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Office of the Inspector General

Pelican Bay State Prison
Medical Inspection Results
Cycle 4

February 2016

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

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PELICAN BAY STATE PRISON
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Cycle 4

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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 Pelican Bay State Prison (PBSP).

The OIG performed its Cycle 4 medical inspection at PBSP from August to October 2015. The inspection included an in-depth clinician review of 82 inmate-patient files, as well as a compliance review of documents from 372 inmate-patient files. The compliance review included 85 objectively scored tests for compliance with policies and procedures applicable to the delivery of medical care. The OIG assessed the case review and compliance results at PBSP 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 scored by compliance inspectors only; both secondary indicators were scored 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 PBSP was ***adequate***.

Health Care Quality Indicators

Fourteen Primary Indicators (Clinical)	All Institutions–Applicability	PBSP 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**	**PBSP Applicability**
15–Internal Monitoring, Quality Improvement, and Administrative Operations	All institutions	Compliance only
16–Job Performance, Training, Licensing, and Certifications	All institutions	Compliance only

Overall Assessment: Adequate

Overall Assessment Rating:

Adequate

Based on the clinical case reviews and compliance testing, the OIG's overall assessment rating for PBSP was *adequate*. For the 12 primary (clinical) quality indicators applicable to PBSP, the OIG found four *proficient* and eight *adequate*. For the two secondary (administrative) quality indicators, the OIG found one *adequate* and one *inadequate*. To determine the overall assessment for PBSP, 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 PBSP.

Clinical Case Review and OIG Clinician Inspection Results

The clinicians' case reviews sampled patients with high medical needs and included a review of 1,056 patient care events.[1] For the 12 primary indicators applicable to PBSP, ten were evaluated by clinician case review; four were *proficient*, and six were *adequate.* When determining the overall adequacy of care, the OIG paid particular attention to the clinical nursing and provider quality indicators, as adequate health care staff can sometimes overcome suboptimal processes and programs. However, the opposite is not true; inadequate health care staff cannot provide adequate care, even though the established processes and programs onsite may be adequate. The OIG clinicians identify inadequate medical care based on the risk of significant harm to the patient, not the actual outcome.

Program Strengths — Case Review

- During the period of review, PBSP provided excellent access to primary care services.
- PBSP also provided excellent diagnostic services, with diagnostic tests performed, results reviewed by providers, and patients notified of results in a timely manner.
- At the time of the OIG medical inspection, PBSP was the only CDCR institution that used an electronic health record system that allowed instantaneous documentation and retrieval of vital health information.
- PBSP administered medications timely to patients, with only rare delays in medication administration. Of particular importance, PBSP administered post-hospital medications without interruption in all hospitalization cases reviewed. The OIG clinicians attributed

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

some of PBSP's success in this area to the real-time electronic health record and computerized provider order entry.

- PBSP provided excellent correctional treatment center (CTC) services. PBSP CTC nursing and provider staff demonstrated highly proficient assessment, diagnostic, treatment, and documentation skills throughout all CTC cases reviewed. The OIG clinicians did not identify a single clinically significant deficiency.

Program Weaknesses — Case Review

- PBSP providers sometimes failed to order clinically appropriate follow-up appointments. This resulted in the premature closure of several medical cases needing further medical follow-up. This pattern prevented OIG clinicians from giving PBSP a *proficient* rating for both the *Quality of Provider Performance* indicator, as well as the overall institutional rating.

Compliance Testing Results

Of the 14 total health care indicators applicable to PBSP, compliance inspectors evaluated 11.[2] There were 85 individual compliance questions within those 11 applicable indicators, generating 1,058 data points, that tested PBSP's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[3] The 85 questions are detailed in *Appendix A — Compliance Test Results*. The institution's inspection scores for the 11 applicable indicators ranged from 44.3 percent to 98.0 percent, with the primary (clinical) indicator *Health Information Management* receiving the lowest score, and the primary indicator *Specialized Medical Housing* receiving the highest. For the nine primary indicators applicable to compliance testing, the OIG rated five *proficient*, three *adequate*, and one *inadequate*. For the two secondary indicators, which involve administrative health care functions, one was rated *adequate* and the other *inadequate*.

Program Strengths — Compliance Testing

As the *Executive Summary Table* on page x indicates, the institution's primary indicator compliance ratings were *proficient* for the following five indicators: *Access to Care* (89.4 percent), *Diagnostic Services* (89.8 percent), *Inter- Intra System Transfers* (93.8 percent), *Pharmacy and Medication Management* (87.7 percent), and *Specialized Medical Housing* (98.0 percent). The following are some of the strengths identified by PBSP's compliance scores for individual questions within all primary health care indicators:

[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.

- Providers completed timely appointments for chronic care patients, new arrival nurse-referred patients, and patients returning from specialty service appointments.

- Nursing staff timely completed face-to-face patient sick call visits, and providers timely saw those patients whom nurses referred.

- Inmate-patients received radiology services within the required time frame. In addition, providers reviewed and communicated the radiology report results to inmate-patients within the required periods.

- Providers communicated laboratory results to inmate-patients within the required time frames.

- PBSP received pathology reports timely, and then providers timely reviewed and communicated the report results to patients.

- PBSP clinicians routinely used legible names and dates to evidence their review of medical reports or their involvement in patients' medical record encounters.

- The institution's clinics were appropriately disinfected, cleaned, and sanitary; health care staff ensured that reusable invasive and non-invasive medical equipment was properly sterilized or disinfected; and clinic protocols were in place to control exposure to blood-borne pathogens and contaminated waste.

- PBSP's medical supply management process adequately supported the needs of the medical health care program, and clinics followed adequate protocols for managing and storing bulk medical supplies.

- The institution's clinic common areas had an adequate environment conducive to providing medical services.

- For newly arrived inmate-patients, nursing staff properly completed the Initial Health Screening form (CDCR Form 7277) by answering all applicable questions, documenting an assessment and disposition, and signing and dating the form on the same day the inmate arrived at the institution.

- PBSP staff ensured that newly arrived inmate-patients received prescribed medication upon arrival without interruption.

- Medication packages for inmate-patients who transferred out of PBSP included all of their prescribed medications and corresponding medication records.

- Nursing staff administered or delivered medications that were newly ordered within the required time frames, and they followed proper administrative protocols when preparing patient medications.

- Inmate-patients at PBSP who transferred from one housing unit to another received their medications without interruption.

- The institution's clinics had strong security controls over both narcotic and non-narcotic medications.

- PBSP medical staff followed hand hygiene contamination control protocols during medication preparation and administration processes.

- The institution's nursing staff followed proper administrative protocols when preparing and distributing medications for inmate-patients.

- The institution's main pharmacy followed general security, organization, and cleanliness management protocols and properly stored medications.

- The institution was prompt in offering annual preventive services in the form of influenza vaccinations and colorectal cancer screenings.

- Correctional treatment center nursing staff completed initial assessments the same day the CTC admitted the patients. Providers completed face-to-face encounters with the patients within one calendar day of admission, and completed a history and physical examination within 72 hours of admission. Further, providers completed subjective, objective, assessment, plan, and education progress notes within required time frames.

- The institution's CTC had a working call button system and a procedure in place to ensure that during an emergent event, medical staff could enter an inmate-patient's cell within a reasonable amount of time.

- High-priority and routine specialty services appointments occurred timely, and PBSP's denials of providers' requests for specialty services were timely.

The following administrative areas showed strengths within the secondary indicators:

- The institution promptly processed inmate medical appeals during the 12 months preceding the OIG's inspection. In addition, the institution's second-level medical appeal responses addressed all of the inmate-patients' appealed issues.

- Monthly Quality Management Committee (QMC) meeting minutes prepared by staff were well documented and indicated the QMC took action when the committee identified improvement opportunities.

- The institution completed timely medical emergency response drills that included required documentation and the involvement of both custody and medical staff for each watch in the most recent quarter.

- The institution's medical staff reviewed and submitted the initial inmate death report to the CCHCS Death Review Unit in a timely manner.

- Providers, the pharmacist-in-charge, and the pharmacy had current required licenses, registrations, and emergency response certifications.

- The institution's custody staff were all current with their medical emergency response certifications.

- Nursing staff were current on required new employee training requirements, licenses, and emergency response certifications.

Program Weaknesses — Compliance Testing

The compliance testing resulted in only one primary indicator with an *inadequate* rating. The indicator was the *Health Information Management (Medical Records) which* received a low score of only 44.3 percent. In the secondary indicator, *Internal Monitoring, Quality Improvement, and Administrative Operations*, PBSP also scored poorly (63.9 percent). The following are some of the weaknesses identified based on PBSP's compliance scores for individual questions within all primary health care indicators:

- Providers did not always review and initial laboratory reports within the required time frame.

- PBSP's medical records staff did not always scan non-dictated provider notes, health screening forms, or health care services request forms into the eUHR within the required time frame.

- The institution's medical records staff periodically mislabeled health care documents that they entered into patients' eUHRs.

- Several inmate-patient restrooms lacked hygiene products.

- Some clinics and exam rooms lacked essential core medical equipment for comprehensive examinations, such as automated vital sign machines and medication refrigerators.

- Emergency response bags in some clinics did not contain required essential items such as non-latex gloves, two CPR micro-masks, two sizes of blood pressure cuffs, or a non-rebreather oxygen mask.

- The institution did not always ensure that patients received their ongoing chronic care medications within required time frames or else ensure that staff followed department policy for refusal or no-shows.

- PBSP's pharmacist-in-charge did not retain evidence of review of staff members' monthly medication physical inventory results for the clinics' narcotic medication storage locations.

- Clinical staff did not properly monitor inmate-patients who took INH tuberculosis medication.

- Nursing staff did not follow required procedures for timely administering, reading, or documenting patient's annual tuberculosis skin tests.

- Clinicians did not ensure that they timely offered certain chronic care patients the pneumonia vaccination.

- Inmate-patients who transferred into PBSP from another institution with an approved specialty service appointment did not routinely receive their services timely after arrival.

The lowest-scoring deficiencies among the secondary indicators related to the following administrative areas:

- The institution did not take steps to ensure the accuracy of its Dashboard data.

- The institution did not adequately identify the status of performance objectives for any of the quality improvement initiatives identified in its 2014 Performance Improvement Work Plan.

- The warden did not routinely sign the Emergency Medical Response Review Committee meeting minutes, and emergency response packages did not include all the required documentation.

- PBSP management did not always complete timely structured clinical performance appraisals for all providers, or the completed reviews did not always include required elements.

The *PBSP 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.

PBSP Executive Summary Table

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

Note: 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	Adequate	Adequate

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

Population-Based Metrics

Overall, PBSP performed well for population-based metrics. For comprehensive diabetes care measures, PBSP outperformed other State and national organizations with its percentage of diabetics considered to be under good control and low percentage of diabetics considered to be under poor control. For diabetic monitoring, PBSP outperformed all organizations in four of five measures. For eye exams, PBSP scored in the mid-range, with a higher score than Medi-Cal, Medicaid, and commercial entities, but a lower score than Kaiser Permanente (Kaiser), Medicare, and the U.S. Department of Veterans Affairs (VA).

While PBSP routinely offered inmate-patients influenza vaccinations and colorectal cancer screening, patients often refused the preventive services, which adversely affected the institution's score. With regard to patients aged 18 to 64, who actually received the influenza immunization, PBSP only scored higher than commercial entities and scored lower than Kaiser and the VA. For adults aged 65 and older, PBSP outperformed the VA, the only comparable entity. With regards for administering pneumococcal vaccinations, PBSP scored higher than Medicare but lower than the VA. For colorectal cancer screenings, PBSP outperformed both commercial entities and Medicare, but the institution scored lower than Kaiser and the VA.

Overall, PBSP's performance demonstrated by the population-based metrics comparison indicates that comprehensive diabetes care, immunizations, and cancer screening were *adequate* in comparison to the other health care organizations reviewed.

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.

Pelican Bay State Prison (PBSP) was the tenth medical inspection of Cycle 4. During the inspection process, the OIG assessed the delivery of medical care to patients using 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

PBSP is designed to house California's most serious criminal offenders in a secure, safe, and disciplined institutional setting. One-half of the prison houses maximum-security inmates in a general population setting. The other half houses inmates in the security housing unit (SHU), designed for inmates presenting serious management concerns, including prison gang members and violent maximum-security inmates. The institution also has a 127-bed psychiatric services unit and a Level 1 minimum-security yard. PBSP operates ten medical clinics where staff handle non-urgent requests for medical services. PBSP also provides inpatient care at the correctional treatment center and treats inmates needing urgent or emergency care in its triage & treatment area (commonly referred to at the institution as the urgent treatment area, or UTA). In addition, in August 2013, PBSP was awarded national accreditation from the Commission on Accreditation for Corrections. This accreditation program is a professional peer review process based on national standards set by the American Correctional Association.

According to information provided by the institution, as of July 2015, PBSP had 138.7 budgeted health care positions, of which 103.5 were filled. PBSP's vacancy rate among licensed medical managers, primary care providers, supervisors, and rank-and-file nurses was 25 percent, or 35.2 vacant health care positions. Of these vacant positions, 33.2 were of nursing positions. Included within the filled positions figure was one nursing staff member who was redirected to a non-patient-care position and six nurses who were on long-term medical leave. In addition to PBSP's total budgeted positions, the institution also employed four additional contracted registry nurses. Lastly, the CEO reported that in July 2015, there were ten nursing staff members under disciplinary review.

On July 11, 2005, through federal court orders, PBSP implemented an electronic health record and scheduling system known as the Madrid Patient Information Management System (MPIMS). PBSP is the only State institution that currently utilizes this system. MPIMS is the institution's primary scheduling system and depository of patient medical information. All health care staff use MPIMS for daily activities such as scheduling appointments, primary care progress notes, primary care orders, nursing assessments, medication administration, chronic care tracking and compliance, and quality management. PBSP also uses the more commonly used statewide electronic unit health record (eUHR) system as its secondary medical record depository. Because MPIMS allows onsite clinicians real-time access to both enter and retrieve most types of patients' medical data, the system is used on a more regular basis than the eUHR.

PBSP Health Care Staffing Resources as of July 2015

	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff		Totals	
Description	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Authorized Positions	5	4%	5.5	4%	11.5	8%	116.7	84%	138.7	100%
Filled Positions	3	60%	5.5	100%	10	87%	85	73%	103.5	75%
Vacancies	2	40%	0	0%	1.5	13%	31.7	27%	35.2	25%
Recent Hires (within 12 months)	1	33%	0	0%	2	20%	15	18%	18	17%
Staff Utilized from Registry	0	0%	0	0%	0	0%	4	5%	4	4%
Redirected Staff (to Non-Patient Care Areas)	0	0%	0	0%	0	0%	1	1%	1	1%
Staff on Long-Term	0	0%	0	0%	1	10%	5	6%	6	6%

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

As of July 20, 2015, the Master Registry for PBSP showed that the institution had 2,781 inmate-patients. Within that total population, 0.5 percent were designated High-Risk, Priority 1 (High 1), and 1.9 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 are. 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.

PBSP Master Registry Data as of July 20, 2015

Risk Medical Level	# of Inmate-Patients	Percentage
High 1	15	0.5%
High 2	54	1.9%
Medium	639	23.0%
Low	2,073	74.6%
Total	**2,781**	**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 PBSP, 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.

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 (an unexpected occurrence 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, PBSP Sample Sets*, the OIG clinicians evaluated medical charts for 82 unique inmate-patients. *Appendix B, Table B–4, PBSP Case Review Sample Summary*, clarifies that both nurses and physicians reviewed charts for 14 of those patients, for 96 reviews in total. Physicians performed detailed reviews of 31 charts, and nurses performed detailed reviews of 21 charts, totaling 52 detailed reviews. For detailed case reviews, physicians or nurses looked at all encounters occurring over an approximate six months of medical care. Nurses also performed a limited or focused review of medical records for an additional 44 inmate-patients. These generated a total of 1,056 clinical reviewed events (*Appendix B, Table B–3, PBSP Event-Program*). The OIG's reporting format provides details on whether the examined 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 methodology specifically calls for only four chronic care patient records, i.e., three diabetes patients and one anticoagulation patient (*Appendix B, Table B–1, PBSP Sample Sets*), the 82 unique inmate-patients sampled actually included patients with 178 chronic care diagnoses. These diagnoses included six additional patients with diabetes for a total of nine (*Appendix B, Table B–2, PBSP 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. 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's 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 PCPs 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 *PBSP 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 August to October 2015, deputy inspectors general attained answers to 85 objective medical inspection test (MIT) questions designed to assess the institution's compliance with critical policies and procedures applicable to the delivery of medical care. To conduct most tests, inspectors randomly selected samples of inmate-patients for whom the testing objectives were applicable and reviewed their electronic unit health records. In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed health records for 372 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 August 3, 2015, field inspectors conducted a detailed onsite inspection of PBSP's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,058 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 PBSP'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- 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 all 85 applicable questions, the OIG derived a score for each primary and secondary quality indicator identified above by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Based on those results, the OIG assigned a rating to each quality indicator of *proficient* (greater than 85 percent), *adequate* (between 75 percent and 85 percent), or *inadequate* (less than 75 percent).

DASHBOARD COMPARISONS

For some of the individual compliance questions, the OIG identified where similar metrics were available within the CCHCS Dashboard, which is a monthly report that consolidates key health care performance measures statewide and by institution. There is not complete parity between the metrics due to time frames when data was collected. As a result, there is some difference between the OIG's findings and the Dashboard results. The OIG compared its compliance test results with the institution's Dashboard results and reported on that comparative data under various applicable quality indicators within the Medical Inspection Results section of this report.

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 for 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 PBSP, the OIG reviewed some of the compliance testing results, randomly sampled additional inmate-patients' records, and obtained PBSP 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 PBSP. 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.

Summary of Case Review Results: The clinical case review component assessed 10 of the 12 primary (clinical) indicators applicable to PBSP. Among these ten indicators, four were *proficient*, and six were *adequate*. To conclude on the indicator assessments, the OIG physicians performed 31 detailed case reviews and rated the overall adequacy of care for each review they conducted. Of the 31 cases reviewed, seven were *proficient*, 17 were *adequate*, and seven were *inadequate*. In total, the 31 case reviews had 1,056 events reviewed and 259 identified deficiencies, of which OIG physicians considered 28 to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

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

There was one adverse event identified in the case reviews at PBSP. The case was not reflective of the overall quality of care at PBSP.

- In case 82, the patient fell off his top bunk and presented to the triage and treatment area (TTA). The TTA provider did not perform an adequate evaluation and sent the patient back to housing. The provider did not order an x-ray and thus missed the diagnosis. Five days later, the PCP in the clinic made the same error. A CT scan five weeks later showed that the patient broke five of his ribs (with three ribs broken in two places) and had significant bleeding into the chest cavity.

This case is also discussed in the *Emergency Services* and the *Quality of Provider Performance* indicators. PBSP performed a root cause analysis of this case and presented its results to the OIG clinicians during the onsite inspection. The root cause analysis process demonstrated PBSP's strong commitment to continuous quality improvement.

Summary of Compliance Results: The compliance component assessed 9 of the 12 primary (clinical) indicators applicable to PBSP. For these nine indicators, OIG inspectors rated four *proficient*, four *adequate*, and one *inadequate*. The results of those assessments are summarized in each applicable indicator in the following pages, while 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:
Proficient
Compliance Score:
Proficient
(89.4%)

Overall Rating:
Proficient

Case Review Results

OIG clinicians reviewed 302 provider, nursing, specialty, and outside hospital encounters where a follow-up needed to be scheduled and found 20 deficiencies relating to *Access to Care*. Nineteen of the deficiencies were of minor significance and did not negatively affect the ratings of the clinical case reviews. The one significant deficiency is described below (case 70). PBSP performed extremely well with regard to *Access to Care*, and the indicator rating was *proficient*.

Provider-to-Provider Follow-up Appointments

PBSP performed very well with provider-ordered follow-up appointments. These are among the most important aspects of the *Access to Care* indicator. Failure to accommodate provider-ordered appointments can often result in lapses in care, or even in patients being lost to follow-up. OIG clinicians reviewed 157 outpatient provider encounters and found only one minor deficiency.

Provider Chart Review Follow-up Encounters

PBSP performed very well with provider-ordered chart reviews. As discussed in the *About the Institution* section of this report, PBSP medical staff primarily documented medical care in a locally developed and maintained electronic health record known as the Madrid Patient Information Management System (MPIMS). This system allowed PBSP providers to perform a significant amount of "desktop medicine," where providers reviewed records, made assessments, and placed clinical orders without performing a face-to-face encounter with the patient. These chart reviews can increase efficiency and improve care, as long as providers perform chart reviews in a judicious and reliable manner. The OIG clinicians reviewed 85 encounters in which PBSP providers performed patient chart reviews, and found only one instance where the provider requested a chart review but the review did not occur (Case 70). This review was to provide follow-up care for a patient with poorly controlled diabetes who had recent changes in his insulin dosage.

Registered Nurse Sick Call Access

In general, PBSP performed well with registered nurse (RN) sick call access; however, a practice employed by the institution caused it to sometimes be non-compliant with CCHCS policy related to same-day review of patient sick call requests. More specifically, OIG clinicians reviewed 127 sick call Health Care Services Request form (CDCR Form 7362) encounters, and identified ten instances where patient requests were not reviewed by an RN the same day they were received as policy requires. Further, these deviations directly resulted in the patients not being assessed by an RN within one business day of receipt of the patients' sick call requests. However, from a qualitative standpoint, OIG clinicians only identified one instance where a patient did not receive a timely nurse evaluation (see case 42 in the *Quality of Nursing Performance* indicator).

With regard to untimely review of sick call requests, OIG clinicians identified a unique practice at PBSP in which medical staff technically operated outside of CCHCS health care policy. This occurred when PBSP's LVNs and LPTs collected sick call forms twice daily—once in the morning before clinic, and again later in the evening after clinic; however, an RN did not always review forms from the second collection on the same day, as policy requires. The institution allowed LVNs and LPTs to informally prescreen the forms (for urgent TTA referrals) for the second collection periods and allowed an RN to formally review the forms the following day. OIG clinicians concluded the practice could be somewhat medically beneficial if properly trained LVNs and LPTs followed due diligence reporting protocols to properly prescreen sick call request forms and report findings to an RN.

While the accelerated collection system was responsible for the case review's findings of delayed RN appointments (discussed above), the delays were artificial; from a qualitative standpoint, the OIG clinicians considered the practice acceptable. Because the practice is technically out of policy, it likely caused the compliance deficiency discussed below regarding nurses' untimely review of patient's health service request forms (MIT 1.003).

In practice, PBSP did not demonstrate any delays in care for sick call access compared to other CDCR institutions. In fact, by picking up sick call requests twice daily, PBSP improved the chances of early medical response to an urgent problem by as much as 8 to 16 hours.

RN-to-Provider Referrals

PBSP performed adequately with RN-to-provider appointments. OIG clinicians identified 47 instances where the clinic RN referred the patient to a PCP. In four instances, the PCP appointment did not occur within the requested time frame (cases 6, 11, 13, and 35). However, in each of those cases, the appointment occurred only a few days late, and the delay had no effect on the quality of care. In two other instances (cases 14 and 58), the PCP appointment did not occur at all.

Provider Follow-up after Specialty Service

PBSP consistently provided patients with a provider follow-up after specialty services. OIG clinicians reviewed 56 diagnostic and consultative specialty services and found no deficiencies with *Access to Care* in this area.

Intra-System Transfers

Nurses assessed newly transferred patients and always referred them to a provider. Providers always saw the patients timely. OIG clinician's review of ten transfer-in patients found no deficiencies with *Access to Care* in this area.

Follow-up after Hospitalization

PBSP had no problems ensuring that providers saw their patients after return from an outside hospital or an emergency department. PBSP had 20 hospitalization and outside emergency events, and OIG clinicians found no deficiencies with *Access to Care* in this area.

Urgent or Emergent Care

PBSP had no difficulty ensuring that PCPs evaluated their patients timely following care in the triage and treatment area. The OIG clinicians reviewed 25 urgent or emergent encounters, eight of which required a PCP follow-up. OIG clinicians found no deficiencies with *Access to Care* in this area.

Specialized Medical Housing

PBSP did very well with provider access during and after admission to the correctional treatment center (CTC). A provider saw patients frequently and within the every-72-hour policy requirement. The OIG clinicians reviewed 18 CTC admissions with 74 CTC provider encounters. In addition to proficient CTC provider access, patients always saw their PCP for follow-up after CTC discharge. There were no deficiencies in this area.

Diagnostic Results Follow-up

During the case review, a pattern emerged in which providers reviewed labs but only rarely requested follow-up appointments, even for abnormal results. OIG clinicians deemed the majority of these instances adequate because PBSP providers demonstrated adequate diagnostic review and decision-making via chart review encounters. However, because PBSP providers rarely requested face-to-face follow-up appointments for diagnostic results, the OIG clinicians could not make a meaningful determination on whether providers' actual follow-up visits were *adequate*.

Specialty Access

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

Clinician Onsite Inspection

During the OIG clinicians' onsite visit, clinical inspectors followed up on some of the sporadic deficiencies found in case review. Most of them were due to scheduling staff's error when entering appointment requests into PBSP's electronic appointment system. Furthermore (as discussed above), the OIG clinicians clarified PBSP's process of collecting sick call requests twice daily, and determined that while the practice created an artificial compliance deficiency (see MIT 1.003 below), the practice actually improved the quality of care delivered and was a commendable PBSP decision.

Clinician Summary

PBSP demonstrated excellent ability to provide patients *Access to Care*. The OIG clinicians found only rare problems in this area, and they were generally not clinically significant. OIG clinicians rated PBSP *proficient* in this indicator.

Compliance Testing Results

The institution received a compliance score of 89.4 percent in the *Access to Care* indicator, and scored in the *proficient* range for the following five indicators:

- All 30 sampled inmate-patients with chronic care conditions received a timely chronic care appointment with a provider (MIT 1.001).

- Inspectors sampled 40 Health Care Services Request forms (CDCR Form 7362) submitted by inmate-patients across all facility clinics. In all sampled instances, nursing staff completed a face-to-face encounter with each inmate-patient within one business day of reviewing (or receiving) the service request form (MIT 1.004).

- Inspectors sampled 20 inmate-patients who had received a specialty service; 19 of them (95 percent) received a timely follow-up appointment with a PCP. The only exception was an inmate-patient who received his follow-up appointment nine days late (MIT 1.008).

- Primary care provider visits occurred timely for 17 of the 18 sampled inmate-patients who either transferred into the institution with a pre-existing chronic care PCP visit need or who upon arrival received a new PCP referral from the PBSP screening nurse (94 percent). For one patient, the appointment was held three days late (MIT 1.002).

- For 16 health care services request forms sampled where nursing staff referred the inmate-patient for a PCP appointment, 15 patients (94 percent) received a timely

appointment. The one exception was an inmate-patient who received his PCP appointment 20 days late (MIT 1.005).

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

- Inmates had access to health care services request forms at seven of nine housing units inspected (78 percent). One inspected housing unit did not have a supply of the forms available for patients' use, and another unit did not have a secured lockable box for inmate-patients to confidentially submit their requests (MIT 1.101).

The institution received an *inadequate* compliance score in the following area:

- Inspectors sampled 40 Health Care Services Request forms and found that nursing staff reviewed the forms on the same day received for only 26 of them (65 percent). For 14 forms sampled, nursing staff reviewed the services request form one to three days after the form was received (MIT 1.003).

CCHCS Dashboard Comparative Data

The Dashboard normally includes the average of nine medical access performance indicators to calculate the score for *Scheduling & Access to Care*. However, due to PBSP's unique electronic medical records system (discussed above), PBSP did not have any comparable Dashboard documents during the sample test for medical services. As indicated in the following table, the OIG's normally calculated comparable score for *Access to Care* was in the high end of the *proficient* range. For this calculation, the OIG reviewed documents from the most recent month as well as documents from the preceding nine months.

Access to Care — PBSP Dashboard and OIG Compliance Results

PBSP DASHBOARD RESULTS	OIG COMPLIANCE RESULTS
Scheduling & Access to Care: Medical Services August 2015	*Access to Care* (1.001, 1.004, 1.005, 1.007**) *Diagnostic Services* (2.001, 2.004) *Specialty Services* (14.001, 14.003) October 2014 – July 2015
***N/A for PBSP**	**96%**

*PBSP did not report any statistics for this Dashboard measure.
**PBSP did not have any applicable samples for this test area.

Recommendations for CCHCS

The OIG recognizes that PBSP has implemented a procedure of collecting patients' Health Care Services Request forms (CDCR Form 7362) twice a day, which has some qualitative health care value but that sometimes may cause the institution to be technically out of compliance with CCHCS policy requiring a same-day RN review. This nuance results from LVN or LPT nurses who may unofficially prescreen health service requests and immediately forward only those requests deemed urgent in nature for an official same-day RN review. As a result, the OIG recommends that

- The CCHCS reevaluate its policy related to required RN review times for those health care services request forms that are collected more frequently than once per day.

While reevaluating the above review times,

- CCHCS should consider the potential health care benefits in requiring nursing staff to collect patient health care service request forms more frequently than once per day.

DIAGNOSTIC SERVICES

Case Review Rating:
Proficient
Compliance Score:
Proficient
(89.8%)

Overall Rating:
Proficient

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.

Case Review Results

The OIG clinicians reviewed 120 diagnostic events and found 18 deficiencies. Sixteen of those related to health information management, such as the timely communication of electrocardiogram (EKG) test results, but these were considered minor deviations. Two other deficiencies related to the non-completion of ordered tests. None of the deficiencies significantly affected the quality of care in the cases reviewed.

PBSP timely provided patients' diagnostic services, and its providers quickly reviewed, initialed, and dated the resulting test reports. PBSP's medical records staff then immediately scanned those reports into the eUHR. Overall, PBSP performed very well in this indicator.

Only one pattern of deficiencies emerged during the OIG clinician chart review:

- PBSP often failed to notify patients of their test results after medical staff performed diagnostic EKGs. OIG clinicians found this deficiency in cases 1, 3, 5, 52, 54, 56, 58, and 70.

The following is provided for quality improvement purposes only since the incidents suggested no pattern of problems:

- In two instances, PBSP failed to complete diagnostic tests as ordered. In case 55, an EKG was not completed. In case 62, a chest x-ray was not performed.

- PBSP providers occasionally failed to initial or date the diagnostic report to evidence their review (cases 59 and 72).

- In case 71, PBSP performed a laboratory test, but no provider reviewed the results and the report was not scanned into the eUHR.

Clinician Summary

PBSP generally did very well in all aspects of diagnostic services, with only minor deficiencies identified. With the exception of notifying patients of their EKG results, the OIG clinicians could not identify any pattern of deficiencies with PBSP's diagnostic services and rated this indicator *proficient*.

Compliance Testing Results

The institution received a *proficient* compliance score of 89.8 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 radiology services sampled, the services were timely performed, the ordering provider timely reviewed the diagnostic report results, and the test results were timely communicated to the patients (MIT 2.001, 2.002, 2.003).

Laboratory Services

- PBSP timely performed eight of ten laboratory services providers ordered (80 percent). However, two patients did not receive their laboratory service within the provider-ordered time frame, with the patients receiving the service one and two days late (MIT 2.004). Also, only seven of those ten patients sampled (70 percent) had adequate eUHR file evidence that the provider reviewed the laboratory report results timely. Three samples had inadequate evidence of a timely review. For one of those patients, the PCP reviewed the laboratory report one day late, and for two other patients, there was no evidence the PCP initialed and dated the report to evidence review of the report results (MIT 2.005). Finally, providers timely communicated nine of the ten diagnostic laboratory reports to the inmate-patient (90 percent). The only exception was when a PCP communicated results to the patient one day late (MIT 2.006).

Pathology Services

- The institution documented eUHR evidence that it timely received a final pathology report for nine of ten inmate-patients sampled (90 percent). However, for one patient, the institution never received a final pathology report (MIT 2.007). Furthermore, of those nine samples where the institution received a final report, providers timely reviewed the results for eight (89 percent). In the one exception, the institution received a final pathology report, but the PCP did not evidence a timely review by documenting both initials and date on the form (MIT 2.008). In a related area, providers communicated the final pathology results to eight of the nine applicable patients (89 percent). One patient never received a provider's communication related to the pathology results (MIT 2.009).

Recommendations

No specific recommendations.

EMERGENCY SERVICES

Case Review Rating:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

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

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

Case Review Results

The OIG clinicians reviewed 25 urgent or emergent encounters and found six notable deficiencies; however, as discussed below, the deficiencies generally did not affect patient care. In general, PBSP performed well with emergency response times, basic life support (BLS) care, and 9-1-1 call activation times. Overall, patients requiring urgent or emergent services received timely and adequate care in the majority of cases reviewed.

Provider Performance

To handle emergency services, the institution maintained a triage and treatment area (TTA), which local clinical staff commonly referred to as the urgent treatment area or UTA. However, for discussion purposes, throughout this medical inspection report, the area will be referred to as a "TTA," since statewide health care policy uses this terminology and stakeholders more commonly recognize the term.

The TTA providers generally saw patients timely and made adequate assessments. The provider made sound triage decisions and sent patients to appropriate levels of care. While the OIG identified a few deficiencies, the quality of provider care in *Emergency Services* was *adequate*.

The OIG clinicians provide the following case examples for quality improvement purposes. These examples were not reflective of the general quality of care provided by the TTA provider:

- In case 5, the TTA provider failed to document a progress note with the decision to transfer the patient with gastrointestinal bleeding to the TTA and the subsequent transfer to an outside hospital.

- In case 82, the TTA provider did not perform an adequate evaluation for a patient who claimed to have fallen off his top bunk. The TTA provider initially misdiagnosed the patient, who had broken five of his ribs (with three ribs broken in two places) and had developed significant bleeding in his chest cavity. Fortunately, the patient did not require any surgical intervention and healed from the injury, despite the delay in care.

- In case 83, the patient's medical record indicated that the TTA provider performed a thigh abscess incision and drainage without first administering any local anesthetic.

Nursing Performance

The nursing care provided to patients during urgent or emergent responses was timely and appropriate. Transfer of care among nursing staff on site and to local emergency medical services (EMS) staff was coordinated and well documented. However, the following deficiencies involved incomplete nursing documentation:

- In case 1, the patient was hypertensive with chest pain at level 6 out of 10, and the RN did not document administration of nitroglycerin per CCHCS nursing chest pain protocol.

- In case 3, an LVN and an RN responded to a "man down" patient with a head laceration with mild active bleeding and memory loss after he slipped and fell. Neither the LVN nor the RN documented an initial assessment of vital signs taken upon their arrival on scene.

- In case 52, numerous clinical and custody staff members participated in an emergency medical BLS response incident with coordinated substitutions for chest compressions and assisted airway maintenance. Although documentation by the paramedics was found in the Code 3 Pre-Hospital Care Report, PBSP nursing staff did not document the method and rate of oxygen administration, times and dose of ACLS protocol medications administered in the TTA by paramedics, defibrillation shocks administered by paramedics prior to departure from the TTA, or assessment of the patient's response to these emergency interventions. Since the event occurred in the TTA, the information should have been documented during this transitional period in which the patient was handed off to the paramedics.

Emergency Medical Response Review Committee

There was a lack of documentation that the Emergency Medical Response Review Committee (EMRRC) reviewed patients with unscheduled transfers out for higher levels of care (cases 1, 2, and 3) as required by current CCHCS policy. The OIG clinicians considered this purely a documentation deficiency that did not affect quality of care. There was evidence that the EMRRC coordinator reviewed all unscheduled transfers and made referrals for additional nursing training for several cases. However, the EMRRC did not include these reviews in its meeting minutes.

Clinician Summary

Overall, the PBSP providers, nursing, and custody staff provided coordinated, timely, and appropriate urgent or emergent care in a safe manner. However, as discussed above, various deficiencies of both provider and nursing staff prevented the OIG clinicians from giving this indicator the highest rating. The OIG clinicians thus rated this indicator *adequate*.

Recommendations

No specific recommendations.

HEALTH INFORMATION MANAGEMENT (MEDICAL RECORDS)

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(44.3)%

Overall Rating:
Adequate

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.

For this indicator, the case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance review resulting in an *inadequate* score. The OIG's internal review process considered the factors that led to both results and ultimately rated this indicator *adequate.* Pelican Bay State Prison utilized a true electronic health record, which largely mitigated PBSP's many eUHR scanning problems. As a result, the OIG inspection team concluded that the case review's *adequate* rating was a more appropriate overall rating for this indicator.

Case Review Results

Inter-Departmental Transmission

- During the period of review, while PBSP maintained the statewide eUHR, the institution also used a separate electronic health record, the Madrid Patient Information Management System (MPIMS) (see the *About the Institution* section). The institution's medical staff used MPIMS to document encounters and enter orders in real time. MPIMS transmitted those orders instantaneously to various onsite clinical departments. Medical staff was then able to retrieve and view the medical documents without any transmission delays. Overall, MPIMS posed no significant problems for the processing of medical information among the institution's internal departments.

Hospital Records

- Regarding medical records received from external entities, PBSP had difficulty with the retrieval of hospital and emergency department (ED) reports. The OIG clinicians reviewed 20 separate hospitalizations and outside emergency events. There were significant delays in the retrieval and scanning of those reports in cases 1, 2, 4, 65, 72, 75, and 82. Further, in cases 5 and 78, PBSP never received and scanned the reports.

- PBSP also had difficulty ensuring that primary care providers (PCPs) initialed and dated hospital and ED reports. This step was necessary to evidence that the PCP reviewed the report and took responsibility for the patient's care. This deficiency was found in cases 1, 2, 4, 64, 65, 66, 72, 75, and 76.

- Despite the problems identified in the processing of hospital records, PBSP had few problems maintaining continuity of care for patients returning from the hospital. PBSP providers maintained open lines of communication with the most frequently used hospitals, which likely mitigated some of PBSP's problems with hospital records.

Specialty Services

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

- Medical records staff mislabeled several specialty reports in the eUHR as "Primary Care MD" progress notes. The OIG clinicians identified multiple deficiencies in cases 59, 73, and 74 and discussed the problem with the health records manager during the onsite inspection.

Diagnostic Reports

- PBSP demonstrated good performance in retrieval and review of diagnostic reports. These findings are discussed in detail in the *Diagnostic Services* indicator.

Urgent or Emergent Records

- PBSP medical staff documented urgent and emergent encounters into MPIMS like any other medical encounter. Thus, the OIG clinicians found no problems with the handling of these records.

Scanning Performance

- The OIG clinicians identified errors in the document scanning process as either mislabeled or misfiled documents. Erroneously scanned documents could greatly hinder providers' ability to find relevant clinical information, especially if the provider did not have access to the MPIMS medical record system. The OIG clinicians found mislabeled documents in the eUHR in cases 17, 44, 59, 66, 72, 73, 74, and 75. There were documents filed in the wrong patient's chart in case 13.

- PBSP did not time scan ambulatory notes into the eUHR. The OIG clinicians identified ubiquitous scanning delays of four to eight weeks in cases 54, 55, 56, 57, 58, 72, 73, 74, 75, and 76. Since the OIG clinicians identified an overwhelming pattern of delayed scanning for these progress notes, they stopped documenting this deficiency in other cases once they established the pattern. OIG clinicians further noted that because PBSP did not depend on

the eUHR for health services information, these delays had no direct impact on the delivery of health services within the institution.

- The OIG clinicians also identified documents that were missing from the eUHR in cases 11, 41, 45, 47, 62, and 73. The majority of those documents had not been printed from MPIMS and thus were not scanned into the eUHR. Since PBSP did not generally depend on the eUHR for health services delivery, these missing documents had negligible impact on health care within the institution, but could have caused problems with continuity of care once patients left PBSP.

- Scanning performance for diagnostic reports was generally acceptable.

Intra-System Transfers

- One area where delays in scanning records into the eUHR had a significant impact was in transfers out of PBSP to another CDCR institution that depended on the eUHR for information access. This is because other institutions do not have access to PBSP's MPIMS. Since PBSP typically took four to eight weeks to scan PCP progress notes from MPIMS into the eUHR, those patients who transferred out of PBSP were at risk for lapses in care. The OIG clinicians identified this problem in case 50, which is further discussed in the *Inter- and Intra-System Transfers* indicator.

Legibility

- Since PBSP medical staff typed most documents into MPIMS, the OIG clinicians had no significant concerns with legibility.

Clinician Summary

- PBSP had moderate difficulty with the retrieval of hospital and ED reports and with ensuring that the PCP reviewed those critically important documents. PBSP also had difficulty with the proper labeling of documents in the eUHR. PBSP had notable difficulty scanning progress notes from MPIMS to the eUHR in a timely manner, with most PCP progress notes taking four to eight weeks, and many documents not scanned at all. However, PBSP did not generally depend on the eUHR for health services, thus problems with eUHR delays and missing documents did not affect health care delivery at the institution. PBSP utilized a true electronic health record with real-time documentation and retrieval capabilities, which largely mitigated PBSP's many eUHR scanning problems (as identified below in the compliance section). The OIG clinicians rated this indicator *adequate*.

Compliance Testing Results

The institution received an *inadequate* compliance score of 44.3 percent in the *Health Information Management (Medical Records)* indicator and has room for improvement in the following areas:

- The institution scored zero in its labeling and filing of documents that medical records staff scanned into inmate-patients' eUHR. Mislabeled documents included physician progress notes labeled as immunology records, and specialty service consulting reports labeled as physician progress notes (MIT 4.006).

- Inspectors tested miscellaneous non-dictated documents, including providers' progress notes, initial health screening forms, and requests for health care services forms, to determine if records management staff scanned the documents timely. Institution staff only timely scanned 5 of 20 documents sampled into the patient's eUHR within three calendar days of the inmate-patient's encounter (25 percent), with 15 documents scanned from 3 to 42 days late (MIT 4.001). Similarly, institutional staff scanned specialty service consultant reports into the inmate-patient's eUHR file within five calendar days for only 9 of 15 documents reviewed (60 percent). Six specialty service reports were scanned from one to 32 days late (MIT 4.003).

The institution performed well in the following area:

- When the OIG reviewed initial health screening forms and specialty service reports to ensure that clinical staff legibly documented their names on the forms, 12 of 13 samples (92 percent) showed compliance (MIT 4.007).

CCHCS Dashboard Comparative Data

As noted in the following table, for each comparative measure, the OIG testing results were based on a review of documents from the most recent month as well as documents from the preceding seven months; PBSP's August Dashboard data reflected only the institution's July 2015 results. Using these disparate time frames, the compliance results for PBSP's availability of non-dictated health information were consistent with the August 2015 PBSP Dashboard data—with a difference of only 1 percentage point—though both scores are in the *inadequate* range. For specialty documents, the OIG's compliance scores were lower than the Dashboard results, with results varying by 15 percentage points.

Health Information Management — PBSP Dashboard and OIG Compliance Results

PBSP DASHBOARD RESULTS	OIG COMPLIANCE RESULTS
Availability of Health Information: Non-Dictated Documents August 2015	*Health Information Management* (4.001) Non-Dictated Medical Documents December 2014 – July 2015
26%	**25%**

Note: The Dashboard results were obtained from the Non-Dictated Documents Drilldown data for "Medical Documents 3 Days."

PBSP DASHBOARD RESULTS	OIG COMPLIANCE RESULTS
Availability of Health Information: Specialty Notes August 2015	*Health Information Management* (4.003) Specialty Documents November 2014 – June 2015
75%	**60%**

Note: The Dashboard measure includes specialty notes from dental, optometry, and physical therapy appointments, which the OIG omits from its sample.

PBSP DASHBOARD RESULTS	OIG COMPLIANCE RESULTS
Availability of Health Information: Community Hospital Records August 2015	*Health Information Management* (4.004) Community Hospital Discharge Documents N/A
***N/A for PBSP**	****N/A for PBSP**

*PBSP did not report any statistics for this Dashboard measure.
**PBSP did not have any applicable samples for this test area.

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:
Adequate
(85.0%)

Overall Rating:
Adequate

Compliance Testing Results

The institution scored well in the *Health Care Environment* indicator, with an *adequate* score of 85.0 percent.

The institution performed at a *proficient* level in the following areas:

- All 12 clinics were appropriately disinfected, cleaned, and sanitary. More specifically, in all clinics inspectors observed areas that were clean and not visibly dusty or dirty. In addition, cleaning logs were present and completed, indicating cleaning crews regularly cleaned the clinic (MIT 5.101).

- Health care staff in all 11 applicable clinics ensured that they properly sterilized and disinfected reusable invasive and non-invasive medical equipment (MIT 5.102).

- When inspecting for proper protocols to mitigate exposure to blood borne pathogens and contaminated waste, the OIG found that the institution was doing a proficient job in all 12 clinics. Specifically, cleaning staff follow protocols to disinfect clinics after biohazard encounters occurred, staff had access to needed personal protective equipment, all clinics had sharps containers, and staff properly secured and disposed of biohazardous waste (MIT 5.105).

- PBSP's non-clinic medical storage areas generally met the supply management process and support needs of the medical health care program. As a result, the institution scored 100 percent (MIT 5.106).

- All 12 clinics followed adequate protocols for managing and storing bulk medical supplies, scoring 100 percent for this test (MIT 5.107).

- The institution's 12 clinic common areas had a proficient environment conducive to providing medical services, receiving a score of 100 percent. More specifically, the clinics

had acceptable wheelchair access, adequate patient waiting areas, and sufficient non-exam-room clinician workspace. Further, the clinics ensured reasonable patient privacy in their common area triage stations, where applicable (MIT 5.109).

The institution performed at an *adequate* level in the following areas:

- Clinicians whom inspectors observed in six of eight clinics adhered to universal hand hygiene precautions; however, in two clinics providers did not sanitize or wash their hands prior to putting on gloves. As a result, the institution scored a 75 percent for this test (MIT 5.104).

- The OIG inspected selected exam rooms within the 12 clinics to determine if appropriate space, configuration, supplies, and equipment allowed clinicians to perform a proper clinical exam. The exam rooms or treatment spaces in 9 of 12 clinics (75 percent) were compliant. However, three clinics had exam rooms that did not have a means to provide visual privacy (see Figure 1), and one of them had a worn exam table (see Figure 2) (MIT 5.110).

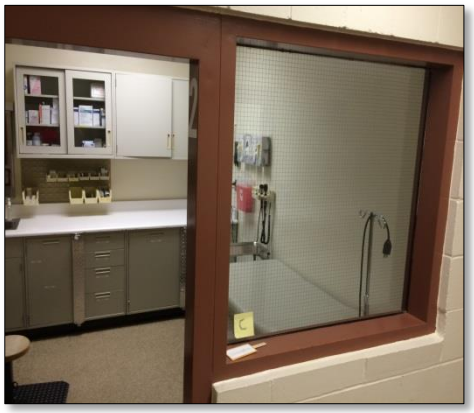

Figure 1 *– Exam space lacking means for visual privacy*

Figure 2 *– Worn exam table, area could harbor infection*

The institution performed at an *inadequate* level in the following areas:

- Clinic common areas and exam rooms were sometimes missing core equipment or other essential supplies necessary to conduct a comprehensive exam. As a result, only 7 of the 12 clinics were compliant (58 percent). Equipment and supply deficiencies included three clinics that did not have automated vital sign equipment, and two of these clinics did not have a medication refrigerator. While the receiving and release clinic area was one of the clinics without either item listed above, it was also missing an exam table in the area, oto-ophthalmoscope, Snellen eye chart, nebulization unit, and peak flow meter. Two other clinics' exam rooms were also missing tongue depressors, or a glucometer and test strips (MIT 5.108).

- The OIG examined the institution's emergency response bags to determine if they were inspected daily and inventoried monthly, and if they contained all essential items. PBSP's emergency response bags were compliant in only six of ten applicable clinics inspected (60 percent). The contents of four inspected bags had one or more of the following items

missing: two sizes of blood pressure cuffs, a CPR micro-mask, a non-rebreather oxygen mask, and non-latex gloves (MIT 5.111).

- When inspectors examined PBSP's 12 clinics to verify that adequate hygiene supplies were available and sinks were operable, only 8 of 12 clinics (67 percent) were in compliance. Specifically, four separate clinics' inmate restrooms did not have sufficient quantities of hygiene supplies such as antiseptic soap and disposable hand towels. More specifically, two locations had no soap, one location had no hand towels, and one location had neither (MIT 5.103).

Other Information Obtained from Non-Scored Results

The OIG gathered information to determine if the institution's physical infrastructure was maintained in a manner that supported health care management's ability to provide timely or adequate health care. This question is not scored. Overall, PBSP's health care management did not have any significant concerns about the existing infrastructure at the institution. The institution had a system in place to identify and report facility infrastructure problems when they occurred. At the time of the inspection, PBSP had three ongoing infrastructure projects that included new clinic space in facilities A and B, as well as refurbishing the two existing medication preparation and delivery space. In addition, PBSP is building a new medication preparation room in the stand-alone administrative segregation unit (MIT 5.999).

Recommendations

The OIG recommends the institution:

- Develop policies and procedures that ensure all inmate-patient restrooms have antiseptic soap and hand towels available in the immediate area.

- Ensure that all clinics have recommended core medical equipment and supplies.

INTER- AND INTRA-SYSTEM TRANSFERS

Case Review Rating:
Adequate
Compliance Score:
Proficient
(93.8%)

Overall Rating:
Adequate

This indicator focuses on the management of inmate-patients' medical needs and continuity of patient care during the inter- and intra-facility transfer process. The patients reviewed for *Inter- and Intra-System Transfers* include inmates received from other CDCR facilities and inmates transferring out of PBSP 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.

For this indicator, the case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance review resulting in a *proficient* score. The OIG's internal review process considered the factors that led to both results and ultimately rated this indicator *adequate*. The case review's *adequate* rating was deemed the more appropriate overall rating for this indicator due to the significant deficiencies identified for one complex high-risk patient transferred to another prison.

Case Review Results

The OIG clinicians reviewed 46 encounters relating to *Inter- and Intra-System Transfers*, including information from both the sending and receiving institutions. These included ten hospitalizations, 18 events related to patients who transferred into PBSP, and 18 events related to patients who transferred out of PBSP. The OIG clinicians rated the *Inter- and Intra-System Transfer*s processes at PBSP *adequate*.

Transfers In

The patients who transferred into PBSP received initial nursing assessments, appropriate referrals, and coordinated continuation of medications.

Transfers Out

Among patients who transferred out of PBSP, most transferred without incident. However, one particular patient's case history indicated problems that many CDCR institutions share regarding the transfer of high-risk patients:

- In case 50, the patient had severe and poorly controlled ulcerative colitis. A gastrointestinal specialist recommended significant medication changes. The patient's primary care provider saw the patient the week following the specialist appointment and determined that the receiving institution could address most of the recommendations after the patient was transferred. The PBSP provider did not place the patient on a medical hold. At the time of transfer, PBSP had not transmitted any information to the receiving institution regarding the recent gastroenterology visit or the new recommendations. Furthermore, there was no physician-to-physician contact prior to the transfer of this high-risk patient. The PBSP provider's progress note was not scanned into the eUHR until six weeks after the patient's transfer. Fortunately, the patient advocated for himself at the new institution and submitted a sick call request. A diligent provider at the receiving institution made contact directly with the gastroenterologist and successfully assumed the patient's care, despite the lack of transfer information provided by PBSP.

Hospitalizations

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

The PBSP hospital return process worked well. Nurses in the triage and treatment area evaluated patients returning from an outside hospital with good assessments, and ensured that the patients received needed medications and follow-up appointments. PBSP had no problems ensuring that primary care providers timely saw patients after their return to the institution. PBSP sometimes had delays in retrieving hospital records and discharge summaries. However, providers who had open lines of communication with the outside facilities mitigated these deficiencies. This issue is further discussed in the *Health Information Management* indicator.

Onsite Visit

The OIG clinicians discussed the hospital transfer process with various medical staff. The combination of competent nursing, computerized order entry, real-time documentation in the Madrid Patient Information Management System (MPIMS), the utilization management coordinator, and available access to care were determined to be the major reasons PBSP was successful in ensuring continuity of care for its hospital return patients.

The OIG clinicians discussed case 50 with both medical and nursing leadership, who were appreciative of the opportunity to review the case and to discover problems in PBSP's transfer-out

process and planned to make changes to minimize the risk of harm to future patients transferring out from PBSP.

Systemwide Transfer Challenges

In reviewing *Inter- and Intra-System Transfers*, the OIG acknowledges systemwide challenges common to all institutions regarding pending specialty services referrals and reports, and the potential for delay in needed follow-up and services. 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 not familiar with the patient's care or who are not part of the primary care team initiated the CDCR Form 7371 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. 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 once CCHCS finalizes it.

Clinician Summary

Most transfers into PBSP occurred without significant deficiencies. While medication continuity was sometimes delayed, these delays were not severe. Most patients who transferred out of PBSP also successfully transferred without incident. However, case 50 illustrated a common problem that most institutions have with the transfer of high-risk patients. PBSP performed very well by providing medical continuity for patients returning from an outside hospital. The OIG clinicians rated this indicator *adequate*.

Compliance Testing Results

The institution obtained a *proficient* compliance score of 93.8 percent in the *Inter- and Intra-System Transfers* indicator, scoring in the *proficient* range in four of the five tests, as described below:

- For all 30 sampled inmate-patients who transferred into the institution from another CDCR facility, nursing staff completed an Initial Health Screening form (CDCR Form 7277) on the same day the patient arrived (MIT 6.001).

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

- For 29 of 30 sampled inmate-patients who transferred into the institution (97 percent) nursing staff timely completed the assessment and disposition sections of the Initial Health

Screening form (CDCR Form 7277) on the same day that they performed the patient's initial health screening. The one exception was when a screening nurse identified an inmate-patient with signs and symptoms of tuberculosis, but did not refer the patient to the triage and treatment area for a more thorough evaluation (MIT 6.002).

- Out of 30 sampled inmate-patients who transferred into the institution, 18 had an existing medication order upon arrival. Inspectors tested those patients' records to determine if they received their medications without interruption, and found that 17 of the 18 patients (94 percent) received them timely. One inmate-patient did not receive his medication upon arrival (MIT 6.003).

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

- Inspectors sampled nine inmate-patients who transferred out of PBSP to another CDCR institution to determine whether the institution identified the patients' previously approved and still pending specialty service appointments on the patients' Health Care Transfer Information form (CDCR Form 7371). Seven of the sampled patients (78 percent) had their specialty services correctly documented. For two inmate-patients, nursing staff did not document the patient's previously approved or pending specialty service on the form (MIT 6.004).

Recommendations

No specific recommendations.

PHARMACY AND MEDICATION MANAGEMENT

Case Review Rating:
Proficient
Compliance Score:
Proficient
(87.7%)

Overall Rating:
Proficient

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 did not identify any significant pharmacy errors in the case reviews.

Nursing Medication Errors

Nursing staff demonstrated good performance related to the accuracy and timeliness of medication administration. Case review also revealed that nurses made appropriate contacts and referrals to providers regarding medication management issues.

Medication Continuity

In the majority of cases reviewed, medication continuity was not a significant problem for patients who transferred into the institution, returned from a community hospital, or received monthly chronic care medications. The OIG clinicians attributed the good performance regarding post-hospital medications to the Madrid Patient Information Management System (MPIMS). With this system in place, both pharmacy and nursing staff received new medication orders immediately. Without any delays in order transmission, nursing staff always had up-to-date medication administration records (MARs) and always knew which medications were due. With the needed information, nurses were able to ensure medication continuity via various backup systems, such as the Omni-cell, physician order changes, and the on-call pharmacist.

For chronic care medication continuity, the OIG clinicians reviewed approximately 56 months' worth of patients' MAR records. They found ten months in which continuity had been broken. In actuality, PBSP probably had a better performance than this number indicates because many of the deficiencies were due to incomplete and inconsistent documentation by nursing staff when entering administration of keep-on-person (KOP) medications into MPIMS. PBSP also explained that there was a system fault in MPIMS that occasionally caused medication continuity errors. For example,

when a PBSP provider used MPIMS to renew a medication, the institution's pharmacy sometimes did not process the medication renewal on the same day. Instead, the use of MPIMS sometimes resulted in a one- to two-day delay in providing patients their medications.

Clinician Summary

PBSP performed very well in *Pharmacy and Medication Management*. The OIG clinicians did not find any significant pharmacy-specific errors. For all reviewed patients, PBSP maintained medication continuity for patients returning from a higher level of care. PBSP did have some minor problems with maintaining medication continuity for chronic medications. These minor problems related to staff's documentation error resulting in short delays of one or two days due to the previously discussed MPIMS program system fault. The OIG clinicians rated the overall *Pharmacy and Medication Management* performance *proficient*.

Compliance Testing Results

The institution received a *proficient* compliance score of 87.7 percent for the *Pharmacy and Medication Management* indicator. For discussion purposes below, this indicator is divided into three sub-indicators: Medication Administration, Observed Medication Practices and Storage Controls, and Pharmacy Protocols.

Medication Administration

For this sub-indicator, the institution received an average score of 79 percent, which fell into the *adequate* range. The institution performed well in the following two areas:

- The institution timely administered or delivered new medication orders to 29 of the 30 patients sampled (97 percent). The lone exception was when one inmate-patient never received a newly ordered medication (MIT 7.002).

- When the OIG sampled 30 inmate-patients at PBSP who had transferred from one housing unit to another, 29 of them received their prescribed medications without interruption (97 percent). One patient did not receive his medication by the next dosing interval after the transfer occurred (MIT 7.005).

The institution could improve in the following medication administration area:

- The institution timely issued chronic care medications to only 13 of 29 inmate-patients sampled, scoring 45 percent for this test. The low score was due to health care staff providing 15 of the sampled patients with their keep-on-person medications between one and 30 days late. One other sampled patient had two unexplained missed doses of a required medication (MIT 7.001).

Observed Medication Practices and Storage Controls

For this sub-indicator, the institution received an average score of 98 percent, scoring in the *proficient* range for all six tests, of which the first five received a score of 100 percent.

- The OIG interviewed nursing staff and inspected narcotic storage areas at ten applicable locations to assess whether strong narcotic security controls existed. All ten areas were adequately controlled (MIT 7.101).

- Non-narcotic medications that did not require refrigeration were properly stored at all 18 clinic and medication line storage locations inspected (MIT 7.102).

- Refrigerated non-narcotic medications were properly stored at all 12 clinic and medication line storage locations inspected (MIT 7.103).

- Nursing staff at all ten sampled medication preparation and administration locations followed proper hand hygiene contamination control protocols during the medication preparation and administration processes (MIT 7.104).

- Nursing staff at all nine applicable medication preparation and administration locations followed appropriate administrative controls when distributing medications to inmate-patients (MIT 7.106).

- PBSP nursing staff at nine of ten sampled locations (90 percent) employed appropriate administrative controls and protocols when preparing inmate-patients' medications. At one medication line location, nursing staff did not have a system in place to validate that newly received medications were correct by reconciling those medications with the physician's orders (MIT 7.105).

Pharmacy Protocols

For this sub-indicator, the institution received an average score of 80 percent, scoring in the *proficient* range for the following test areas:

- The institution's main pharmacy followed general security, organization, and cleanliness management protocols; properly stored non-refrigerated medications; and properly stored and monitored non-narcotic medications that required refrigeration. As a result the institution scored 100 percent in all the three test areas (MIT 7.107, 7.108, 7.109).

- PBSP's pharmacist-in-charge (PIC) timely processed all 25 inspector sampled medication error reports (MIT 7.111).

However, the institution could improve in the following area:

- The institution's PIC did not document and retain evidence to support the required oversight review for sampled clinic and medication line storage locations' monthly narcotic inventory results. As a result, the institution scored zero for this test (MIT 7.110).

Non-Scored Tests

In addition to testing reported medication errors, inspectors followed up on any significant medication errors found during the case reviews or compliance testing to determine whether the errors were properly identified and reported. The OIG provides those results for information purposes only; however, at PBSP, the OIG did not find any applicable medication errors subject to this test area (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. Inspectors interviewed all 36 of the institution's applicable inmates, and all of them indicated that they had their rescue medications (MIT 7.999).

CCHCS Dashboard Comparative Data

The CCHCS Dashboard uses five indicators from the Medication Administration Process Improvement Program (MAPIP) audit tool to calculate the average score for medication administration. The OIG compared PBSP's compliance scores with four of the five applicable Dashboard indicators. As noted in the table on the following page, the OIG test results were based on a review of sampled documents from the most recent month as well as documents from the preceding eight months; PBSP's August 2015 Dashboard data reflected only the institution's July 2015 results. Overall, the institution's Dashboard score of 99 percent was a significant 24 points higher than the OIG's calculated average score of 75 percent. The point disparity was primarily caused by the OIG's finding that the institution was not adequately ensuring chronic care patients timely received their ongoing medications.

Pharmacy and Medication Management —
PBSP Dashboard and OIG Compliance Results

PBSP DASHBOARD RESULTS	OIG COMPLIANCE RESULTS
Medication Management: Medication Administration August 2015	*Medication Administration* (7.001, 7.002) (Chronic Care & New Meds) *Preventive Services* (9.001) (Administering INH Medication) November 2014 – July 2015
99%	**75%**

Note: The Dashboard results were obtained from the Medication Administration Drilldown data for Chronic Care Meds — Medical, New Outpatient Orders — Medical, New Outpatient Orders — Psychiatric, and Administration — TB Medications. Variances may exist because CCHCS includes medication administration of KOP medications only for the first two drilldown measures, while the OIG tests KOP, DOT, and nurse-administered medication administration.

Recommendations

The OIG recommends that the institution develop record retention policies and procedures that establish time frames for retaining key documents that are periodically reviewed as a core function of the pharmacist-in-charge's manager function. Such retention time frames should include those for monthly narcotic inventory results for the institution's clinic and medication line storage locations.

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:
Adequate
(76.4%)

Overall Rating:
Adequate

Compliance Testing Results

The institution performed in the *adequate* range in the *Preventive Services* indicator, with a compliance score of 76.4 percent. The institution scored in the *proficient* range for the following two tests:

- The institution timely offered all 30 sampled inmate-patients an influenza vaccination, scoring 100 percent for this test (MIT 9.004).

- The institution scored 97 percent in colorectal cancer screening. More specifically, the OIG sampled 30 inmate-patients to determine whether the patients either had a normal colonoscopy within the last ten years or were offered a fecal occult blood test (FOBT) in the last year. For only one sampled patient, was there insufficient eUHR evidence that colorectal cancer screening timely occurred (MIT 9.005).

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

- The institution scored 83 percent for administering timely anti-tuberculosis medications (INH) to inmate-patients with tuberculosis. Five of six inmate-patients received their medication timely, while one inmate-patient missed a required INH dose and did not receive the required provider counseling for the missed dosage (MIT 9.001).

The institution could improve in the following three test areas:

- When the OIG reviewed the institution's monthly monitoring of six sampled patients who received anti-tuberculosis medications, the institution was in compliance for only four of those patients (67 percent). For two patients sampled, there was a one-month lapse during which health care staff did not complete the required tuberculosis monitoring assessment (MIT 9.002).

- OIG inspectors sampled 30 inmate-patients to determine whether they received a tuberculosis 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 sampled patients were classified as a Code 22 (requiring a tuberculosis skin test in addition to a signs and

symptoms check). The institution only scored 53 percent for its ability to timely and properly conduct these annual tuberculosis screenings. More specifically, nurses timely screened 14 of 15 sampled Code 34 patients, with only one who did not receive a recent screening; however, for sampled Code 22 patients, only 2 of 15 received properly completed nurse screenings. Inspectors identified two primary deficiencies related to the manner in which PBSP nurses performed Code 22 patient screenings. First, health care management allowed LVNs or licensed psychiatric technicians (LPTs) to review skin test results instead of RNs, as CCHCS policy requires. This deficiency occurred in 9 of the 15 applicable samples. Second, nurses failed to always include the date and specific time the skin test either began or ended. This oversight often prevented OIG inspectors from confirming that the test was timely completed within the required 48-to-72-hour time frame. This deficiency occurred in 10 of the 15 applicable samples. There was one patient for whom the test was completed 15 minutes beyond the allowable 72 hours (MIT 9.003).

- The OIG tested whether inmate-patients who suffered from a chronic care condition were offered vaccinations for influenza, pneumonia, and hepatitis. At PBSP, only 7 of 12 patients sampled (58 percent) received all recommended vaccinations at the required interval. Five patients had no record of ever being offered or receiving the recommended pneumonia vaccination within the last five years (MIT 9.008).

CCHCS Dashboard Comparative Data

As indicated below, the OIG's score of 97 percent for colon cancer screening is slightly higher than the Dashboard's findings of 96 percent. Overall, both scores were in the *proficient* range.

Preventive Services — PBSP Dashboard and OIG Compliance Results

PBSP DASHBOARD RESULTS	OIG COMPLIANCE RESULTS
Colon Cancer Screening August 2015	Colon Cancer Screening (9.005) August 2015
96%	**97%**

Recommendations

No specific recommendations.

QUALITY OF NURSING PERFORMANCE

Case Review Rating:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

The *Quality of Nursing Performance* indicator is a qualitative evaluation of the institution's nursing services. The evaluation is completed entirely by OIG nursing clinicians within the case review process, and, therefore, does not have a score under the compliance testing component. The OIG nurses conduct case reviews that include reviewing face-to-face encounters related to nursing sick call requests identified on the Health Care Services Request form (CDCR Form 7362), urgent walk-in visits, referrals for medical services by custody staff, 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 the *Emergency Services* indicator.

Case Review Results

The OIG clinicians rated the *Quality of Nursing Performance* at PBSP *adequate*. The clinicians evaluated 360 nursing encounters for the PBSP case review, of which 242 were outpatient. Of the 242 outpatient nursing encounters reviewed, the majority were for sick call requests (CDCR Form 7362). In general, PBSP's nursing services performed well during sick call encounters. There were 75 deficiencies in outpatient nursing services, of which 46 involved the provision of direct and indirect nursing care, and 29 related to the timeliness of reviewing sick call requests by an RN. The majority of deficiencies were unlikely to cause patient harm; nevertheless, those areas are established in CCHCS policy as requirements for nursing care and practice, and therefore are subject to appropriate quality improvement strategies.

However, the OIG clinicians considered several cases more serious in nature due to the potential for adverse outcomes or unnecessary delays in needed health care services for patients presenting with a medical problem in outpatient clinics.

Nursing Assessment and Documentation

- In case 29, the patient had various sick call complaints, including urinary frequency and inability to completely empty his bladder. The RN did not address urinary complaints during the visit, and noted on the encounter form that the urinalysis test was "not applicable."

- In case 42, the patient submitted four sick call requests for vision and acid reflux issues. The LPT received the four sick call request forms—one on Friday, one on Saturday, and two on Sunday. A registered nurse did not review any of the four request forms until Monday, at which time a nurse subsequently saw the patient the same day for a face-to-face sick call assessment. CCHCS policy requires that an RN review sick call requests on the same day the requests are received.

- In case 63, the sick call nurse assessed the patient for three days of sharp right upper quadrant pain. The RN noted the patient had seen the provider three months previously for similar complaints, and the RN did not refer the patient back to the provider. Approximately one month later, the patient had a sudden onset of right-sided abdominal pain for six hours, with tenderness on examination; the nurse ordered an as-needed follow-up instead of a same-day provider evaluation. The next day, the patient required a higher level of care at a local community hospital, and subsequently underwent a laparoscopic appendectomy for acute appendicitis.

- In case 82, about one week after an unwitnessed fall from the top bunk, the patient refused to come to the medication line and to a RN sick call assessment visit. The patient's Refusal of Examination and/or Treatment form (CDCR Form 7225) documented the reason for the refusal as "I cannot walk." While both the RN and LPT noted the patient's declination to sign the refusal form, neither clinician assessed the patient's inability to walk. The next day, custody staff informed the LPT of the patient's threat to go "man-down" if he did not see a nurse about his shortness of breath and severe back and rib pain. Soon after, the patient walked to the housing unit rotunda for a vital signs check, where an RN instructed an LPT to have the patient fill out a sick call form. The LPT gave the patient acetaminophen and his inhaler. Later, the patient reported somewhat decreased pain, and the LPT told the patient to rest and to inform medical staff if his shortness of breath worsened. The RN did not complete a physical assessment on this patient, who had an unwitnessed fall from a top bunk eight days previously and who was currently also complaining of shortness of breath and severe back and rib pain.

Medication Administration

Medication administration was generally timely and reliable. See the *Pharmacy and Medication Management* and *Emergency Services* indicators for specific findings.

Emergency Care

See the *Emergency Services* indicators for specific findings.

Inter- and Intra-System Transfers

There were no major nursing issues found in the cases reviewed. See the *Inter- and Intra-System Transfers* and *Diagnostic Services* indicators for specific findings.

Specialized Medical Housing

Patients received *proficient* nursing care in PBSP's CTC. See the *Specialized Medical Housing* indicator for specific findings.

OIG Clinicians' Onsite Visit

During the onsite visit, the OIG clinicians observed active participation by sick call and medication nurses, providers, and schedulers in the outpatient clinic's primary care team morning huddles at PBSP. Although clinic huddles were well attended, custody staff did not usually attend unless there were custody-related issues. In general, the CTC, TTA, clinics, and nursing work areas were clean and well equipped with supplies and medical equipment. Privacy was not a significant qualitative issue in any of the clinical areas. However, as discussed in the *Health Care Environment* indicator section, compliance testing identified some concerns regarding clinic equipment, supplies, and privacy.

The approximately one dozen nursing staff members interviewed onsite were very knowledgeable about their responsibilities and site-specific processes, and took pride in their accomplishments. However, they demonstrated inconsistencies in job satisfaction. Also, various nursing staff described issues such as lack of communication in sharing information with line staff from CCHCS headquarters, one-way directives from nursing management rather than opportunities for staff to provide feedback, and nursing staff meetings not being conducted on a regular basis. Strengths found in nursing services included a well-managed staff development unit, implementation of clinical case management with two assigned nurses at each clinic, and a well-defined system in place for back-up nurses to assist in crisis situations.

Recommendations

The deficiencies described within this indicator can be addressed as areas for quality improvement. The institution has an opportunity to implement strategies to provide ongoing nursing education in basic nursing assessment and documentation, oversight and monitoring for adherence to established CCHCS nursing policy and procedure, and establishing regularly scheduled meetings with nursing and line staff.

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 236 medical provider encounters and identified 52 deficiencies related to provider performance at PBSP. As a whole, the OIG clinicians rated PBSP provider performance *adequate.*

Assessment and Decision-Making

PBSP providers made sound assessments and accurate diagnoses. Poor assessment and misdiagnosis were rare. There was one notable exception, which prompted PBSP to perform a root cause analysis.

- In case 82, the patient fell off his top bunk and had broken five of his ribs (with three ribs broken in two places), with associated significant bleeding into the chest cavity. However, the TTA provider failed to perform an adequate assessment, did not order an x-ray, and missed the diagnosis. Five days later, a primary care provider made the same error, which caused a significant delay in care. Fortunately, the patient healed from his injuries and did not require surgical intervention.

Despite the example above, most cases demonstrated good to excellent provider diagnostic skills.

- In case 5, the patient developed abdominal pain and bloody stools over one week. During the patient encounter, the provider immediately considered the possibility of inflammatory bowel disease and requested appropriate studies. The provider made an early diagnosis and initiated prompt treatment. Unfortunately, the patient's disease was quite severe, and despite good medical care by PBSP providers, he still required removal of his colon to control his disease.

The OIG clinicians found a pattern whereby providers would not order appropriate follow-up for their patients. This problem was primarily responsible for the majority of cases that the OIG physicians rated *inadequate*. The following are two notable examples:

- In case 70, the provider recognized that the patient's diabetes was out of control, but did not order any physician follow-up for another five months. Two months later, a repeat lab test showed persistently out-of-control diabetes, but the provider again did not order a follow-up appointment. After another two months, yet another lab test showed the diabetes was out of control, but the provider again did not request any follow-up.

- In case 73, the patient had a non-healing fracture of his left ankle, even after undergoing surgery for it several months earlier. Despite reviewing the most recent specialty recommendations to repeat the x-rays, the provider did not order any more x-rays and did not order a follow-up appointment. The patient was not seen until he resubmitted a sick call request four months later.

The OIG clinicians found the practice of providers not ordering appropriate follow-up visits to be a significant problem. In addition to the two examples above, the problem occurred in cases 2, 12, 57, 63, 71, and 74.

Review of Records

PBSP providers generally performed thorough chart reviews, which greatly aided in their diagnostic assessments. Overall, as highlighted in the following case, PBSP providers performed well in this regard.

- In case 53, the provider was meticulous regarding chart review and expertly managed all of the patient's multiple medical conditions of prostate cancer, hypertension, asthma, and hepatitis C. The provider closely monitored the patient's cancer for recurrence, and the hypertension was well controlled. The provider ordered appropriate tests when the patient's asthma symptoms did not correlate with his physical examination. The provider also performed a thorough evaluation for hepatitis C, ordered needed tests, and provided proper interpretation to determine the likelihood that the patient would benefit from hepatitis C treatment.

However, occasionally providers did not perform adequate chart reviews, which led to a small number of problems. The OIG clinicians identified inadequate chart review in cases 2, 69, 70, and 75, with case 2 highlighted below:

- In case 2, one provider reviewed the CCHCS master registry and found that the patient's recent blood pressure and cholesterol tests were normal. The provider removed the patient from the chronic care program. Unfortunately, the provider failed to recognize that the blood pressure readings occurred during the patient's hunger strike, and the cholesterol test was performed while he was on cholesterol medication. This oversight contributed to a lapse in medical care, with both conditions going out of control. PBSP providers eventually sent the patient to an outside emergency department for hypertensive urgency.

Emergency Care

PBSP emergency care provider performance was good. The only exception was in case 82, as previously discussed in both this indicator as well as the *Emergency Services* indicator.

Chronic Care

With the exception of diabetic management (discussed below), chronic care performance was adequate. The onsite specialty RN handled anticoagulation management at PBSP in consultation with the chief medical executive (CME) or the acting chief physician and surgeon (CP&S). The OIG clinicians did not identify any significant deficiencies with anticoagulation management at PBSP.

Hepatitis C management at PBSP was excellent. In all cases reviewed, providers demonstrated an in-depth knowledge and understanding about this disease. Patients were properly evaluated and treated, both when the hepatitis C condition was mild and of little clinical significance as well as when the patient had end-stage liver disease and required close monitoring and follow-up to ensure condition stability.

PBSP's diabetic management was inconsistent. Some providers demonstrated excellent diabetic management skills, while others demonstrated significant room for improvement.

- In case 56, the provider reviewed a lab that showed that the patient's diabetes was out of control. The provider quickly evaluated the patient and began intensive monitoring. The provider started the patient on insulin, and reviewed the fingerstick blood sugars weekly. The provider expertly adjusted insulin on a weekly basis. Within four to five weeks, the patient's sugars were under ideal control. This example was representative of this provider's consistently excellent care. The OIG physicians commended this provider to PBSP leadership and to CCHCS because of this provider's exceptionally high-quality care.

- In contrast, the patient in case 71 presented to the provider with a markedly elevated random blood sugar of 473. The provider made some medication changes, but failed to order fingerstick monitoring to see if the severely elevated blood sugar improved. The provider ordered a follow-up appointment three months later. When lab tests confirmed that the patient's diabetes was indeed rampantly out of control, the provider did not order a follow-up appointment, instead allowing the patient's diabetes to run out of control for more than two months before the provider re-evaluated the patient.

- In case 69, PBSP nurses called on-call providers numerous times to report extremely high blood sugar tests. In the majority of instances, the on-call provider failed to inquire about the recent trend of blood sugar readings and failed to order a blood sugar review by the PCP. When the PCP saw the patient, the PCP made an erroneous assessment that the diabetes was stable and at goal. The provider ordered a lengthy 180-day follow-up with no chart review in

between. Furthermore, the provider neglected to monitor fasting blood glucose levels while the patient was taking basal insulin. In fact, toward the end of the review period, the provider rapidly and dangerously escalated the dose of basal insulin without monitoring the fasting blood glucose. While no harm came to the patient, this placed the patient at increased risk of hypoglycemia.

Specialty Services

PBSP providers referred patients for specialty services diligently and appropriately the vast majority of the time. The Institutional Utilization Management Committee (IUMC), composed of medical providers, approved referrals that were appropriate. This is further discussed in the *Specialty Services* indicator.

Documentation Quality

PBSP providers typed all of their progress notes into an electronic medical record, the Madrid Patient Information Management System (MPIMS). The average progress note was extensive and included all relevant aspects of preventive health care. The OIG clinicians found only minor evidence of progress note "cloning," where outdated medical information is carried forward inappropriately to a current progress note. Overall, PBSP health care documentation quality was excellent.

Provider Continuity

Case review found provider continuity to be excellent.

Onsite Inspection

As there has been a vacancy for many months for the chief medical executive, PBSP had an acting chief physician and surgeon serve in the leadership role until his recent retirement. The CP&S had hosted teleconference phone calls each morning for all clinics. The CP&S and the on-call provider discussed all after-hours patient events. This institution-wide teleconference served to keep each primary care team abreast of any new or outstanding issues with their patients. This teleconference was very similar in function to the morning report held in several southern region CDCR institutions. Immediately following the institution-wide teleconference, each primary care team conducted its own primary care team huddle, in which each team discussed patient-specific issues and plans.

Most PBSP providers attributed much of the current quality of provider performance to the efforts of the CP&S. The providers described the CP&S as extremely intelligent, with excellent clinical skills, and usually correct in making medical assessments. PBSP medical leadership attributed the institution's ability to deliver cost-effective and efficient care to the leadership of the CP&S. However, the strong personality of the CP&S intimidated some providers. When these providers felt

that the CP&S inappropriately denied some needed medical services for their patients, this intimidation prevented them from further pursuing care and advocating for the patient.

The OIG clinicians discussed the problem of providers failing to order appropriate follow-up appointments with PBSP medical leadership. PBSP purposefully used a high number of chart review appointments in lieu of face-to-face appointments to improve provider efficiency due to concerns of clinic backlogs and impaired access to care. Likewise, PBSP providers often would not order follow-up appointments due to similar concerns regarding access to care. The OIG clinicians provided several case review examples that demonstrated how failure to order appropriate follow-up sometimes compromised medical care.

PBSP executives were also concerned about provider staffing levels. PBSP's CME position was vacant at the time of the OIG's inspection. The acting CP&S performed many of the administrative duties, but retired since the OIG's onsite inspection. PBSP executive staff expressed concerns about ongoing physician recruitment and retention. The OIG clinicians concurred with PBSP executives regarding the physician staffing.

Clinician Summary

As a whole, PBSP providers performed well. They usually made sound and accurate diagnoses and provided adequate treatment plans. They reviewed records with appropriate depth, provided good emergency care, and anticoagulation and hepatitis C management was excellent. PBSP providers referred patients for specialty services appropriately, and their documentation was excellent. However, the OIG clinicians found a strong pattern of providers not ordering appropriate follow-ups. In addition, some providers demonstrated poor diabetic management. Ultimately, despite some excellent provider performance found during the case reviews, the OIG clinicians found some problems that were too important to ignore. The OIG clinicians, therefore, considered the appropriate rating for this indicator to be *adequate.*

Recommendations

The OIG recommends that:

- PBSP's medical leadership institute a training program ensuring that providers recognize and order the next scheduled follow-up appointment during all scheduled encounters, chart reviews, and specialty and lab report reviews. This type of training may help PBSP reduce the number of patients lost to follow-up due to provider oversight.

- Providers with inadequate diabetic management skills receive additional training.

- PBSP work closely with CCHCS to help ensure the timely recruitment and long-term retention of new providers, and medical leadership.

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. PBSP's only specialized medical housing unit is a correctional treatment center (CTC).

Case Review Rating:
Proficient
Compliance Score:
Proficient
(98.0%)

Overall Rating:
Proficient

Case Review Results

PBSP had a licensed 20-bed CTC onsite with ten beds designated for medical patients and ten beds for mental health crisis patients. The OIG clinicians reviewed a total of 74 provider encounters and 56 nursing encounters across 18 admissions to the CTC for higher level of supervised medical treatment and monitoring. The OIG clinicians identified only one minor deficiency with CTC care, which did not negatively affect patient care.

Nursing Performance

Nursing care provided to patients in the CTC was *proficient*, with appropriate assessments, timely interventions, and thorough documentation throughout the patients' specialized medical housing stays. The one notable exception was in case 61, a CTC RN documented the same vital signs on the patient's CTC admission that were documented 20 minutes previously in the TTA. There was also a weight difference of six pounds between the two nursing encounters.

Provider Performance

PBSP provider performance in the CTC was very good. Providers performed all admission history and physicals (H&Ps) timely. The H&Ps were generally of good to excellent quality. Providers completed CTC patient rounds at appropriate time intervals, both as mandated by state licensing requirements as well as when clinically indicated. Providers made timely and accurate assessments and prescribed appropriate medical management. At the time of patients' discharge, CTC providers documented adequate discharge summaries.

Onsite Inspection

CTC medical staff participated in the morning teleconference, as did all other medical clinics. The CTC provider paid special attention to all patients currently hospitalized, as well as those sent out for emergency services. In practice, the CTC provider acted as a liaison for these patients, and helped to ensure care continuity when patients returned to the institution. While PBSP had not formalized the role of physician liaison, the OIG clinicians found the practice to be a sound process that only improved the quality of care at the institution.

Clinician Summary

Nursing and provider staff provided excellent quality of care in the PBSP CTC. As a result, the OIG clinicians rated the PBSP CTC care as *proficient*.

Compliance Testing Results

The institution received a *proficient* compliance score of 98.0 percent in the *Specialized Medical Housing* indicator, which focused on the institution's correctional treatment center. Further, the institution received a *proficient* score in all five of the indicator's individual test areas, which included the following:

- Providers evaluated all ten sampled inmate-patients within 24 hours of admission, and they also completed a history and physical within 72 hours of admission (MIT 13.002, 13.003).

- Providers completed their subjective, objective, assessment, plan, and education (SOAPE) notes at required three-day intervals for all ten sampled patients (MIT 13.004).

- Inspectors tested the working order of PBSP's CTC patient room call buttons and found that they were in good working condition. Also, 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 just over one minute, which the institution's management believed to be reasonable. As a result, the institution received a score of 100 percent for this test (MIT 13.101).

- Nursing staff completed an initial assessment on the day the patient was admitted to the CTC for nine of ten sampled patients (90 percent). The one exception was a CTC admission in which a nurse did not complete an initial assessment at all (MIT 13.001).

Recommendations

No specific recommendations.

SPECIALTY SERVICES

Case Review Rating:
Adequate
Compliance Score:
Adequate
(83.3%)

Overall Rating:
Adequate

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

Case Review Results

The OIG clinicians reviewed 104 events related to *Specialty Services*, 56 of which were specialty consultations and procedures. The OIG clinicians found 14 deficiencies in this indicator, mostly related to the mislabeling of specialty service documents in the eUHR or delays in receiving consultants' reports.

Access to Specialty Services

Specialty services were generally provided within adequate time frames for routine services. However, specialty services of an urgent priority were generally marked "routine" by the PCP, and the priority was then determined by the local Institutional Utilization Management Committee (IUMC). For the cases reviewed, this review process usually worked well; PBSP completed most specialty referrals within acceptable time frames. However, as discussed further in the *Quality of Provider Performance* indicator, the OIG clinicians identified some problems related to providers not making needed follow-up orders at the conclusion of a specialty service.

Nursing Performance

PBSP nurses performed adequate assessments for patients returning from specialty appointments. The OIG clinicians did not identify any deficiencies in this regard.

Provider Performance

PBSP providers initiated referrals when medically needed and directed patients to appropriate specialists. However, providers almost always ordered the referral with routine priority, even if the clinical condition warranted urgency. For example:

- In case 5, the patient had poorly controlled and worsening ulcerative colitis. His abdominal pain had worsened with bloody diarrhea despite a trial of oral steroid therapy. The provider ordered a gastroenterology consultation and colonoscopy with only routine priority.

- In case 59, the patient's CT scan showed gastric wall thickening that was indicative of a possible stomach cancer. The patient needed an urgent endoscopy procedure, but the provider ordered it with only a routine priority.

The OIG clinicians discussed this pattern with various providers during the onsite inspection. PBSP providers explained that medical management had instructed them to mark the referrals with routine priority, regardless of the medical necessity, since the actual priority would be determined by the IUMC. PBSP providers said that the reason for doing so was that referrals marked urgent or emergent were tracked in a different manner. As discussed below, OIG clinicians concluded this practice was unacceptable.

While OIG clinicians did not find any pattern of harm in PBSP's practice of always marking referrals as routine regardless of medical necessity, this practice did increase the risk of harm because it transferred the responsibility of determining referral priority from the PCP to the IUMC. Since the IUMC is a step removed from the actual patient evaluation, the IUMC could be more prone to erroneous judgment than the PCP who actually performed the evaluation. During the onsite inspection, some providers complained that dominant personalities manipulated the IUMC decisions, and sometimes inappropriately denied patients' needed services. The process placed some providers in the very uncomfortable and embarrassing position of defending their recommendations for specialty referral, even when the need was obvious. This type of pressure and fear of embarrassment made some providers reluctant to order specialty services, even when they felt they were necessary. Additionally, if the IUMC could not meet for any reason, the risk for delays in care markedly increased for those referrals that should have initially been marked with higher priority.

Health Information Management

There were occasional delays in the retrieval of specialty reports, such as in cases 1, 59, and 72. During the onsite inspection, PBSP provided evidence that in each of these cases, the fault lay with the specialist, who did not return the report in a timely manner. PBSP provided evidence that it utilized a tracking system to ensure that all specialty reports were retrieved.

PBSP also often mislabeled specialty reports in the eUHR as "Progress Notes – Primary Care MD." This error occurred on multiple occasions in cases 59, 73, and 74.

Clinician Summary

Providers identified and referred patients appropriately when needed. There was evidence of a well-functioning utilization review process, despite several provider complaints that overbearing personalities dominated the IUMC, which sometimes may have inappropriately discouraged needed specialty services. Specialty access was generally adequate and specialty report handling was good, even with occasional delays in report retrieval due to the specialty provider. Specialty referrals were usually marked routine, regardless of clinical appropriateness. Providers told OIG inspectors that PBSP managers had instructed them to mark the specialty referrals as routine, regardless of the clinical condition. Overall, despite the problems identified, PBSP provided patients with needed specialty care. OIG clinicians thus rated this indicator *adequate.*

Compliance Testing Results

The institution received an *adequate* compliance score of 83.3 percent in the *Specialty Services* indicator. PBSP scored in the *proficient* range in the following test areas:

- For all five inmate-patients sampled, their high-priority specialty service appointment occurred within 14 calendar days of the provider's order. In addition, 15 other inmate-patients sampled also received their routine specialty services appointment within 90 calendar days of the provider's order (MIT 14.001, 14.003).

- The institution timely denied providers' specialty service requests for 19 of 20 sampled patients (95 percent). One exception was noted in which a provider's progress note indicated that the service was denied by the institution's IUMC; however, the decision was not documented in the actual IUMC meeting minutes (MIT 14.006).

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

- Providers timely received and reviewed the specialists' reports for four of the five sampled patients (80 percent). For one inmate-patient, the institution received the specialist's report 17 days late and the provider reviewed the report an additional 14 days late (MIT 14.002).

- Providers received and reviewed 12 of the 15 sampled specialists' reports (80 percent) within the required time frame. However, three reports were reviewed from one to eight days late (MIT 14.004).

- For 18 patients sampled who had a specialty service denied by the institution's health care management, 14 patients (78 percent) received timely notification of the denied service, including the provider meeting with the patient within 30 days to discuss alternate treatment strategies. For three sampled patients, this requirement was not met at all; one other patient received a follow-up visit six days late (MIT 14.007).

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

- When inmate-patients at one institution have an approved pending or scheduled specialty services appointment and then transfer to a different institution, policy requires that the receiving institution reschedule or provide the patient's appointment within the required time frame. Of 16 sampled patients who transferred to PBSP with an approved appointment, only eight patients (50 percent) timely received their specialty services upon arrival. Of those remaining eight patients who did not receive their services timely, six did not receive their service at all and the PBSP provider did not timely meet with the patient to reassess the need for service. The two other sampled patients received their specialty services late by 71 and 109 days (MIT 14.005).

Recommendations

The OIG recommends that PBSP PCPs mark their CDCR Form 7342 specialty service referrals with the priority level they believe is most clinically appropriate instead of marking the referral at the urgency level "routine" by default.

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 PBSP.

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 PBSP in August 2015. They also reviewed documents obtained from the institution and from CCHCS prior to the start of the inspection.

For comparative purposes, the *PBSP Executive Summary Table* on page x 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
(63.9%)

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 the *Internal Monitoring, Quality Improvement, and Administrative Operations* indicator, receiving an overall score of 63.9 percent. The low score primarily resulted from the following three test areas, each of which received a score of zero:

- The institution had not taken adequate steps to ensure the accuracy of its Dashboard data. Specifically, PBSP's Quality Management Committee meetings did not discuss methodologies used to conduct periodic validation and testing of Dashboard data, and the committee did not discuss methodologies used to train staff who collected Dashboard data (MIT 15.004).

- The PBSP's 2014 Performance Improvement Work Plan (PIWP) did not include adequate evidence demonstrating the institution's achievement of targeted performance objectives for any of its four quality improvement initiatives. In general, the work plan included insufficient progress information to demonstrate that for each of its performance objectives it either improved or reached the targeted level (MIT 15.005).

- None of the 11 sampled Emergency Medical Response Review Committee's (EMRRC) incident packages included the required Emergency Medical Response Review Event Checklist form. In addition, for two of the six months captured by the 11 sampled incident packages, a warden correctly approved the corresponding EMMRC meeting minutes. However, the other four sampled months' worth of minutes were incorrectly approved by a warden designee. Because CCHCS policy requires the warden to sign the meeting minutes and for the committee to use the required EMRRC checklist, PBSP received a score of zero

for this test (MIT 15.007). In addition to the above findings, the institution was following an outdated 2006 CCHCS policy that only required EMRRC reviews for deaths, suicide attempts, and use of Code 3 ambulances. The institution was not following the July 2012 revised CCHCS Policy (Vol. 4, Ch. 12.8) that requires the EMRRC to review all deaths, suicide attempts, and *all* unscheduled transfers out of the institution.

The institution performed in the *proficient* or *adequate* range for the following six tests, scoring 100 percent in five of them, as identified below:

- PBSP processed inmate medical appeals timely for all 12 of the most recent months (MIT 15.001).

- Inspectors sampled ten second-level inmate medical appeals; all of the appeal responses addressed the inmate's initial complaint (MIT 15.102).

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

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

- Medical staff promptly submitted the Initial Inmate Death Report (CDCR Form 7229A) to CCHCS Death Review Unit for the one applicable death that occurred at PBSP in the prior 12-month period (MIT 15.103).

- Inspectors reviewed PBSP's local governing body (LGB) meeting minutes to determine if the LGB met quarterly to exercise its responsibility for the quality management of patient heath care. However, the institution's LGB only met during three of the four most recent quarters; there was no LGB meeting for the July 1, 2014, to September 30, 2014, quarter. As a result, PBSP scored 75 percent for this test (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 the Death Review Committee at CCHCS headquarters did not timely complete its death review summary for the one death that occurred during the testing period. The CCHCS Death Review Committee is required to complete a death review summary within 30 business days of the death and submit it to the institution's CEO. However, for the one death that occurred, the committee completed its summary 26 days late (46 business days after the death) and submitted the summary to the CEO 15 days after that (MIT 15.996).

- Inspectors met with the institution's chief executive officer for health care services (CEO) to inquire about PBSP's protocols for tracking appeals. Inspectors learned that management received monthly updates on appeals then categorized the appeals by type. A monthly report identified how soon an appeal was due, the person assigned the appeal, and the stage of the appeal. The appeals coordinator also tracked the subject of each appeal. The report also helped management identify the frequency of problem areas, and allowed management to correct those areas to reduce the number of future appeals. According to the CEO, the most critical appeals related to provider-ordered medication reductions for patients upon their arrival. When providers cut back on prescriptions through the pain management committee, inmate-patients often appealed the reduction in medication until they became acclimated to the medication reduction. The CEO believed the medication review process was important for patient health (MIT 15.997).

- Non-scored data gathered regarding the institution's practices for implementing local operating procedures (LOPs) indicated that the institution has an effective process in place for developing LOPs. The institution's health program manager III (HPM) maintains a tracking log for all LOPs to track when they need to be reviewed and updated. Approximately 90 days prior to the LOP approval date, the HPM sends the LOP to the institution's LOP review committee and other stakeholders for a first review and comments. The HPM then incorporates received comment changes and sends the LOP out for a second review. Once the HPM receives all stakeholder approvals, the draft LOP is sent to the QMC committee for their review and approval. After the QMC committee approves the draft LOP, a final copy is routed for signature and the final LOP is routed to staff. At the time of the OIG's inspection, the institution had implemented 43 of the 49 applicable LOPs that relate to the core topical areas recommended by the clinical experts who helped develop the OIG's medical inspection compliance program (88 percent) (MIT 15.998).

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

Recommendations

No specific recommendations.

JOB PERFORMANCE, TRAINING, LICENSING, AND CERTIFICATIONS

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

***Case Review Rating**:*
Not Applicable
***Compliance Score**:*
Adequate
(85.0%)

Overall Rating:
Adequate

Compliance Testing Results

PBSP received an *adequate* score of 85.0 percent in the *Job Performance Training, Licensing, and Certifications* indicator.

This indicator is made up of eight tests of which the following six tests received *proficient* scores of 100 percent:

- All ten nurses sampled were current on their clinical competency validations (MIT 16.102).
- All active duty providers, nurses, and custody staff were current with their emergency response certifications (MIT 16.104).
- All nurses and the pharmacist-in-charge were current with their professional licenses and certification requirements (MIT 16.105).
- All providers were current with their professional licenses (MIT 16.001).
- The institution's pharmacy and providers who prescribed controlled substances were current with their Drug Enforcement Agency registrations (MIT 16.106).
- All nursing staff hired within the last year timely received new employee orientation training (MIT 16.107).

The institution received an *adequate* score of 80 percent on the following test:

- Inspectors evaluated a sample of nursing supervisors to determine if they completed the required number of their subordinate nurses' performance evaluation reviews. Four of the five sampled supervisors had sufficiently completed all of the required reviews. The one exception was a nursing supervisor who completed the review but failed to discuss the employee's performance areas deemed well done (MIT 16.101).

While the institution scored well in areas above, there is room for improvement in the following area:

- Zero of the institution's seven providers had a proper clinical performance appraisal completed on their behalf. While two providers did not have a performance appraisal completed in the last year, another provider had no prior performance appraisals on file at all. Four other providers had a Unit Health Record Clinical Appraisal completed, but the reviewers' results were not discussed with the providers. In addition, for three of five applicable reviews, the reviewer also did not complete the required 360 Degree Evaluation for the provider (MIT 16.103).

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. HEDIS data is often used to produce health plan report cards, analyze quality improvement activities, and benchmark performance.

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 Pelican Bay State Prison, nine HEDIS measures were selected and are listed in the following *PBSP 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. From a case review standpoint, the OIG clinicians identified some problems related to PBSP's diabetic management, as discussed in the *Quality of Provider Performance* indicator. However, from a compliance standpoint, PBSP performed well with its management of diabetes when compared to available HEDIS measures.

When compared statewide, PBSP significantly outperformed the Medi-Cal scores in all five of the diabetic measures selected. Similarly, when compared to Kaiser North and Kaiser South, PBSP outperformed Kaiser in all diabetic measures, except for diabetic patient eye exams. For this measure, PBSP scored 7 percentage points lower than Kaiser North and 19 points lower than Kaiser South.

Similar to statewide comparisons, PBSP outperformed national averages for Medicaid and commercial health plans (based on data obtained from health maintenance organizations) in all diabetic measures. In addition, PBSP also outperformed Medicare and the U.S. Department of Veterans Affairs (VA) in all comparable diabetic measure areas with the exception of diabetic patient eye exams. For this measure, PBSP underperformed Medicare and the VA by 7 and 28 percentage points, respectively.

Immunizations

Comparative data for immunizations was only fully available for the VA and was partially available for Kaiser Permanente (statewide), commercial plans (national), and Medicare (national). With respect to administering influenza shots to adults aged 18 to 64, PBSP's comparable statewide rate was 3 percentage points lower than Kaiser North and 4 percentage points lower than Kaiser South. When compared nationally, PBSP was 14 percentage points lower than the VA, but slightly higher than the average rate for commercial plans. With respect to administering influenza shots to adults aged 65 and older, PBSP scored 12 percentage points higher than the VA and 16 percentage points higher than Medicare. With regard to administering pneumococcal vaccines, PBSP scored 5 percentage points lower than the VA, but 18 percentage points higher than Medicare. With respect to influenza shots, inspectors found that all of PBSP's sampled patients were offered the shot, and most received the immunization while some refused it. While no instances were found where a patient was not at least offered the immunization, the situations where the patient was offered but refused the shot negatively affected PBSP's comparable score.

Cancer Screening

With respect to colorectal cancer screening, PBSP's score of 77 percent was 3 and 5 percentage points lower than Kaiser North and South, respectively. Nationally, PBSP performed significantly higher than both commercial plans and Medicare, but performed 5 percentage points lower than the VA. However, patient refusals impacted the institution's performance for this measure; seven of the eight patients who did not receive the screening timely had refused it. The seven refusals accounted for 20 percent of the total sample size.

Summary

Overall, PBSP's performance reflects a high-performing chronic care program, corroborated by the institution's *adequate* ratings in the *Quality of Provider Performance, Quality of Nursing Performance,* and *Access to Care* indicators, and its *proficient* rating in the *Preventive Services* indicator. With regard to the institution's low scores for diabetic patient eye exams, immunizations (influenza and pneumonia), and colorectal cancer screenings, the institution has an opportunity to make interventions to ensure that patients receive timely screenings and to initiate patient education to help lower the rate of patient refusals. Lowering patient refusal rates will correspondingly improve the institution's comparable HEDIS scores.

PBSP Results Compared to State and National HEDIS Scores

Clinical Measures	California				National			
	PBSP Cycle 4 Results[1]	HEDIS Medi-Cal 2015 [2]	HEDIS Kaiser (No.CA) 2015 [3]	HEDIS Kaiser (So.CA) 2014 [3]	HEDIS Medicaid 2015 [4]	HEDIS Com-mercial 2015 [4]	HEDIS Medicare 2015 [4]	VA Average 2012 [5]
Comprehensive Diabetes Care								
HbA1c Testing (Monitoring)	**100%**	83%	95%	94%	86%	91%	93%	99%
Poor HbA1c Control (>9.0%)[6,7]	**8%**	44%	18%	24%	44%	31%	25%	19%
HbA1c Control (<8.0%)[6]	**85%**	47%	70%	62%	47%	58%	65%	-
Blood Pressure Control (<140/90)[6]	**90%**	60%	84%	85%	62%	65%	65%	80%
Eye Exams	**62%**	51%	69%	81%	54%	56%	69%	90%
Immunizations								
Influenza Shots - Adults (18–64)[8]	**51%**	-	54%	55%	-	50%	-	65%
Influenza Shots - Adults (65+)[6]	**88%**	-	-	-	-	-	72%	76%
Immunizations: Pneumococcal[6]	**88%**	-	-	-	-	-	70%	93%
Cancer Screening								
Colorectal Cancer Screening	**77%**	-	80%	82%	-	64%	67%	82%

1. Unless otherwise stated, data was collected in August 2015 by reviewing medical records from a sample of PBSP'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 plans, and Medicare was obtained from the 2015 *State of Health Care Quality Report*, available on the NCQA website: www.ncqa.org. The results for commercial plans were based on data received from various health maintenance organizations.
5. The Department of Veterans Affairs (VA) data was obtained from the *VHA Facility Quality and Safety Report - Fiscal Year 2012 Data*.
6. For this indicator, the entire applicable PBSP 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

Pelican Bay State Prison Range of Summary Scores: 44.33% - 98.00%	
Indicator	**Overall Score (Yes %)**
Access to Care	89.42%
Diagnostic Services	89.75%
Emergency Services	Not Applicable
Health Information Management (Medical Records)	44.33%
Health Care Environment	85.00%
Inter- and Intra-System Transfers	93.78%
Pharmacy and Medication Management	87.73%
Prenatal and Post-Delivery Services	Not Applicable
Preventive Services	76.39%
Quality of Nursing Performance	Not Applicable
Quality of Provider Performance	Not Applicable
Reception Center Arrivals	Not Applicable
Specialized Medical Housing (OHU, CTC, SNF, Hospice)	98.00%
Specialty Services	83.25%
Internal Monitoring, Quality Improvement, and Administrative Operations	63.89%
Job Performance, Training, Licensing, and Certifications	85.00%

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?	30	0	30	100.00%	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?	17	1	18	94.44%	12
1.003	**Clinical appointments:** Did a registered nurse review the inmate-patient's request for service the same day it was received?	26	14	40	65.00%	0
1.004	**Clinical appointments:** Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed?	40	0	40	100.00%	0
1.005	**Clinical appointments:** If the registered nurse determined a referral to a primary care provider was necessary, was the inmate-patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter?	15	1	16	93.75%	24
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?	Not Applicable				
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?	Not Applicable				
1.008	**Specialty service follow-up appointments:** Do specialty service primary care physician follow-up visits occur within required time frames?	19	1	20	95.00%	0
1.101	**Clinical appointments:** Do inmate-patients have a standardized process to obtain and submit Health Care Services Request forms?	7	2	9	77.78%	0
Overall Percentage:					**89.42%**	

Reference Number	*Diagnostic Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
2.001	**Radiology:** Was the radiology service provided within the time frame specified in the provider's order?	10	0	10	100.00%	0
2.002	**Radiology:** Did the primary care provider review and initial the diagnostic report within specified time frames?	10	0	10	100.00%	0
2.003	**Radiology:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	10	0	10	100.00%	0
2.004	**Laboratory:** Was the laboratory service provided within the time frame specified in the provider's order?	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?	9	1	10	90.00%	0
2.007	**Pathology:** Did the institution receive the final diagnostic report within the required time frames?	9	1	10	90.00%	0
2.008	**Pathology:** Did the primary care provider review and initial the diagnostic report within specified time frames?	8	1	9	88.89%	1
2.009	**Pathology:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	8	1	9	88.89%	1
Overall Percentage:					**89.75%**	

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 Services Request forms scanned into the eUHR within three calendar days of the inmate-patient encounter date?	5	15	20	25.00%	0
4.002	Are dictated / transcribed documents scanned into the eUHR within five calendar days of the inmate-patient encounter date?	Not Applicable				
4.003	Are specialty documents scanned into the eUHR within five calendar days of the inmate-patient encounter date?	9	6	15	60.00%	0
4.004	Are community hospital discharge documents scanned into the eUHR within three calendar days of the inmate-patient date of hospital discharge?	Not Applicable				
4.005	Are medication administration records (MARs) scanned into the eUHR within the required time frames?	Not Applicable				
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?	12	1	13	92.31%	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?	Not Applicable				
Overall Percentage:					**44.33%**	

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?	12	0	12	100.00%	0
5.102	**Infection control:** Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	11	0	11	100.00%	1
5.103	**Infection Control:** Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	8	4	12	66.67%	0
5.104	**Infection control:** Does clinical health care staff adhere to universal hand hygiene precautions?	6	2	8	75.00%	4
5.105	**Infection control:** Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	12	0	12	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%	11
5.107	**Clinical areas:** Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	12	0	12	100.00%	0
5.108	**Clinical areas:** Do clinic common areas and exam rooms have essential core medical equipment and supplies?	7	5	12	58.33%	0
5.109	**Clinical areas:** Do clinic common areas have an adequate environment conducive to providing medical services?	12	0	12	100.00%	0
5.110	**Clinical areas:** Do clinic exam rooms have an adequate environment conducive to providing medical services?	9	3	12	75.00%	0
5.111	**Emergency response bags:** Are TTA and clinic emergency medical response bags inspected daily and inventoried monthly, and do they contain essential items?	6	4	10	60.00%	2
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:					**85.00%**	

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?	30	0	30	100.00%	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?	17	1	18	94.44%	12
6.004	**For inmate-patients transferred out of the facility:** Were scheduled specialty service appointments identified on the Health Care Transfer Information Form 7371?	7	2	9	77.78%	0
6.101	**For inmate-patients transferred out of the facility:** Do medication transfer packages include required medications along with the corresponding Medical Administration Record (MAR) and Medication Reconciliation?	9	0	9	100.00%	0
Overall Percentage:					**93.78%**	

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?	13	16	29	44.83%	1
7.002	Did health care staff administer or deliver new order prescription medications to the inmate-patient within the required time frames?	29	1	30	96.67%	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?	Not Applicable				
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?	29	1	30	96.67%	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?	10	0	10	100.00%	11
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?	18	0	18	100.00%	3
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?	12	0	12	100.00%	9
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?	10	0	10	100.00%	11
7.105	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when preparing medications for inmate-patients?	9	1	10	90.00%	11
7.106	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when distributing medications to inmate-patients?	9	0	9	100.00%	12
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
7.108	**Pharmacy:** Does the institution's pharmacy properly store	1	0	1	100.00%	0

Reference Number	*Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
	non-refrigerated medications?					
7.109	**Pharmacy:** Does the institution's pharmacy properly store refrigerated or frozen medications?	1	0	1	100.00%	0
7.110	**Pharmacy:** Does the institution's pharmacy properly account for narcotic medications?	0	1	1	0.00%	0
7.111	**Pharmacy:** Does the institution follow key medication error reporting protocols?	25	0	25	100.00%	0
7.998	**For Information Purposes Only:** During eUHR compliance testing and case reviews, did the OIG find that medication errors were properly identified and reported by the institution?	Information Only				
7.999	**For Information Purposes Only:** Do inmate-patients in isolation housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications?	Information Only				
Overall Percentage:					**87.73%**	

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?	5	1	6	83.33%	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?	4	2	6	66.67%	0
9.003	**Annual TB Screening:** Was the inmate-patient screened for TB within the last year?	16	14	30	53.33%	0
9.004	Were all inmate-patients offered an influenza vaccination for the most recent influenza season?	30	0	30	100.00%	0
9.005	**All inmate-patients from the age 50 through the age of 75:** Was the inmate-patient offered colorectal cancer screening?	29	1	30	96.67%	0
9.006	**Female inmate-patients from the age of 50 through the age of 74:** Was the inmate-patient offered a mammogram in compliance with policy?	Not Applicable				
9.007	**Female inmate-patients from the age of 21 through the age of 65:** Was the inmate-patient offered a pap smear in compliance with policy?	Not Applicable				
9.008	Are required immunizations being offered for chronic care inmate-patients?	7	5	12	58.33%	0
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:					**76.39%**	

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?	9	1	10	90.00%	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?	10	0	10	100.00%	0
13.003	**For OHU, CTC, & SNF only:** Was a written history and physical examination completed within 72 hours of admission?	10	0	10	100.00%	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?	10	0	10	100.00%	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:					**98.00%**	

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?	5	0	5	100.00%	0
14.002	Did the PCP review the high-priority specialty service consultant report within the required time frame?	4	1	5	80.00%	0
14.003	Did the inmate-patient receive the routine specialty service within 90 calendar days of the PCP order?	15	0	15	100.00%	0
14.004	Did the PCP review the routine specialty service consultant report within the required time frame?	12	3	15	80.00%	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?	8	8	16	50.00%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	19	1	20	95.00%	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?	14	4	18	77.78%	2
Overall Percentage:					**83.25%**	

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	4	4	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?	3	1	4	75.00%	0
15.007	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	0	11	11	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?	3	0	3	100.00%	0
15.102	Did the institution's second level medical appeal response address all of the inmate-patient's appealed issues?	10	0	10	100.00%	0
15.103	Did the institution's medical staff review and submit the initial inmate death report to the Death Review Unit in a timely manner?	1	0	1	100.00%	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:					**63.89%**	

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?	7	0	7	100.00%	0
16.101	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	4	1	5	80.00%	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	7	7	0.00%	0
16.104	Are staff current with required medical emergency response certifications?	3	0	3	100.00%	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?	1	0	1	100.00%	0
Overall Percentage:					**85.00%**	

APPENDIX B — CLINICAL DATA

Table B-1: PBSP Sample Sets	
Sample Set	**Total**
Anticoagulation	1
CTC/OHU	5
Death Review/Sentinel Events	3
Diabetes	3
Emergency Services– Non-CPR	5
High Risk	7
Hospitalization	6
Intra-System Transfers-in	3
Intra-System Transfers-out	3
RN Sick Call	41
Specialty Services	5
	82

Table B-2: PBSP Chronic Care Diagnoses

Diagnosis	Total
Anemia	2
Anticoagulation	1
Arthritis/Degenerative Joint Disease	10
Asthma	11
COPD	3
Cancer	1
Cardiovascular Disease	5
Chronic Pain	18
Cirrhosis/End Stage Liver Disease	3
Coccidioidomycosis	1
Deep Venous Thrombosis/Pulmonary Embolism	1
Diabetes	9
Gastroesophageal Reflux Disease	10
Gastrointestinal Bleed	2
Hepatitis C	21
Hyperlipidemia	19
Hypertension	34
Mental Health	21
Sleep Apnea	2
Thyroid Disease	4
	178

Table B-3: PBSP Event - Program

Program	Total
Diagnostic Services	120
Emergency Care	38
Hospitalization	15
Intra-System Transfers in	18
Intra-System Transfers out	18
Not Specified	1
Outpatient Care	576
Specialized Medical Housing	166
Specialty Services	104
	1056

Table B-4: PBSP Case Review Sample Summary

	Total
MD Reviews Detailed	31
MD Reviews Focused	0
RN Reviews Detailed	21
RN Reviews Focused	44
Total Reviews	96
Total Unique Cases	82
Overlapping Reviews (MD & RN)	14

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

Pelican Bay State Prison			
Quality Indicator	**Sample Category (number of patients)**	**Data Source**	**Filters**
Access to Care	Chronic Care (30—Basic Level) (40—Inter Level)	Master Registry	• Chronic care conditions (at least one condition per inmate-patient—any risk level) • **Randomize**
	Nursing Sick Call (5 per clinic) (minimum of 30)	MedSATS	• Clinic (each clinic tested) • Appt. date (2–9 months) • **Randomize**
	Returns from Community Hospital (30)	Inpatient Claims Data	• See ***Health Information Management (Medical Records)*** *(returns from community hospital)*
Diagnostic Services	Radiology (10)	Radiology Logs	• Appt. Date (90 days–9 months) • **Randomize** • Abnormal
	Laboratory (10)	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • **Randomize** • Abnormal
	Pathology (10)	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • **Randomize**
Health Information Management (Medical Records)	Timely Scanning (20 each)	OIG Qs: 1.001, 1.002, 1.006, & 9.004	• Non-dictated documents • First 5 inmate-patients selected for each question
		OIG Q: 1.001	• Dictated documents • First 20 inmate-patients selected
		OIG Qs: 14.002 & 14.004	• Specialty documents • First 10 inmate-patients selected for each question
		OIG Q: 4.008	• Community hospital discharge documents • First 20 inmate-patients selected for the question
		OIG Q: 7.001	• MARs • First 20 inmate-patients selected
	Legible Signatures and Review (40)	OIG Qs: 4.008, 6.001/6.002, 7.001, 12.001/12.002, & 14.002	• First 8 inmates sampled • One source document per inmate-patient
	Complete and Accurate Scanning	Documents for any tested inmate	• Any incorrectly scanned eUHR document identified during OIG eUHR file review, e.g., mislabeled, misfiled, illegibly scanned, or missing
	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)

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
Health Care Environment	Clinical Areas (number varies by institution)	OIG Inspector Onsite Review	• Identify and inspect all onsite clinical areas.
Inter- and Intra-System Transfers	Intra-System transfers (30)	SOMS	• Arrival date (3–9 months) • Arrived from (another CDCR facility) • Rx count • **Randomize**
	Specialty Service Send-outs (20)	MedSATS	• Date of Transfer (3–9 months) • **Randomize**
Pharmacy and Medication Management	Chronic Care Medication (30—Basic Level) (40—Inter Level)	OIG Q: 1.001	*See **Access to Care*** • (At least one condition per inmate-patient—any risk level) • **Randomize**
	New Medication Orders (30—Basic Level) (40—Inter Level)	Master Registry	• Rx Count • **Randomize** • Ensure no duplication of inmate-patients tested in chronic care medications
	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 (high–low)–*inmate-patient must have NA/DOT meds to qualify for testing* • **Randomize**
	En Route (10)	SOMS	• Date of transfer (2–8 months) • Sending institution (another CDCR facility) • **Randomize** • Length of stay (minimum of 2 days) • NA/DOT meds
	Returns from Community Hospital (30)	*Inpatient Claims Data*	• See ***Health Information Management (Medical Records)*** *(returns from community hospital)*
	Medication Preparation and Administration Areas	OIG Inspector Onsite Review	• Identify and inspect onsite clinical areas that prepare and administer medications
	Pharmacy	OIG Inspector Onsite Review	• Identify and inspect onsite pharmacies
	Medication Error Reporting	OIG Inspector Review	• Any medication error identified during OIG eUHR file review, e.g., case reviews and/or compliance testing
Prenatal and Post-Delivery Services	Recent Deliveries (5) *N/A at this institution*	OB Roster	• Delivery date (2–12 months) • **Most recent** deliveries (within date range)
	Pregnant Arrivals (5) *N/A at this institution*	OB Roster	• Arrival date (2–12 months) • **Earliest** arrivals (within date range)

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
Preventive Services	Chronic Care Vaccinations (30—Basic Level) (40—Inter Level) *Not all conditions require vaccinations*	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per inmate-patient—any risk level) • **Randomize** • Condition must require vaccination(s)
	INH (all applicable up to 30)	Maxor	• Dispense date (past 9 months) • Time period on INH (at least a full 3 months) • **Randomize**
	Colorectal Screening (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • **Randomize**
	Influenza Vaccinations (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • **Randomize** • Filter out inmate-patients tested in chronic care vaccination sample
	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**
	Mammogram (30) *N/A at this institution*	SOMS	• Arrival date (at least 2 years prior to inspection) • Date of birth (age 52–74) • **Randomize**
	Pap Smear (30) *N/A at this institution*	SOMS	• Arrival date (at least three years prior to inspection) • Date of birth (age 24–53) • **Randomize**
	Valley Fever (number will vary, up to 20) *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	RC (20) *N/A at this institution*	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • **Randomize**
Specialized Medical Housing	OHU, CTC, SNF, Hospice (10 per housing area)	CADDIS	• Admit date (1–6 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • **Randomize**

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
Specialty Services Access	High-Priority (10)	MedSATS	• Approval date (3–9 months) • **Randomize**
	Routine (10)	MedSATS	• Approval date (3–9 months) • Remove optometry, physical therapy or podiatry • **Randomize**
	Specialty Service Arrivals (20)	MedSATS	• Arrived from (other CDCR institution) • Date of transfer (3–9 months) • **Randomize**
	Denials (20)* **Ten InterQual* *Ten MARs*	InterQual	• Review date (3–9 months) • **Randomize**
		IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • **Randomize**
Internal Monitoring, Quality Improvement, and Administrative Operations	Medical Appeals (all)	Monthly Medical Appeals Reports	• Medical appeals (12 months)
	Adverse/Sentinel Events (5)	Adverse/Sentinel Events Report	• Adverse/sentinel events (2–8 months)
	QMC Meetings (12)	Quality Management Committee Meeting Minutes	• Meeting minutes (12 months)
	Performance Improvement Plans (12)	Performance Improvement Work Plan	• Performance Improvement Work Plan with updates (12 months)
	Local Governing Body (12)	Local Governing Body Meeting Minutes	• Meeting minutes (12 months)
	EMRRC (6)	EMRRC Meeting Minutes	• Meeting minutes (6 months)
	Medical Emergency Response Drills (3)	OIG Inspector Onsite Review	• Most recent full quarter • Each watch
	2nd Level Medical Appeals (10)	OIG Inspector Onsite Review	• Medical appeals denied (6 months)
	Death Reports (10)	OIG Inspector Onsite Review	• Death reports (12 months)
	Local Operating Procedures (all)	OIG Inspector Onsite Review	• Review all

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
Job Performance and Training, Licensing, and Certifications	RN Review Evaluations (5)	OIG Inspector Onsite Review	• Current Supervising RN reviews
	Nursing Staff Validations (10)	OIG Inspector Onsite Review	• Review annual competency validations • **Randomize**
	Provider Annual Evaluation Packets (all)	OIG Inspector Onsite Review	• All required performance evaluation documents
	Medical Emergency Response Certifications (all)	OIG Inspector Onsite Review	• All staff o Providers (ACLS) o Nursing (BLS/CPR) o Custody (CPR/BLS)
	Nursing staff and Pharmacist-in-charge Professional Licenses and Certifications (all)	OIG Inspector Onsite Review	• All licenses and certifications
	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations (all)	OIG Inspector Onsite Review	• All current DEA registrations
	Nursing Staff New Employee Orientations (all)	OIG Inspector Onsite Review	• New employees (within the last 12 months)

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

February 5, 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 Pelican Bay State Prison conducted from August 2015 to October 2015. 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
Roy Wesley, Chief Deputy Inspector General, OIG
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