-up in three to five weeks. While the provider care was generally adequate for patients with diabetes, scheduling backlogs often prevented appropriate follow-up appointments. Diabetes management requires close coordination of provider appointments, labs, and follow-up appointments. The lack of appropriate follow-up appointments also interfered with the OIG clinicians' full review of MCSP providers' diabetic management.

Specialty Services

MCSP providers appropriately referred patients for specialty services.

Documentation Quality

Many instances of insufficient documentation were identified, the most common of which were failure to address one or more medical problems, inadequate discussion to support the medical decision, and the lack of documentation altogether.

Insufficient documentation was identified in cases 5, 7, 15, 16, 25, 26, 28, 30, 31, 32, and 69. The majority of these errors were considered minor.

MCSP providers almost never documented their telephone encounters when assigned on-call duty (POC). This deficiency was widespread, and was identified in cases 4, 5, 6, 7, 15, 17, 25, 27, and 69. This lack of documentation made it impossible to assess the performance of nurses and providers when performing telephone consultation. Nevertheless, the vast majority of triage decisions that resulted from these telephone encounters were seemingly appropriate.

Provider Continuity

Case review found provider continuity adequate in a majority of outpatient cases reviewed. However, some cases demonstrated poor continuity (cases 7, 8, and 36). Also, continuity in the CTC was remarkably poor during the period reviewed.

Onsite Inspection

During the majority of the case review period, MCSP had a vacant chief medical executive (CME) position, and the chief physician and surgeon (CP&S) solely managed the providers. MCSP providers expressed split opinions about their supervision. Some providers praised the CP&S for his hands-off approach and his lack of micromanagement. Others criticized his lack of provider monitoring and supervision. Some providers said that the CP&S was always available and supportive, while others said that he did not provide direction and was not receptive to new ideas. Most providers voiced that the CP&S did not adequately lead by example. The CP&S performed clinical work only on the minimum-security yard, which housed the patients with the least medical complexity. In addition, the CP&S took excessive time off and routinely came to work several hours later than the rest of the providers. Some providers said that the providers' vacations were distributed equally and fairly, while others claimed the opposite.

Onsite interview of MCSP clinic schedulers revealed that some providers certainly took much more time off than other providers did. One provider was having medical problems, and was often absent, creating a functional vacancy. The CP&S explained that there was little that he could do regarding that individual. Schedulers also complained that another provider took excessive time off from the clinic. The CP&S explained that MCSP was severely understaffed. One provider could retire at any time, and that the institution liberally granted time off to this provider out of fear of losing the provider to retirement and being unable to find a replacement. Management was of the opinion that it was preferable to have suboptimal productivity than to have none at all.

Onsite review of MCSP provider personnel files in February 2016 revealed that provider annual performance appraisals had not been timely performed. Out of ten provider files examined, only one file contained an up-to-date annual performance appraisal. Most providers had their last appraisals performed between 2012 and 2014. Some providers had never had an annual appraisal performed while at MCSP, with their last appraisal performed at a prior work location, dating as far back as 2009. Provider UHR clinical appraisals completed by MCSP were superficial. The vast majority of checkmarks for all providers were in the "good" column, with minimal or no comments regarding strengths, weaknesses, or suggested improvements.

Most providers, including the CP&S, complained of poor morale and overall dissatisfaction with their jobs. Adjectives providers used to describe their situation included "brow-beaten," "overworked," "understaffed," "overwhelmed," and "disconnected." Providers acknowledged that they did not document their telephone encounters when on call, mainly because of the sheer volume of calls they received. Likewise, they did not document their combined nursing-provider consultations because of the daily clinic workload. The CP&S expressed frustration with the amount of non-clinically relevant administrative work he was tasked with, and shared imminent plans to retire because of it.

MCSP executive leadership, the CP&S, and other providers were all extremely concerned about physician recruitment and retention. For the majority of 2015, MCSP had two vacant physician

positions. MCSP also had five additional vacant physician positions earmarked to staff the newly completed MCSP infill facility. The CP&S relayed that he interviewed dozens of candidates but had extreme difficulty hiring physicians. After only a few months, one physician, whom MCSP was able to hire, left to work for a large health maintenance organization, attributing his reason for leaving to CDCR's non-competitive salary and retirement benefits. One other physician, hired in 2015, expressed that he had always had a strong interest in correctional medicine and had joined MCSP enthusiastically. However, the provider incorrectly understood the retirement benefits prior to joining CDCR, severely regretted the decision, and was actively looking for a different position. The CP&S confirmed that in early 2016, MCSP hired a less qualified, mid-level provider instead of a physician because there were no physician candidates.

Clinician Summary

MCSP provider performance was marginally adequate. Providers demonstrated good assessment and decision-making for their patients' primary medical concerns. The deficiencies identified were reflective of a combination of the patient population's high medical complexity and poor access to care due to provider understaffing. Providers often did well with addressing a patient's primary medical concerns, but overlooked important secondary issues. Since MCSP could not provide patients with adequate follow-up, care for those secondary medical issues was often delayed or dropped. Strong patterns of deficiencies, such as providers ordering inappropriately long follow-up intervals, performing cursory review of records, and documenting poorly, were likely reflective of the providers' feelings of being overworked and understaffed. The lack of medical provider leadership and supervision was evidenced by the vacant CME position during much of the case review period as well as the missing provider performance appraisals and superficially completed Unit Health Record Clinical Appraisals (UCAs). Provider morale was poor. All levels of MCSP staff were extremely concerned about their inability to recruit and retain qualified physicians. Despite the numerous challenges facing MCSP providers, the OIG clinicians attributed many of the provider deficiencies to the overarching system challenges at MCSP. The OIG concluded that the majority of the deficiencies were not reflective of MCSP providers' innate ability or work ethic, and thus rated this indicator *adequate*.

Recommendations

No specific recommendations.

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

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

Case Review Rating:
Inadequate
Compliance Score:
Adequate
(84.0%)

Overall Rating:
Inadequate

In this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *inadequate* rating and the compliance testing resulting in an *adequate* score. The OIG's internal review process considered those factors that led to both scores and ultimately rated this indicator *inadequate*. The key factors were that the case review found a high incidence of "cloned" nursing progress notes, poor documentation of wound care, and poor provider continuity in the CTC. In addition, case review found that providers did not always complete patient visits every three days, and the institution also scored poorly in compliance testing of provider patient visits.

Case Review Results

At the time of the OIG's inspection, MCSP had a ten-bed CTC. Only two of the rooms were designated as medical beds, including one negative pressure room (designed to minimize the spread of airborne infection). The other eight rooms were designated as mental health crisis beds. During the OIG's inspection, both medical rooms were occupied. The OIG clinicians reviewed 30 CTC provider encounters and 42 nursing encounters. There were 40 deficiencies, nine of which were significant.

Nursing Performance

The majority of serious practice issues involved inadequate assessment and improper documentation by the nursing staff. The consistent use of cloned documentation over consecutive days and illegible handwriting made meaningful evaluation of nursing care extremely difficult. Documentation was considered cloned when entries were worded exactly the same or similar to the previous entries, making it impossible to distinguish notes from one date of service to another. Numerous incidents of cloned nursing notes by CTC nurses showed exact or almost exact copies of previous encounters, which could potentially have resulted in inaccurate medical records and poor patient care. There were multiple issues in nursing, demonstrated by findings in the following care review examples:

- In case 67, upon the patient's admission to the CTC, the RN did not perform a head-to-toe assessment, examine the patient for presence of rectal bleeding, or check the condition of the surgical site on the patient's right leg. During the patient's stay in the CTC, the nurses never documented a detailed assessment of the surgical site. The RNs used cloned documentation.

When the patient came back from his most recent surgery, the progress notes were similar to notes written prior to the surgery, and nurses failed to assess the new surgical site on the left thigh. Medications were not administered timely, and the nurses failed to document the effectiveness of anxiety and pain medications.

- In case 68, there were numerous cloned nursing documents. One of the CTC nurses documented that the patient had swelling on the lower leg for several days, whereas other nurses noted that there was no swelling during those same days. In addition, some of the cloned notes reflected the nurses' failure to assess the patient's bedsore on his lower back. On several occasions, a nurse failed to address the patient's complaints of abdominal pain and to document pain management or the effectiveness of the pain medication.

- In case 70, the CTC nurses used cloned notes in their documentation. The RN also failed to properly monitor fluid restrictions on several days and to obtain the patient's weight. When the patient's blood pressure and heart rate were below normal, the RN did not document a change in condition on the progress note, recheck or monitor vital signs, or notify the PCP of the abnormal readings. An RN documented that the patient's wound on his buttocks was covered with a wet-to-dry dressing, instead of a dry dressing as ordered by the physician.

Provider Performance

CTC providers generally displayed good assessment and decision-making in the CTC, as they did in the clinics, except when provider continuity was poor. Poor CTC provider continuity was associated with inadequate chart review and inadequate provider discharge summaries in cases 68, 69, and 70.

Another serious problem regarded specialty services for patients housed in the CTC. Because patients in the CTC were considered by MCSP to be receiving inpatient care, schedulers did not regularly generate 14-day PCP follow-up appointments upon the patients' return from specialty services. In addition, there was often no notification to the CTC provider, so at the next rounding appointment, the providers were unaware that specialty services had been performed, resulting in lapses in care.

- In case 67, the patient had a chronic blood clotting disorder requiring life-long anticoagulation measures. While the patient was in the CTC, MCSP sent him to a hematologist for consultation. There was no evidence that the CTC provider reviewed the specialty report or was even aware that the consultation had occurred.

- In case 68, while housed in the CTC, the patient was sent for a sleep study, which showed that the patient had severe obstructive sleep apnea. The specialist recommended treatment with positive airway pressure. However, the CTC provider was seemingly completely unaware of the consultation and did not address the issue. The treatment order was finally written only after the patient transferred to another institution a month later.

- In case 69, MCSP treated the patient for endocarditis (heart valve infection) in the CTC. The patient was referred via telemedicine to an infectious disease specialist, who was concerned about leg swelling. The specialist recommended imaging studies of the left leg. However, there was no evidence that the CTC provider was aware that the consultation occurred, and so specialty recommendations were not addressed.

Access to Care

There were recurrent deficiencies when the CTC provider did not visit the patient at least every 72 hours, as required by state regulations and CCHCS policy. This deficiency occurred repeatedly in cases 68 and 69.

In addition to failing to see the patient within policy time frames, when a provider was needed to see the patient sooner for medical reasons, the consultation often did not occur.

- In case 67, the patient had a worsening leg wound infection. The nurses suspected that the patient was picking at his wounds, exacerbating his condition. The doctor saw the patient and started antibiotics, but wanted the patient to be seen for follow-up the following day for re-evaluation. No CTC provider follow-up visit occurred.

Onsite Inspection

During the onsite visit, the CTC had adequate medical supplies, clinical space, and nursing staff. Nursing staff interviewed were generally new to their assigned areas. When asked about their orientation and training, the nurses stated that they received no formal or structured training, and that most became aware of CTC procedures through verbal instructions from nursing supervisors or coworkers. One of the CTC nurses interviewed was unaware of the institution's call-button system or negative pressure room.

Compliance Testing Results

The institution received an *adequate* score of 84.0 percent in the *Specialized Medical Housing* indicator, which focused on the institution's correctional treatment center (CTC). The institution received a *proficient* score in the two tests below:

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

- Inspectors found MCSP had a call-button system that operated properly. According to knowledgeable staff who regularly worked in the CTC, during an emergent event responding staff could access a patient's room in an average of one minute, which the institution's management believed was a reasonable amount of time. As a result, the institution received a score of 100 percent on this test (MIT 13.101).

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

- Providers evaluated four out of the five patients sampled within 24 hours of admission to the CTC (80 percent). The provider evaluated one patient two days late (MIT 13.002).

- Providers completed a history and physical exam within 72 hours of admission for four of the five patients (80 percent). For one patient, the provider did not complete a History and Physical exam at all (MIT 13.003).

MCSP has room for improvement in the following area:

- Providers completed their subjective, objective, assessment, plan, and education (SOAPE) notes at the required three-day intervals for only three of the five patients tested (60 percent). For two patients, PCP's SOAPE notes were one or two days late (MIT 13.004).

Recommendations

The OIG recommends that MCSP take the following steps:

- Evaluate the process currently in place in the CTC for monitoring nursing performance regarding completion of nursing assessments and accurate, legible documentation. Nursing assessments should accurately reflect the patient's current health condition.

- Create a process to ensure that when a specialist evaluates a CTC patient, the encounter is communicated to the CTC provider for appropriate action.

SPECIALTY SERVICES

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(62.6%)

Overall Rating:
Inadequate

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

Case Review Results

The OIG clinicians reviewed 161 events related to *Specialty Services*, 93 of which were specialty consultations and procedures. The OIG clinicians found 80 deficiencies in this category. Though 20 deficiencies were identified as significant as they placed the patients at serious risk of harm, there was no actual harm.

Access to Specialty Services

The vast majority of routine specialty services were provided in a timely manner. However, access to urgent specialty services was problematic. A pattern was detected wherein many urgent priority services were not provided within the time frame requested.

Delayed access to specialty services was identified in cases 20, 26, 27, 28, 36, 63, and 70. The majority of these cases involved services that required higher priority.

- In case 20, the patient returned from the hospital after having surgery for an infected left shoulder wound. The surgeon was concerned about the infection and wanted to see the patient for follow-up in three days, but the appointment did not occur until ten days later.

- In case 70, the patient underwent repair of a heart valve. After the surgery, the cardiac surgeon requested a one-week follow-up appointment, but the appointment did not occur and the cardiac surgeon never saw the patient again.

Nursing Performance

MCSP nurses performed inadequate assessments for patients returning from offsite specialty appointments. The nursing assessments were superficial, lacking depth and substance. Vital signs were not typically obtained upon return from the consultation, with most patients "refusing" to have their vital signs read. Nurses evaluated patients and released them to custody in only a few minutes.

Inadequate nursing assessments for patients returning from offsite specialty services were identified in cases 16, 19, 26, 27, 28, 70, and the following two cases:

- In case 20, the patient returned from the orthopedic surgeon after having surgery on an infected shoulder wound. The nurse did not perform a surgical site wound assessment, and did not identify the location of the surgery, the presence of drainage, the condition of the dressing, or a circulatory assessment of the opposite limb. The nurse failed to perform an in-depth pain assessment, and did not refer the patient to follow up with a provider. Failure to refer the patient to the provider created a high risk of a lapse in care.

- In case 67, the RN used a cloned note to document the patient's return from a specialty appointment. The RN did not document if the specialist's report was received, if the recommendations were reviewed, or if the PCP was notified.

MCSP offsite return nurses and telemedicine nurses sometimes did not adequately identify specialty assessments and recommendations, and did not communicate them to the appropriate provider. These findings were identified in cases 20, 67, and the following two cases:

- In case 7, the telemedicine orthopedic specialist was concerned about the patient's finger joint and recommended that the patient be referred immediately to a hand surgeon for further evaluation and treatment. A same day consultation with a MCSP provider was required, but the RN did not refer the patient immediately.

- In case 70, the patient returned from a preoperative consultation. The specialist recommended that the patient stop taking aspirin and enalapril. Instead, the nurse advised the patient to stop taking aspirin and metoprolol prior to the surgery. The advice regarding metoprolol was in error. The nurse also did not notify a MCSP provider of the specialist's recommendation.

At MCSP, the telemedicine nurses were responsible for ensuring that the relevant health care information was transmitted to the specialist and that the specialist was aware of those reports. Typical reports transmitted to the specialist included MCSP provider progress notes, labs, diagnostic tests, hospital summaries, and other specialty consultation reports. MCSP telemedicine nurses sometimes failed to transmit important information to the specialist. These deficiencies were identified in the following cases:

- In case 7, the telemedicine RN did not transmit the recent hand surgeon's evaluation to the specialist and make the specialist aware of recently completed MRIs. With incomplete information, the telemedicine specialist made duplicative recommendations – to see a hand specialist, and to obtain two MRI tests. Since the patient had already had these services, there was a delay in care.

- In case 8, the telemedicine RN did not provide critical documentation needed by the neurology specialist to make an informed evaluation. The RN should have provided the specialist with the most recent hospital discharge summary, which contained another neurologist's assessment that the patient was having non-epileptic seizures.

Health Information Management

Specialty reports were frequently mislabeled in the eUHR as "Other." This finding was widespread throughout the cases reviewed. Mislabeling of the document type created an additional barrier to care and increased the risk of lapses in care.

- In case 25, the patient underwent a seven-day cardiac monitoring test called an "event monitor." At the follow-up appointment, the provider noted that the event monitor report was not available, when in fact it had been scanned into the eUHR. The report was scanned into the eUHR under the document type "Other," so the provider was unable to locate it. There was no evidence that any MCSP provider reviewed the test.

There were frequent delays in the retrieval of specialty reports: cases 5, 16, 27, 28, 29, 35, 36, 69, and 70. MCSP also failed to retrieve some specialty reports altogether in cases 5, 7, 16, 27, and 28. Delays in retrieval or non-retrieval of specialty reports significantly increased the risk of delays or lapses in care.

There was not a reliable process whereby specialty reports were forwarded to the appropriate provider for review and action. Most specialty reports were scanned into the eUHR without evidence of appropriate provider review. Specialty reports not signed or initialed by a provider were identified in cases 4, 5, 6, 7, 8, 16, 18, 25, 26, 28, 29, 31, 35, 36, 67, 68, and 69. MCSP seemingly expected providers to address the specialty report at the follow-up appointment. However, since MCSP often was unable to provide those follow-up appointments (discussed in the *Access to Care* indicator), many of these specialty reports were never adequately addressed.

Another serious problem was for those specialty services that occurred while the patient was admitted to the correctional treatment center (CTC). Since CTC care was inpatient, when the patients returned from an offsite specialty service, they were not given a provider follow-up appointment. Presumably, since the patient was inpatient, MCSP expected that the CTC provider would address the specialty service during CTC rounds. However, case reviews demonstrated there was little or no communication with the CTC provider when a specialty service occurred. The CTC provider was seemingly unaware of the specialty service and did not address it in cases 67, 68, and 69. These cases are discussed further in the *Specialized Medical Housing* indicator.

Provider Performance

MCSP providers generally made appropriate referrals for specialty services. Most diagnostic and consultative requests were appropriate with proper priority specified on the referral for services (CDCR Form 7243). When providers were able to see patients for follow-up after specialty

services, they were addressed adequately. Some providers had difficulty locating mislabeled specialty reports in the eUHR.

Utilization Management

The case review process did not identify any significant problems with MCSP's utilization management program.

Clinician Summary

Providers did a good job of identifying and referring patients appropriately when needed. Routine specialty access was generally adequate, but high-priority specialty access was unreliable. MCSP nursing performance for specialty services was inadequate. Nurses often did not perform adequate assessments upon patients' return to the institution, did not thoroughly review the specialist's assessments or recommendations, and did not communicate them to the appropriate provider. Telemedicine nurses also occasionally did not perform adequate assessments or make appropriate referrals to the MCSP provider. Specialty reports were often mislabeled in the eUHR. Specialty report handling was poor, with frequent delays in report retrieval or non-retrieval altogether. MCSP also lacked a reliable process whereby specialty reports were forwarded to the responsible provider for review and action. MCSP had marked problems notifying the CTC provider and ensuring that specialty services were adequately followed up on for patients in the CTC. The OIG clinicians rated this indicator *inadequate*.

Compliance Testing Results

The institution received an *inadequate* compliance score of 62.6 percent in the *Specialty Services* indicator. MCSP scored in the *inadequate* range in the following test areas:

- For 20 patients sampled who had a specialty service denied by the institution's health care management, inspectors found that five patients (25 percent) received timely notification of the denied service that included the provider meeting with the patient within 30 days to discuss alternate treatment strategies. For 13 patients sampled, this requirement was not met at all; two other patients received a follow-up visit one and 17 days late (MIT 14.007).

- Providers timely received and reviewed the specialists' reports for only 6 of 12 sampled patients who received a high-priority specialty service (50 percent). Four patients' high-priority reports were received from 3 to 21 days late, delaying the providers' review; for another patient, there was no evidence when the report was received, only that it was reviewed eight days after the service was provided. For the remaining patient, the provider reviewed the report results one day late (MIT 14.002).

- Providers timely received and reviewed only 8 of the 15 sampled specialists' reports for patients who received a routine specialty service (53 percent). For five patients, providers reviewed their routine specialty service report from 3 to 27 days late; for another patient,

there was no evidence the provider reviewed the report results at all. For the remaining patient, the provider's review was delayed because the report was received nine days late (MIT 14.004).

- The institution timely denied providers' specialty service requests for 11 of 20 patients sampled (55 percent). Nine of the specialty services requests were denied between one and 14 days late (MIT 14.006).

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

- Twelve of the 15 patients sampled (80 percent) received or refused their high-priority specialty services appointment or service within 14 calendar days of the provider's order. Three patients received their specialty service from one to six days late (MIT 14.001).

- When inmate-patients are approved or scheduled for specialty services appointments at one institution and then transfer to another institution, policy requires that the receiving institution ensure that the patient's appointment is timely rescheduled or scheduled, and held. Fifteen of 20 patients sampled (75 percent) who transferred to MCSP with an approved specialty service appointment received it within the required time frame. Five patients received their appointment from one to 28 days late (MIT 14.005).

The institution scored in the *proficient* range, receiving a score of 100 percent in the following test area:

- All 15 patients sampled received their routine specialty service appointment within 90 days of the provider's order (MIT 14.003).

Recommendations

No specific recommendations.

SECONDARY (ADMINISTRATIVE) QUALITY INDICATORS OF HEALTH CARE

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

To test both the scored and non-scored areas within these two secondary quality indicators, OIG inspectors interviewed key institutional employees and reviewed documents during their onsite visit to MCSP in December 2015. They also reviewed documents obtained from the institution and from CCHCS prior to the start of the inspection. The test questions used to assess compliance for each indicator are detailed in *Appendix A*.

For comparative purposes, the *MCSP Executive Summary Table* on page viii of this report shows the case review and compliance ratings for each applicable indicator.

INTERNAL MONITORING, QUALITY IMPROVEMENT, AND ADMINISTRATIVE OPERATIONS

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(51.1%)

Overall Rating:
Inadequate

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

Compliance Testing Results

The institution scored within the *inadequate* range in this indicator, receiving a compliance score of 51.1 percent, showing need for improvement in the following five areas:

- The institution had not taken adequate steps to ensure the accuracy of its Dashboard data reporting. Specifically, the OIG found nothing in MCSP's Quality Management Committee (QMC) meeting minutes or other forum that addressed methodologies used to train staff who collected Dashboard data. As a result, MCSP received a score of zero on this test (MIT 15.004).

- While MCSP's 2014 Performance Improvement Work Plan did include some information about each of its five quality improvement initiatives, for each of those initiatives, some information was missing regarding whether the institution had either improved or reached targeted performance objectives. As a result, MCSP received a score of zero on this test (MIT 15.005).

- Among the 12 emergency medical response incidents reviewed by the institution's Emergency Medical Response Review Committee during the prior six-month period, none included the required Emergency Medical Response Review Event Checklist form. Also, the related meeting minutes for one of the 12 incident packages was signed by the warden almost four months late. As a result, MCSP received a score of zero on this test (MIT 15.007).

- Emergency response drill packages for the three medical emergency response drills conducted in the prior quarter did not include required documentation. Specifically, all three drill packages lacked the following forms: 1st Medical Responder – Data Collection Tool

(CDCR Form 7463), Triage and Treatment Services Flowsheet (CDCR Form 7464), Medical Report of Injury or Unusual Occurrence (CDCR Form 7219), and Crime/Incident report (CDCR Form 837). One of the packages was also missing the Interdisciplinary Progress Notes (CDCR Form 7230), which was required for the drill scenario. As a result, MCSP received a score of zero on this test (MIT 15.101).

- Medical staff promptly submitted the Initial Inmate Death Report (CDCR Form 7229A) to CCHCS's Death Review Unit for only three of the five applicable deaths that occurred at MCSP in the prior 12-month period (60 percent). Two deaths were reported less than two hours late (MIT 15.103).

The institution received a *proficient* score of 100 percent in each of the following four tests:

- MCSP timely processed all inmate medical appeals in each of the most recent 12 months. Based on data received from the institution, there were no overdue medical appeals during the entire test period (MIT 15.001).

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

- Inspectors sampled ten second-level medical appeals and found that the institution's responses addressed all of the inmate-patients' appealed issues (MIT 15.102).

- MCSP's local governing body (LGB) met quarterly during the most recent 12-month period, and all meeting minutes provided a detailed narrative of the LGB's general management and planning of patient health care (MIT 15.006).

Other Information Obtained from Non-Scored Areas

- The OIG gathered non-scored data regarding the completion of death review reports and found that CCHCS's Death Review Committee did not timely complete its death review summary for each of the five deaths that occurred during the testing period. The CCHCS Death Review Committee is required to complete a death review summary within 30 business days of an inmate-patient's death and submit it to the institution's chief executive officer (CEO) five business days later. However, for the five deaths tested, the committee completed its summary from 12 to 210 days late (53 to 253 calendar days after the death). As a result, none of the summary reports were timely submitted to MCSP's CEO (MIT 15.996).

- Inspectors met with the institution's CEO to inquire about MCSP's protocols for tracking appeals. The health care appeals coordinator provided monthly appeals summary reports to the CEO, who shared the reports with management staff. The reports addressed appeal dispositions, statistics on appeals filed and their status, overdue appeals, and appealed issues

listed by category. Management used the reports to track overdue appeals regarding medical disagreements with treatment, monitor issues, and identify trends to improve training. One critical problem area that management addressed was complaints from inmate-patients about the lengthy evening medication lines, which impacted their yard program time. Management met with the Inmate Advisory Council to understand their concerns, then provided medication line training to staff to resolve them (MIT 15.997).

- Non-scored data regarding the institution's practices for implementing local operating procedures (LOPs) indicated that the institution had an effective process in place for revising existing LOPs and developing new ones. When new or revised policies and procedures were received from CCHCS, the Health Program Specialist (HPS) met with the subject matter expert (SME) and developed recommendations for a new LOP or a revision to an existing LOP, as needed. The new or revised LOPs were sent to the medical sub-committee and QMC for review. Once approved, the LOPs were distributed to department heads, who then communicated the LOPs to their staff and provided training, as needed. At the time of the OIG's inspection in December 2015, MCSP had implemented, or was developing, 43 of the 49 stakeholder-recommended LOPs (88 percent) (MIT 15.998).

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

Recommendations

No specific recommendations.

JOB PERFORMANCE, TRAINING, LICENSING, AND CERTIFICATIONS

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

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(58.3%)

Overall Rating:
Inadequate

Compliance Testing Results

The institution received an *inadequate* compliance score of 58.3 percent in the *Job Performance Training, Licensing, and Certifications* indicator.

MCSP scored in the *inadequate* range in the following four tests:

- The OIG inspected nursing supervisors' monthly nursing reviews conducted for three nurses during October 2015. Inspectors identified the following deficiencies for each of the three nurses' monthly nursing reviews (MIT 16.101):
    - The supervisor did not complete the required number of reviews;
    - The supervisor documented neither aspects of nursing care that were well done nor those that needed improvement;
    - The documentation did not confirm that the supervising nurse discussed the findings with the nurse.
- None of the institution's nine providers who required a structured clinical performance appraisal appropriately received one. Inspectors found the following deficiencies (MIT 16.103):
    - Eight providers did not receive timely appraisals. Five had not received an annual performance appraisal in over two years, and another had worked at the institution for almost eight months, but had not yet received a probationary appraisal;
    - Seven providers' most recent performance appraisal package lacked a 360-Degree evaluation;
    - Two providers' performance appraisal packages lacked required UCAs.

- Six nursing staff hired by MCSP within the prior 12 months did not receive new employee orientation training within 60 days of their arrival. Therefore, the institution scored zero for this test (MIT 16.107).

- The OIG tested provider, nursing, and custody staff records to determine if the institution ensured that those staff members had current emergency response certifications. The institution's provider and nursing staff were all compliant, but custody managers were not. While the California Penal Code exempts custody managers who primarily perform managerial duties from medical emergency response certification training, CCHCS policy does not allow for such an exemption. As a result, the institution received a score of 67 percent in this inspection area (MIT 16.104).

The institution received a *proficient* score of 100 percent in the following test areas:

- All ten nurses sampled were current with their clinical competency validations (MIT 16.102).

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

- The institution's pharmacy and providers who prescribed controlled substances were current with their Drug Enforcement Agency registrations (MIT 16.106).

Recommendations

No specific recommendations.

POPULATION-BASED METRICS

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

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

Methodology

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

Comparison of Population-Based Metrics

For Mule Creek State Prison, nine HEDIS measures were selected and are listed in the following *MCSP Results Compared to State and National HEDIS Scores* table. Multiple health plans publish their HEDIS performance measures at the State and national levels. The OIG has provided selected results for several health plans in both categories for comparative purposes.

Results of Population-Based Metric Comparison

Comprehensive Diabetes Care

For chronic care management, the OIG chose measures related to the management of diabetes. Diabetes is the most complex common chronic disease requiring a high level of intervention on the part of the health care system in order to produce optimal results. MCSP either outperformed or performed similarly to all other entities in four of the five diabetic measures selected, but scored lower than some of the others entities in conducting required dilated eye exams for diabetic patients.

When compared statewide, MCSP outperformed Medi-Cal in all five diabetic measures selected. The institution also outperformed Kaiser Permanente in four of the five measures, scoring lower than the Kaiser South region in conducting diabetic eye examinations. When compared nationally, MCSP outperformed or matched the performance of Medicaid, Medicare, and commercial health plans (based on data obtained from health maintenance organizations) in each of the five diabetic measures. MCSP outperformed or closely matched the U.S. Department of Veterans Affairs (VA) in all applicable measures, except diabetic eye exams for which it scored 21 percentage points lower than the VA.

Immunizations

Comparative data for immunizations was only fully available for the VA and partially available for Kaiser, commercial entities, and Medicare. Regarding the administration of influenza shots to younger adults, MCSP considerably outperformed Kaiser, commercial entities, and the VA. Also, MCSP outperformed both Medicare and the VA in administering flu shots to older adults. With regard to administering pneumococcal vaccinations to older adults, MCSP significantly outperformed Medicare, but scored lower than the VA. However, for all immunization measures, MCSP routinely offered patients these preventive services, but many of them refused the offers; these refusals adversely affected the institution's scores.

Cancer Screening

In colorectal cancer screening, MCSP scored lower than Kaiser and the VA, but higher than commercial entities and Medicare. Similar to immunizations, MCSP had timely offered the screening to all but one of the patients sampled, but many patients subsequently refused the offer, negatively affecting the results for the institution.

Summary

Mule Creek State Prison's population-based metrics performance reflects an adequate chronic care program, corroborated by the institution's *adequate* rating in the *Quality of Provider Performance* indicator. The institution has an opportunity for improvement in timely conducting dilated eye exams for its diabetic patients. Also, some of MCSP's comparative scores for administering pneumococcal vaccines to older adults and administering cancer screenings indicate improvement is needed in those measures, which the institution can address by making interventions to lower patient refusals.

MCSP Results Compared to State and National HEDIS Scores

Clinical Measures	California				National			
	MCSP Cycle 4 Results [1]	HEDIS Medi-Cal 2014 [2]	Kaiser (No.CA) HEDIS Scores 2015 [3]	Kaiser (So.CA) HEDIS Scores 2015 [3]	HEDIS Medicaid 2015[4]	HEDIS Com-mercial 2015[4]	HEDIS Medicare 2015 [4]	VA Average 2012 [5]
Comprehensive Diabetes Care								
HbA1c Testing (Monitoring)	**97%**	83%	95%	94%	86%	91%	93%	99%
Poor HbA1c Control (>9.0%) [6,7]	**7%**	44%	18%	24%	44%	31%	25%	19%
HbA1c Control (<8.0%) [6]	**83%**	47%	70%	62%	47%	58%	65%	-
Blood Pressure Control (<140/90)	**87%**	60%	84%	85%	62%	65%	65%	80%
Eye Exams	**69%**	51%	69%	81%	54%	56%	69%	90%
Immunizations								
Influenza Shots - Adults (18–64) [8]	**81%**	-	54%	55%		50%	-	65%
Influenza Shots - Adults (65+)	**78%**	-	-	-	-	-	72%	76%
Immunizations: Pneumococcal	**87%**	-	-	-	-	-	70%	93%
Cancer Screening								
Colorectal Cancer Screening	**76%**	-	80%	82%	-	64%	67%	82%

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

APPENDIX A — COMPLIANCE TEST RESULTS

Mule Creek State Prison Range of Summary Scores: 51.11% - 84.44%	
Indicator	**Compliance Score (Yes %)**
Access to Care	67.93%
Diagnostic Services	84.44%
Emergency Services	Not Applicable
Health Information Management (Medical Records)	68.91%
Health Care Environment	61.06%
Inter- and Intra-System Transfers	82.67%
Pharmacy and Medication Management	58.26%
Prenatal and Post-delivery Services	Not Applicable
Preventive Services	66.48%
Quality of Nursing Performance	Not Applicable
Quality of Provider Performance	Not Applicable
Reception Center Arrivals	Not Applicable
Specialized Medical Housing (OHU, CTC, SNF, Hospice)	84.00%
Specialty Services	62.62%
Internal Monitoring, Quality Improvement, and Administrative Operations	51.11%
Job Performance, Training, Licensing, and Certifications	58.33%

Reference Number	*Access to Care*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
1.001	**Chronic care follow-up appointments:** Was the inmate-patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter?	16	24	40	40.00%	0
1.002	**For endorsed inmate-patients received from another CDCR institution:** If the nurse referred the inmate-patient to a provider during the initial health screening, was the inmate-patient seen within the required time frame?	6	7	13	46.15%	17
1.003	**Clinical appointments:** Did a registered nurse review the inmate-patient's request for service the same day it was received?	28	2	30	93.33%	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?	29	1	30	96.67%	0
1.005	**Clinical appointments:** If the registered nurse determined a referral to a primary care provider was necessary, was the inmate-patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter?	5	15	20	25.00%	10
1.006	**Sick call follow-up appointments:** If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified?	3	1	4	75.00%	26
1.007	**Upon the inmate-patient's discharge from the community hospital:** Did the inmate-patient receive a follow-up appointment within the required time frame?	25	5	30	83.33%	0
1.008	**Specialty service follow-up appointments:** Do specialty service primary care physician follow-up visits occur within required time frames?	14	13	27	51.85%	3
1.101	**Clinical appointments:** Do inmate-patients have a standardized process to obtain and submit health care services request forms?	6	0	6	100.00%	0
Overall Percentage:					**67.93%**	

Reference Number	*Diagnostic Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
2.001	**Radiology:** Was the radiology service provided within the time frame specified in the provider's order?	10	0	10	100.00%	0
2.002	**Radiology:** Did the primary care provider review and initial the diagnostic report within specified time frames?	9	1	10	90.00%	0
2.003	**Radiology:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	9	1	10	90.00%	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?	7	3	10	70.00%	0
2.006	**Laboratory:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	8	2	10	80.00%	0
2.007	**Pathology:** Did the institution receive the final diagnostic report within the required time frames?	8	2	10	80.00%	0
2.008	**Pathology:** Did the primary care provider review and initial the diagnostic report within specified time frames?	8	2	10	80.00%	0
2.009	**Pathology:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	9	1	10	90.00%	0
Overall Percentage:					**84.44%**	

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

Reference Number	*Health Information Management (Medical Records)*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated progress notes, initial health screening forms, and health care service request forms scanned into the eUHR within three calendar days of the inmate-patient encounter date?	19	1	20	95.00%	0
4.002	Are dictated / transcribed documents scanned into the eUHR within five calendar days of the inmate-patient encounter date?	3	3	6	50.00%	0
4.003	Are specialty documents scanned into the eUHR within the required time frame?	19	1	20	95.00%	0
4.004	Are community hospital discharge documents scanned into the eUHR within three calendar days of the inmate-patient date of hospital discharge?	18	2	20	90.00%	0
4.005	Are medication administration records (MARs) scanned into the eUHR within the required time frames?	15	5	20	75.00%	0
4.006	During the eUHR review, did the OIG find that documents were correctly labeled and included in the correct inmate-patient's file?	0	12	12	0.00%	0
4.007	Did clinical staff legibly sign health care records, when required?	18	14	32	56.25%	0
4.008	**For inmate-patients discharged from a community hospital:** Did the preliminary hospital discharge report include key elements and did a PCP review the report within three calendar days of discharge?	27	3	30	90.00%	0
Overall Percentage:					**68.91%**	

Reference Number	*Health Care Environment*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
5.101	**Infection Control:** Are clinical health care areas appropriately disinfected, cleaned and sanitary?	4	5	9	44.44%	0
5.102	**Infection control:** Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	7	1	8	87.50%	1
5.103	**Infection Control:** Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	8	1	9	88.89%	0
5.104	**Infection control:** Does clinical health care staff adhere to universal hand hygiene precautions?	2	5	7	28.57%	2
5.105	**Infection control:** Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	9	0	9	100.00%	0
5.106	**Warehouse, Conex and other non-clinic storage areas:** Does the medical supply management process adequately support the needs of the medical health care program?	1	0	1	100.00%	0
5.107	**Clinical areas:** Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	9	0	9	100.00%	0
5.108	**Clinical areas:** Do clinic common areas and exam rooms have essential core medical equipment and supplies?	3	6	9	33.33%	0
5.109	**Clinical areas:** Do clinic common areas have an adequate environment conducive to providing medical services?	5	4	9	55.56%	0
5.110	**Clinical areas:** Do clinic exam rooms have an adequate environment conducive to providing medical services?	3	6	9	33.33%	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?	0	6	6	0.00%	3
5.999	**For Information Purposes Only:** Does the institution's health care management believe that all clinical areas have physical plant infrastructures sufficient to provide adequate health care services?	Information Only				
Overall Percentage:					**61.06%**	

Reference Number	*Inter- and Intra-System Transfers*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
6.001	**For endorsed inmate-patients received from another CDCR institution or COCF:** Did nursing staff complete the initial health screening and answer all screening questions on the same day the inmate-patient arrived at the institution?	23	7	30	76.67%	0
6.002	**For endorsed inmate-patients received from another CDCR institution or COCF:** When required, did the RN complete the assessment and disposition section of the health screening form; refer the inmate-patient to the TTA, if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening?	29	1	30	96.67%	0
6.003	**For endorsed inmate-patients received from another CDCR institution or COCF:** If the inmate-patient had an existing medication order upon arrival, were medications administered or delivered without interruption?	11	11	22	50.00%	8
6.004	**For inmate-patients transferred out of the facility:** Were scheduled specialty service appointments identified on the Health Care Transfer Information Form 7371?	18	2	20	90.00%	0
6.101	**For inmate-patients transferred out of the facility:** Do medication transfer packages include required medications along with the corresponding Medical Administration Record (MAR) and Medication Reconciliation?	3	0	3	100.00%	2
Overall Percentage:					**82.67%**	

Reference Number	*Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.001	Did the inmate-patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows?	27	13	40	67.50%	0
7.002	Did health care staff administer or deliver new order prescription medications to the inmate-patient within the required time frames?	29	11	40	72.50%	0
7.003	**Upon the inmate-patient's discharge from a community hospital:** Were all medications ordered by the institution's primary care provider administered or delivered to the inmate-patient within one calendar day of return?	15	15	30	50.00%	0
7.004	**For inmate-patients received from a county jail:** Were all medications ordered by the institution's reception center provider administered or delivered to the inmate-patient within the required time frames?	Not Applicable				
7.005	**Upon the inmate-patient's transfer from one housing unit to another:** Were medications continued without interruption?	25	5	30	83.33%	0
7.006	**For inmate-patients en route who lay over at the institution:** If the temporarily housed inmate-patient had an existing medication order, were medications administered or delivered without interruption?	Not Applicable				
7.101	**All clinical and medication line storage areas for narcotic medications:** Does the institution employ strong medication security controls over narcotic medications assigned to its clinical areas?	0	8	8	0.00%	9
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?	10	6	16	62.50%	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?	7	3	10	70.00%	7
7.104	**Medication preparation and administration areas:** Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes?	3	4	7	42.86%	10
7.105	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when preparing medications for inmate-patients?	6	1	7	85.71%	10
7.106	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when distributing medications to inmate-patients?	3	4	7	42.86%	10
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	100.00%	0

Reference Number	*Pharmacy and Medication Management*	Scored Answers				
		Yes	No	Yes + No	Yes %	N/A
7.108	***Pharmacy:*** *Does the institution's pharmacy properly store non-refrigerated medications?*	0	1	1	0.00%	0
7.109	**Pharmacy:** Does the institution's pharmacy properly store refrigerated or frozen medications?	0	1	1	0.00%	0
7.110	**Pharmacy:** Does the institution's pharmacy properly account for narcotic medications?	1	0	1	100.00%	0
7.111	**Pharmacy:** Does the institution follow key medication error reporting protocols?	29	1	30	96.67%	0
7.998	**For Information Purposes Only:** During eUHR compliance testing and case reviews, did the OIG find that medication errors were properly identified and reported by the institution?	Information Only				
7.999	**For Information Purposes Only:** Do inmate-patients in isolation housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications?	Information Only				
Overall Percentage:					**58.26%**	

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

Reference Number	*Preventive Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
9.001	**Inmate-patients prescribed INH:** Did the institution administer the medication to the inmate-patient as prescribed?	3	6	9	33.33%	0
9.002	**Inmate-patients prescribed INH:** Did the institution monitor the inmate-patient monthly for the most recent three months he or she was on the medication?	5	4	9	55.56%	0
9.003	**Annual TB Screening:** Was the inmate-patient screened for TB within the last year?	15	15	30	50.00%	0
9.004	Were all inmate-patients offered an influenza vaccination for the most recent influenza season?	29	1	30	96.67%	0
9.005	**All inmate-patients from the age of 50 through the age of 75:** Was the inmate-patient offered colorectal cancer screening?	28	2	30	93.33%	0
9.006	**Female inmate-patients from the age of 50 through the age of 74:** Was the inmate-patient offered a mammogram in compliance with policy?	Not Applicable				
9.007	**Female inmate-patients from the age of 21 through the age of 65:** Was the inmate-patient offered a pap smear in compliance with policy?	Not Applicable				
9.008	Are required immunizations being offered for chronic care inmate-patients?	14	6	20	70.00%	20
9.009	Are inmate-patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	Not Applicable				
Overall Percentage:					**66.48%**	

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

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

Reception Center Arrivals	Scored Answers
This indicator is not applicable to this institution.	**Not Applicable**

Reference Number	*Specialized Medical Housing (OHU, CTC, SNF, Hospice)*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	**For all higher level care facilities:** Did the registered nurse complete an initial assessment of the inmate-patient on the day of admission, or within eight hours of admission to CMF's Hospice?	5	0	5	100.00%	0
13.002	**For OHU, CTC, & SNF only:** Did the primary care provider for OHU or attending physician for a CTC & SNF evaluate the inmate-patient within 24 hours of admission?	4	1	5	80.00%	0
13.003	**For OHU, CTC, & SNF only:** Was a written history and physical examination completed within 72 hours of admission?	4	1	5	80.00%	0
13.004	**For all higher level care facilities:** Did the primary care provider complete the Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes on the inmate-patient at the minimum intervals required for the type of facility where the inmate-patient was treated?	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 inmate-patient's cells?	1	0	1	100.00%	0
Overall Percentage:					**84.00%**	

Reference Number	*Specialty Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	Did the inmate-patient receive the high-priority specialty service within 14 calendar days of the PCP order?	12	3	15	80.00%	0
14.002	Did the PCP review the high priority specialty service consultant report within the required time frame?	6	6	12	50.00%	3
14.003	Did the inmate-patient receive the routine specialty service within 90 calendar days of the PCP order?	15	0	15	100.00%	0
14.004	Did the PCP review the routine specialty service consultant report within the required time frame?	8	7	15	53.33%	0
14.005	**For endorsed inmate-patients received from another CDCR institution:** If the inmate-patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames?	15	5	20	75.00%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	11	9	20	55.00%	0
14.007	Following the denial of a request for specialty services, was the inmate-patient informed of the denial within the required time frame?	5	15	20	25.00%	0
Overall Percentage:					**62.62%**	

Reference Number	*Internal Monitoring, Quality Improvement, and Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.001	Did the institution promptly process inmate medical appeals during the most recent 12 months?	12	0	12	100.00%	0
15.002	Does the institution follow adverse/sentinel event reporting requirements?	Not Applicable				
15.003	Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified?	6	0	6	100.00%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	0	1	1	0.00%	0
15.005	For each initiative in the Performance Improvement Work Plan (PIWP), has the institution performance improved or reached the targeted performance objective(s)?	0	5	5	0.00%	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?	4	0	4	100.00%	0
15.007	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	0	12	12	0.00%	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?	0	3	3	0.00%	0
15.102	Did the institution's second level medical appeal response address all of the inmate-patient's appealed issues?	10	0	10	100.00%	0
15.103	Did the institution's medical staff review and submit the initial inmate death report to the Death Review Unit in a timely manner?	3	2	5	60.00%	0
15.996	**For Information Purposes Only:** Did the CCHCS Death Review Committee submit its inmate death review summary to the institution timely?	Information Only				
15.997	**For Information Purposes Only:** Identify the institution's protocols for tracking medical appeals.	Information Only				
15.998	**For Information Purposes Only:** Identify the institution's protocols for implementing health care local operating procedures.	Information Only				
15.999	**For Information Purposes Only:** Identify the institution's health care staffing resources.	Information Only				
Overall Percentage:					**51.11%**	

Reference Number	*Job Performance, Training, Licensing, and Certifications*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
16.001	Do all providers maintain a current medical license?	10	0	10	100.00%	0
16.101	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	0	3	3	0.00%	0
16.102	Are nursing staff who administer medications current on their clinical competency validation?	10	0	10	100.00%	0
16.103	Are structured clinical performance appraisals completed timely?	0	9	9	0.00%	1
16.104	Are staff current with required medical emergency response certifications?	2	1	3	66.67%	0
16.105	Are nursing staff and the Pharmacist-in-Charge current with their professional licenses and certifications?	5	0	5	100.00%	1
16.106	Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	1	0	1	100.00%	0
16.107	Are nursing staff current with required new employee orientation?	0	1	1	0.00%	0
Overall Percentage:					**58.33%**	

APPENDIX B — CLINICAL DATA

Table B-1: MCSP Sample Sets	
Sample Set	**Total**
Anticoagulation	3
CTC/OHU	5
Death Review/Sentinel Events	4
Diabetes	2
Emergency Services - CPR	3
Emergency Services - Non-CPR	5
High Risk	5
Hospitalization	5
Intra-System Transfers in	3
Intra-System Transfers out	3
RN Sick Call	25
Specialty Services	2
	65

Table B-2: MCSP Chronic Care Diagnoses	
Diagnosis	**Total**
Anemia	2
Anticoagulation	5
Arthritis/Degenerative Joint Disease	3
Asthma	14
COPD	3
Cancer	5
Cardiovascular Disease	9
Chronic Kidney Disease	5
Chronic Pain	14
Cirrhosis/End Stage Liver Disease	4
Coccidioidomycosis	1
Deep Venous Thrombosis/Pulmonary Embolism	3
Diabetes	11
Gastroesophageal Reflux Disease	12
HIV	2
Hepatitis C	26
Hyperlipidemia	18
Hypertension	36
Mental Health	16
Rheumatological Disease	2
Seizure Disorder	3
Sleep Apnea	3
Thyroid Disease	3
	200

Table B-3: MCSP Event/Program	
Program	**Total**
Diagnostic Services	132
Emergency Care	70
Hospitalization	45
Intra-System Transfers in	12
Intra-System Transfers out	10
Outpatient Care	490
Specialized Medical Housing	96
Specialty Services	161
	1,016

Table B-4: MCSP Case Review Sample Summary	
	Total
MD Reviews, Detailed	24
MD Reviews, Focused	3
RN Reviews, Detailed	19
RN Reviews, Focused	39
Total Reviews	85
Total Unique Cases	65
Overlapping Reviews (MD & RN)	20

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

Mule Creek State Prison			
Quality Indicator	**Sample Category (number of samples)**	**Data Source**	**Filters**
Access to Care			
MIT 1.001	Chronic care patients (40)	Master Registry	• Chronic care conditions (at least one condition per inmate-patient—any risk level) • **Randomize**
MIT 1.002	Nursing Referrals (13)	OIG Q: 6.001	• See ***Intra-system Transfers***
MITs 1.003-006	Nursing sick call (5 per clinic) 30	MedSATS	• Clinic (each clinic tested) • Appointment date (2–9 months) • **Randomize**
MIT 1.007	Returns from community hospital (30)	OIG Q: 4.008	• See ***Health Information Management (Medical Records)*** (returns from community hospital)
MIT 1.008	Specialty services follow-up (27)	OIG Q: 14.001 & 14.003	• See ***Specialty Services***
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**
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	(6)	OIG Q: 1.001	• Dictated documents • First 20 IPs selected
MIT 4.003	(20)	OIG Qs: 14.002 & 14.004	• Specialty documents • First 10 IPs for each question
MIT 4.004	(20)	OIG Q: 4.008	• Community hospital discharge documents • First 20 IPs selected
MIT 4.005	(20)	OIG Q: 7.001	• MARs • First 20 IPs selected
MIT 4.006	(12)	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (12 or more = No)
MIT 4.007	Legible signatures & review (32)	OIG Qs: 4.008, 6.001, 6.002, 7.001, 12.001, 12.002 & 14.002	• First 8 IPs sampled • One source document per IP

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Health Information Management (Medical Records) (continued)			
MIT 4.008	Returns from community hospital (30)	Inpatient claims data	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • **Randomize** (each month individually) • First 5 inmate-patients from each of the 6 months (if not 5 in a month, supplement from another, as needed)
Health Care Environment			
MIT 5.101-111	Clinical areas (9)	OIG inspector onsite review	• Identify and inspect all onsite clinical areas.
Inter- and Intra-System Transfers			
MIT 6.001-003	Intra-system transfers (30)	SOMS	• Arrival date (3–9 months) • Arrived from (another CDCR facility) • Rx count • **Randomize**
MIT 6.004	Specialty services send-outs (20)	MedSATS	• Date of transfer (3–9 months) • **Randomize**
MIT 6.101	Transfers out (3)	OIG inspector onsite review	• R&R IP transfers with medication
Pharmacy and Medication Management			
MIT 7.001	Chronic care medication (40)	OIG Q: 1.001	*See **Access to Care*** • At least one condition per inmate-patient—any risk level • **Randomize**
MIT 7.002	New Medication Orders (40)	Master Registry	• Rx count • **Randomize** • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns from Community Hospital (30)	OIG Q: 4.008	• See ***Health Information Management (Medical Records)*** *(returns from community hospital)*
MIT 7.004	RC arrivals – medication orders *N/A at this institution*	OIG Q: 12.001	• See ***Reception Center Arrivals***
MIT 7.005	Intra-facility moves (30)	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • **Randomize**
MIT 7.006	En Route (0)	SOMS	• Date of transfer (2–8 months) • Sending institution (another CDCR facility) • **Randomize** • NA/DOT meds

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
Pharmacy and Medication Management (continued)			
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 (7)	OIG inspector onsite review	• Identify and inspect onsite clinical areas that prepare and administer medications
MITs 7.107-110	Pharmacy (1)	OIG inspector onsite review	• Identify & inspect all onsite pharmacies
MIT 7.111	Medication error reporting (30)	Monthly medication error reports	• All monthly statistic reports with Level 4 or higher • Select a total of 5 months
MIT 7.999	Isolation unit KOP medications (19)	Onsite active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in isolation units
Prenatal and Post-Delivery Services			
MIT 8.001-007	Recent Deliveries *N/A at this institution*	OB Roster	• Delivery date (2–12 months) • **Most recent** deliveries (within date range)
	Pregnant Arrivals *N/A at this institution*	OB Roster	• Arrival date (2–12 months) • **Earliest** arrivals (within date range)
Preventive Services			
MITs 9.001–002	TB medications (9)	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • **Randomize**
MIT 9.003	TB Code 22, annual TST (15)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (22) • **Randomize**
	TB Code 34, annual screening (15)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (34) • **Randomize**
MIT 9.004	Influenza vaccinations (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • **Randomize** • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal cancer screening (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • **Randomize**
MIT 9.006	Mammogram *N/A at this institution*	SOMS	• Arrival date (at least 2 yrs prior to inspection) • Date of birth (age 52–74) • **Randomize**
MIT 9.007	Pap smear *N/A at this institution*	SOMS	• Arrival date (at least three yrs prior to inspection) • Date of birth (age 24–53) • **Randomize**
MIT 9.008	Chronic care vaccinations (20)	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • **Randomize** • Condition must require vaccination(s)

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
Preventive Services (continued)			
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**
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 Access			
MITs 14.001–002	High-priority (15)	MedSATS	• Approval date (3–9 months) • **Randomize**
MITs 14.003–004	Routine (15)	MedSATS	• Approval date (3–9 months) • Remove optometry, physical therapy or podiatry • **Randomize**
MIT 14.005	Specialty services arrivals (20)	MedSATS	• Arrived from (other CDCR institution) • Date of transfer (3–9 months) • **Randomize**
MIT 14.006-007	Denials (20)	InterQual	• Review date (3–9 months) • **Randomize**
	(0)	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • **Randomize**
Internal Monitoring, Quality Improvement, & Administrative Operations			
MIT 15.001	Medical appeals (all)	Monthly medical appeals reports	• Medical appeals (12 months)
MIT 15.002	Adverse/sentinel events (0)	Adverse/sentinel events report	• Adverse/sentinel events (2–8 months)
MITs 15.003–004	QMC Meetings (6)	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.005	Performance improvement work plans (PIWP) (5)	Institution PIWP	• PIWP with updates (12 months) • Medical initiatives

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Internal Monitoring, Quality Improvement, & Administrative Operations (continued)			
MIT 15.006	LGB (4)	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.007	EMRRC (12)	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.101	Medical emergency response drills (3)	Onsite summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	2nd level medical appeals (10)	Onsite list of appeals/closed appeals files	• Medical appeals denied (6 months)
MIT 15.103	Death Reports (5)	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.996	Death Review Committee (5)	OIG summary log - deaths	• Between 35 business days & 12 months prior • CCHCS death reviews
MIT 15.998	Local operating procedures (LOPs) (all)	Institution LOPs	• All LOPs
Job Performance, Training, Licensing, and Certifications			
MIT 16.001	Provider licenses (10)	Current provider listing (at start of inspection)	• Review all
MIT 16.101	RN Review Evaluations (3)	Onsite supervisor periodic RN reviews	• RNs who worked in clinic or emergency setting six or more days in sampled month • **Randomize**
MIT 16.102	Nursing Staff Validations (10)	Onsite nursing education files	• On duty one or more years • Nurse administers medications • **Randomize**
MIT 16.103	Provider Annual Evaluation Packets (all)	OIG Q:16.001	• All required performance evaluation documents

MIT 16.104	Medical Emergency Response Certifications (all)	Onsite certification tracking logs	• All staff
			  ○ Providers (ACLS)
			  ○ Nursing (BLS/CPR)
			  ○ Custody (CPR/BLS)

MIT 16.105	Nursing staff and Pharmacist-in-charge Professional Licenses and Certifications (all)	Onsite tracking system, logs, or employee files	• All required licenses and certifications

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Job Performance, Training, Licensing, and Certifications (continued)			
MIT 16.106	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations (all)	Onsite listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 16.107	Nursing Staff New Employee Orientations (all)	Nursing staff training logs	• New employees (hired within last 12 months)

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

May 11, 2016

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

Dear Mr. Barton:

The purpose of this letter is to inform you that the Office of the Receiver has reviewed the draft report of the Office of the Inspector General (OIG) Medical Inspection Results for Mule Creek State Prison (MCSP) conducted from December 2015 to February 2016. California Correctional Health Care Services (CCHCS) acknowledges all OIG findings.

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

Sincerely,

Janet Lewis

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

cc: Clark Kelso, Receiver
Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Richard Kirkland, Chief Deputy Receiver
Jared Goldman, Counsel to the Receiver
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