

# California State Prison, Sacramento Medical Inspection Results Cycle 4



March 2017

**Fairness ♦ Integrity ♦ Respect ♦  
Service ♦ Transparency**

**Office of the Inspector General  
CALIFORNIA STATE PRISON,  
SACRAMENTO  
Medical Inspection Results  
Cycle 4**

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March 2017

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## EXECUTIVE SUMMARY

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

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

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

The OIG performed its Cycle 4 Medical Inspection at SAC from July to September 2016. The inspection included in-depth reviews of 89 patient files conducted by clinicians, as well as reviews of documents from 409 patient files, covering 92 objectively scored tests of compliance with policies and procedures applicable to the delivery of medical care. The OIG assessed the case review and compliance results at SAC using 14 health care quality indicators applicable to the institution, made up of 12 primary clinical indicators and 2 secondary administrative indicators. To conduct clinical case reviews, the OIG employs a clinician team consisting of a physician and a registered nurse consultant, while compliance testing is done by a team of deputy inspectors general and registered nurses trained in monitoring medical compliance. Of the 12 primary indicators, 7 were rated by both case review clinicians and compliance inspectors, 3 were rated by case review clinicians only, and 2 were rated by compliance inspectors only; both secondary indicators were rated by compliance inspectors only. See the *Health Care Quality Indicators* table on page *ii*. Based on that analysis, OIG experts made a considered and measured overall opinion that the quality of health care at SAC was *inadequate*.

## Health Care Quality Indicators

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

## ***Overall Assessment: Inadequate***

Based on the clinical case reviews and compliance testing, the OIG’s overall assessment rating for SAC was *inadequate*. Of the 12 primary (clinical) quality indicators applicable to SAC, the OIG found 3 *adequate* and 9 *inadequate*. Of the two secondary (administrative) quality indicators, the OIG found both *inadequate*. To determine the overall assessment for SAC, 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 SAC.

**Overall Assessment  
Rating:**

***Inadequate***

## ***Clinical Case Review and OIG Clinician Inspection Results***

The clinicians’ case reviews sampled patients with high medical needs and included a review of 1,210 patient care events.<sup>1</sup> Of the 12 primary indicators applicable to SAC, 10 were evaluated by clinician case review; none was *proficient*, 3 were *adequate*, and 7 were *inadequate*. When determining the overall adequacy of care, the OIG paid particular attention to the clinical nursing and provider quality indicators, as adequate health care staff can sometimes overcome suboptimal processes and programs. However, the opposite is not true; inadequate health care staff cannot provide adequate care, even though the established processes and programs onsite may be adequate. The OIG clinicians identify inadequate medical care based on the risk of significant harm to the patient, not the actual outcome.

Several pervasive factors contributed to SAC’s poor performance. This report’s findings should be considered against the backdrop of the following conditions. The SAC inmate population presented unique challenges to the delivery of adequate medical care. A large portion of the population had serious mental health and behavioral problems. High levels of patients that do not comply increased the documentation burden for nurses and providers, interfered with their care plans, and complicated SAC’s normal scheduling mechanisms. Behaviorally challenged patients placed a perpetual strain on the morale of nurses and providers, which may have led to various levels of “compassion fatigue.”

Yet another problem was a critical shortage of providers. SAC medical leadership described a seemingly unprecedented inability to recruit and retain medical providers for the past 18 months. Due to the provider shortage, SAC yard providers were each performing the work of two providers. SAC providers complained that the current work conditions were unsustainable, and many were actively looking for employment elsewhere. SAC’s provider shortage is further discussed in the *Quality of Provider Performance* indicator.

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<sup>1</sup> Each OIG clinician team includes a board-certified physician and registered nurse consultant with experience in correctional and community medical settings.



### **Program Strengths — Clinical**

- Upon patients' return from outside hospitals, SAC nurses did a good job with reviewing the hospital paperwork and ensuring that the proper medications were ordered.
- SAC nurses and providers closely monitored patients who were on long-term warfarin (anticoagulant) treatment, and made appropriate medication changes when indicated.

### **Program Weaknesses — Clinical**

- The institution suffered from a severe shortage of providers due to its inability to hire and retain physicians. Provider shortages contributed to many of the provider deficiencies identified in this inspection.
- SAC's emergency cardiopulmonary resuscitation (CPR) response times were sometimes seriously delayed.
- A high number of adverse events (seven) occurred during the inspection period. This was among the most of any institution inspected during this OIG inspection cycle. These events are described in the *Medical Inspection Results* section beginning on page 12.
- For patients who transferred from another institution, SAC could not reliably provide timely provider or specialty appointments. For patients returning from a community hospital, SAC could not reliably maintain medication continuity.
- When sick call nurses triaged health care requests, they often did not see their patients timely if the patient complained of urgent symptoms. When they did see patients, sick call nurses often failed to perform adequate assessments, failed to formulate appropriate care plans, and failed to refer the patients to providers.
- Providers often did not make adequate assessments or decisions. They often failed to review medical records appropriately, practiced problematic opioid prescribing habits, and demonstrated poor documentation.

## ***Compliance Testing Results***

Of the 14 health care indicators applicable to SAC, 11 were evaluated by compliance inspectors.<sup>2</sup> There were 92 individual compliance questions within those 11 indicators, generating 1,371 data points, that tested SAC's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.<sup>3</sup> Those 92 questions are detailed in *Appendix A — Compliance Test Results*. The institution's inspection scores in the 11 applicable indicators ranged from 55.5 percent to 100.0 percent, with the primary indicator *Health Information Management (Medical Records)* receiving the lowest score, and the primary indicator *Specialized Medical Housing* receiving the highest. Of the nine primary indicators applicable to compliance testing, the OIG rated one *proficient*, two *adequate*, and six *inadequate*. Both of the two secondary indicators, which involve administrative health care functions, were rated *inadequate*.

### **Program Strengths — Compliance**

As the *SAC Executive Summary Table* on page *viii* indicates, the institution's compliance rating was *proficient*, scoring above 85 percent, in the primary indicator *Specialized Medical Housing*. The following are some of SAC's strengths based on its compliance scores on individual questions in all the primary health care indicators:

- Registered nurses timely reviewed each patient's request for service and completed a face-to-face patient sick call visit within the required time frame.
- Providers timely communicated the results of radiology results to patients.
- Final pathology reports were received by the institution within the required time frame.
- Clinical health care areas were appropriately disinfected, cleaned, and sanitized. Reusable invasive and non-invasive medical equipment was properly sterilized or disinfected, and exposure to blood-borne pathogens and contaminated waste was controlled.
- For newly arrived patients, nursing staff completed the assessment and disposition section of the health screening form (CDCR Form 7277); referred the patient to TTA if tuberculosis (TB) signs and symptoms were present; and signed and dated the form on the same day the patient arrived at the institution.

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

<sup>3</sup> 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.

- Health care staff timely administered or delivered newly ordered prescription medications and, for patients transferring from one housing unit to another, medications were continued without interruption.
- The institution employed appropriate administrative controls and protocols when preparing medications for patients.
- Patients were offered an influenza vaccination for the most recent influenza season, and most patients aged 50 to 75 were offered a colorectal cancer screening.
- The institution's CTC had a working call button system, and the OHU staff completed required 30-minute welfare checks on patients. In addition, the institution had a procedure in place at the CTC and OHU to ensure that during an emergent event, medical staff could enter a patient's cell within a reasonable amount of time.
- The institution provided timely denials of provider requests for specialty services.

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

- The Emergency Medical Response Review Committee performed timely incident package reviews, including the use of required documents.
- All nursing staff received required new employee orientation, and all nursing staff who administered medications were current on their clinical competency validation.

### **Program Weaknesses — Compliance**

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

- Patients who transferred to SAC from another facility and who were referred to a provider during the initial health screening did not always timely receive those appointments.
- After being discharged from community hospitals, patients did not always receive timely follow-up appointments with a provider; providers did not timely review hospital discharge reports; and patients frequently did not receive their ordered discharge medications.

- Providers did not review and initial pathology reports timely or communicate those results to the patient timely.
- Clinic exam rooms did not have an environment conducive to providing medical services; problems included confidential records accessible to inmate-porters, exam tables with torn vinyl that could harbor infection, and exam rooms that compromised visual privacy.
- Clinical health care staff did not always follow universal hand hygiene precautions.
- Emergency response bags were not always inventoried per CCHCS policy, and several bags were missing essential items such as blood pressure cuffs, non-rebreather oxygen masks, and fully charged oxygen tanks.
- Patients with chronic care conditions, as well as patients who were temporarily staying at SAC en route to other institutions, frequently did not receive their ordered medications timely.
- SAC did not employ strong controls over narcotic medications or properly store non-narcotic medications.
- Patients were not properly screened for tuberculosis (TB). Patients taking TB medications did not always receive their medications as ordered and did not receive required monthly or weekly monitoring.
- Providers did not always timely review patients' high-priority and routine specialty service reports. In addition, providers did not always communicate specialty service denials to patients within required time frames.

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

- The institution did not promptly process patient medical appeals during the most recent 12 months.
- The institution's supervising registered nurse did not conduct complete periodic reviews of nursing staff.
- Structured clinical performance appraisals were not completed timely.

The *SAC 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.

## SAC Executive Summary Table

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

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

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

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

## ***Population-Based Metrics***

In general, SAC performed adequately as measured by population-based metrics. In three of the five comprehensive diabetes care measures, SAC outperformed other State and national organizations. This included Medi-Cal, Kaiser Permanente, Medicaid, Medicare, commercial entities, and the United States Department of Veterans Affairs (VA). For blood pressure control of diabetics, SAC performed less well than Kaiser (both North and South regions); for diabetic patient eye exams, SAC scored lower than Kaiser (both North and South regions), Medicare, and the VA.

With regard to immunization measures, SAC's scores were lower than the other entities that reported data for administering influenza vaccinations to both younger and older adults. With regard to administering pneumococcal vaccines to older adults, SAC scored higher than Medicare but lower than the VA. The institution's scores for colorectal cancer screening were lower than Kaiser's, commercial plans', and the VA's, but matched Medicare's score. SAC routinely offered patients their required immunizations and cancer screenings, but many of them refused the offers; these refusals adversely affected the institutions scores.

Overall, SAC's performance demonstrated by population-based metrics indicated that comprehensive diabetes care was adequate in comparison to statewide and national health care organizations. The institution could improve its scores in immunizations and cancer screenings by making interventions to reduce patient refusals by educating patients on the benefits of immunizations and cancer screenings.

## **INTRODUCTION**

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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.

California State Prison, Sacramento (SAC) was the 34th medical inspection of Cycle 4. During the inspection process, the OIG assessed the delivery of medical care to patients for 12 primary clinical health care indicators and two secondary administrative health care indicators applicable to the institution. It is important to note that while the primary quality indicators represent the clinical care being provided by the institution at the time of the inspection, the secondary quality indicators are purely administrative and are not reflective of the actual clinical care provided.

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

## **ABOUT THE INSTITUTION**

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The mission of California State Prison, Sacramento (SAC), is to protect the public by housing maximum-security inmates serving long sentences or those who have proven to be management problems at other institutions. SAC also houses inmates requiring specialized mental health programming and inmates with high-risk medical concerns.

The institution operates multiple clinics where staff members handle non-urgent requests for medical services and treat inmates needing urgent or emergency care in three triage and treatment areas (TTAs). Screenings for inmates upon their arrival are conducted in the receiving and release (R&R) clinic. There is also a clinic for onsite and telemedicine specialty services. SAC has a correctional treatment center (CTC) for inpatient services, which includes a 20-bed psychiatric inpatient program. Patients who require assistance with the activities of daily living but who do not require a higher level of inpatient care are treated in the outpatient housing unit (OHU).

California Correctional Health Care Services (CCHCS) has designated SAC an "intermediate" prison for medical purposes; these institutions are predominately located in urban areas close to care centers and specialty care providers likely to be used by an inmate population with higher medical needs for the most cost-effective care.

On August 17, 2015, the institution received national recertification for accreditation from the Commission on Accreditation for Corrections. This accreditation program is a professional peer review process based on national standards set by the American Correctional Association.

Based on staffing data the OIG obtained from the institution, SAC’s overall vacancy rate among medical managers, primary care providers, supervisors, and non-supervisory nurses was 11 percent in June 2016. As indicated in the table below, SAC had 136.5 budgeted health care positions, of which 120 were filled. Based on its authorized and filled positions, the institution reported 14.5 vacant positions, with the highest vacancy percentages among primary care providers. SAC had three (43 percent) vacant provider positions. The institution reported that 52 registry nurses had been utilized to supplement nursing needs. The chief executive officer also reported that there were nine medical staff members recently under CDCR disciplinary review and working in clinical settings at the institution.

### SAC Health Care Staffing Resources as of June 2016

Description	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff		Totals	
	Number	%	Number	%	Number	%	Number	%	Number	%
<i>Authorized Positions</i>	5	4%	7	5%	10.5	8%	114	84%	136.5	100%
<i>Filled Positions</i>	4	80%	4	57%	10	95%	102	89%	120	88%
<i>Vacancies</i>	1	20%	3	43%	0.5	5%	10	9%	14.5	11%
<i>Recent Hires (within 12 months)</i>	2	50%	0	0%	2	20%	22	22%	26	22%
<i>Staff Utilized from Registry</i>	0	0%	0	0%	0	0%	52	51%	52	43%
<i>Redirected Staff (to Non-Patient Care Areas)</i>	0	0%	0	0%	0	0%	0	0%	0	0%
<i>Staff on Long-term Medical Leave</i>	0	0%	0	0%	0	0%	1	1%	1	1%

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



As of June 20, 2016, the Master Registry for SAC showed that the institution had a total population of 2,431. Within that total population, 5.2 percent were designated as high medical risk, Priority 1 (High 1), and 14.6 percent were designated as high medical risk, Priority 2 (High 2). Patients' assigned risk levels are based on the complexity of their required medical care related to their specific diagnoses, frequency of higher levels of care, age, and abnormal laboratory tests and procedures. High 1 has at least two high-risk conditions; High 2 has only one. Patients at high medical risk are more susceptible to poor health outcomes than those at medium or low medical risk. Patients at high medical risk also typically require more health care services than do patients with lower assigned risk levels. The chart below illustrates the breakdown of the institution's medical risk levels at the start of the OIG medical inspection.

**SAC Master Registry Data as of June 20, 2016**

Medical Risk Level	# of Inmate-Patients	Percentage
High 1	126	5.2%
High 2	363	14.6%
Medium	1,259	52.0%
Low	683	28.2%
<b>Total</b>	<b>2,431</b>	<b>100.0%</b>

## Commonly Used Abbreviations

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

## OBJECTIVES, SCOPE, AND METHODOLOGY

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

The OIG rates each of the quality indicators applicable to the institution under inspection based on case reviews conducted by OIG clinicians and compliance tests conducted by OIG deputy inspectors general and registered nurses. The ratings may be derived from the case review results alone, the compliance test results alone, or a combination of both these information sources. For example, the ratings for the primary quality indicators *Quality of Nursing Performance* and *Quality of Provider Performance* are derived entirely from the case review results, while the ratings for the primary quality indicators *Health Care Environment* and *Preventive Services* are derived entirely from compliance test results. As another example, primary quality indicators such as *Diagnostic Services* and *Specialty Services* receive ratings derived from both sources. At SAC, 14 of the quality indicators were applicable, consisting of 12 primary clinical indicators and 2 secondary administrative indicators. Of the 12 primary indicators, 7 were rated by both case review clinicians and compliance inspectors, 3 were rated by case review clinicians only, and 2 were rated by compliance inspectors only; both secondary indicators were rated by compliance inspectors only.

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

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

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

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## **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 patients. The OIG's clinicians perform a retrospective chart review of selected patient files to evaluate the care given by an institution's primary care providers and nurses. Retrospective chart review is a well-established review process used by health care organizations that perform peer reviews and patient death reviews. Currently, CCHCS uses retrospective chart review as part of its death review process and in its pattern-of-practice reviews. CCHCS also uses a more limited form of retrospective chart review when performing appraisals of individual primary care providers.

### ***PATIENT SELECTION FOR RETROSPECTIVE CASE REVIEWS***

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

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

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

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

1. If the institution is able to provide adequate clinical care to the most challenging patients with multiple complex and interdependent medical problems, it will be providing adequate care to patients with less complicated health care issues. Because clinical expertise is required to determine whether the institution has provided adequate clinical care, the OIG utilizes experienced correctional physicians and registered nurses to perform this analysis.
2. The health of less complex patients is more likely to be affected by processes such as timely appointment scheduling, medication management, routine health screening, and immunizations. To review these processes, the OIG simultaneously performs a broad compliance review.
3. Patient charts generated during death reviews, sentinel events (unexpected occurrences involving death or serious injury, or risk thereof), and hospitalizations are mostly of high-risk patients.

### ***BENEFITS AND LIMITATIONS OF TARGETED SUBPOPULATION REVIEW***

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

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

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

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

### ***CASE REVIEWS SAMPLED***

As indicated in *Appendix B, Table B-1: SAC Sample Sets*, the OIG clinicians evaluated medical charts for 89 unique patients. *Appendix B, Table B-4: SAC Case Review Sample Summary*, clarifies that both nurses and physicians reviewed charts for 23 of those patients, for 112 reviews in total. Physicians performed detailed reviews of 30 charts, and nurses performed detailed reviews of 20 charts, totaling 50 detailed reviews. For detailed case reviews, physicians or nurses looked at all encounters occurring in approximately six months of medical care. Nurses and physicians also performed a limited or focused review of medical records for an additional 62 reviews. These generated 1,210 clinical events for review (*Appendix B, Table B-3: SAC Event — Program*). The reporting format provides details on whether the encounter was adequate or had significant deficiencies, and identifies deficiencies by programs and processes to help the institution focus on improvement areas.

While the sample method specifically pulled only six chronic care patient records, i.e., three diabetic patients and three anticoagulation patients (*Appendix B, Table B-1: SAC Sample Sets*), the 89 unique patients sampled included patients with 273 chronic care diagnoses, including 14 additional patients with diabetes (for a total of 17, *Appendix B, Table B-2: SAC Chronic Care Diagnoses*). The OIG's sample selection tool allowed evaluation of many chronic care programs because the complex and high-risk patients selected from the different categories often had multiple medical problems. While the OIG did not evaluate every chronic disease or health care staff member, the overall operation of the institution's system and staff were assessed for adequacy. The OIG's case review methodology and sample size matched other qualitative research. The empirical findings, supported by expert statistical consultants, showed adequate conclusions after 10 to 15 charts had undergone full clinician review. In qualitative statistics, this phenomenon is known as "saturation." The OIG asserts that the physician sample size of 30 detailed reviews certainly far exceeds the saturation point necessary for an adequate qualitative review. With regard to reviewing charts from different providers, the case review is not intended to be a focused search for poorly performing providers; rather, it is focused on how the system cares for those patients who need care the most. Nonetheless, while not sampling cases by each provider at the institution, the OIG inspections adequately review most providers. Providers would only escape OIG case review if institutional management successfully mitigated patient risk by having the more poorly performing providers care for the less complicated, low-utilizing, and lower-risk patients. The OIG's clinicians concluded that the case review sample size was more than adequate to assess the quality of services provided.

Based on the collective results of clinicians' case reviews, the OIG rated each quality indicator as either *proficient* (excellent), *adequate* (passing), *inadequate* (failing), or *not applicable*. A separate confidential *SAC 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*.

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## COMPLIANCE TESTING

### *SAMPLING METHODS FOR CONDUCTING COMPLIANCE TESTING*

From July to September 2016, deputy inspectors general and registered nurses attained answers to 92 objective medical inspection test (MIT) questions designed to assess the institution's compliance with critical policies and procedures applicable to the delivery of medical care. To conduct most tests, inspectors randomly selected samples of 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 409 individual patients and analyzed specific transactions within their records for evidence that critical events occurred. Inspectors also reviewed management reports and meeting minutes to assess certain administrative operations. In addition, during the week of July 11, 2016, field inspectors conducted a detailed onsite inspection of SAC's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,371 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 SAC'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, and Specialty Services*.

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

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

### ***DASHBOARD COMPARISONS***

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

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### **OVERALL QUALITY INDICATOR RATING FOR CASE REVIEWS AND COMPLIANCE TESTING**

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

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



## **POPULATION-BASED METRICS**

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

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# MEDICAL INSPECTION RESULTS

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## 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 SAC. Of those 12 indicators, 7 were rated by both the case review and compliance components of the inspection, 3 were rated by the case review component alone, and 2 were rated by the compliance component alone.

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

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

The OIG physicians rated the overall adequacy of care for each of the 30 detailed case reviews they conducted. Of these 30 cases, 3 were *proficient*, 14 were *adequate*, and 13 were *inadequate*. In the 1,210 events reviewed, there were 487 deficiencies, of which 154 were considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

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

There was one near miss, two sentinel events, and four unsafe conditions identified in the case reviews at SAC.

- In case 2, the patient had a recent severe trauma, which required insertion of a chest tube for hemopneumothorax (presence of blood and air in the chest cavity). Shortly after the tube was removed, the patient complained of difficulty breathing. The TTA nurse did not notify the on-call provider and sent the patient back to housing. The nurse referred the patient for an appointment to follow up with the TTA provider the following morning, but the follow-up appointment did not occur. The patient was transferred to another facility without ever being re-evaluated for his breathing. Fortunately, the patient's symptoms resolved on their own. This was considered an adverse event, unsafe condition. This case is discussed in the *Emergency Services* indicator.

- In case 13, the patient became unresponsive shortly after custody was summoned and arrived at the cell front. Custody staff did not begin CPR until 12 minutes after the start of the emergency event and 7 minutes after the arrival of medical staff. The death was not preventable, as a subsequent autopsy determined that the death was due to an accidental overdose. The OIG clinicians, nevertheless, considered this an adverse, sentinel event due to the severely delayed CPR by first responders. This case is discussed in the *Emergency Services* indicator.
- In case 17, the patient's medical care was completely dropped after he transferred into SAC. He died from coronary artery disease eight months after his transfer to SAC. He never saw a provider at SAC, and his chronic medications, including aspirin and simvastatin, expired only a month after he arrived. While it was impossible to determine the extent that the patient's lack of medical care contributed to his death, the OIG clinicians classified the death as possibly preventable and an adverse, sentinel event. SAC has already performed a root cause analysis as to why the patient's medical care was dropped at the time of transfer. This case is also discussed in the *Intra- and Intra-System Transfers* and *Pharmacy and Medication Management* indicators.
- In case 18, the patient had leg swelling that could have been caused by a blood clot. The provider did not order a same-day ultrasound to confirm whether or not a blood clot existed or make plans to review the blood tests. The provider did not treat the patient while waiting for the tests. Even when the blood test came back abnormal, the provider did not obtain a same-day ultrasound, and left the patient untreated. The ultrasound did not occur until ten days after the patient first complained of his leg swelling. This prolonged delay without treatment placed the patient at high risk of harm if he did have had a blood clot. Fortunately, the patient did not have a blood clot, and the error resulted in no harm. The OIG classified the failure to evaluate the leg swelling adequately as an adverse event, unsafe condition. This case is also discussed in the *Quality of Provider Performance* indicator.
- In case 22, the patient complained of severe abdominal pain and bloody diarrhea. The patient was brought to the TTA in a wheelchair because he could no longer walk. The provider did not perform an evaluation and inappropriately sent the patient back to housing in a wheelchair. Later that evening, the patient returned to the TTA on a gurney for the same symptoms. The provider again sent the patient back to housing without an evaluation. The following day, despite severe abdominal pain and documented bloody stool, the provider allowed the patient to wait in the TTA for at least five hours before deciding to send the patient to a higher level of care. The patient improved after receiving appropriate care in the hospital. This series of severe delays was considered an adverse event, unsafe condition. This case is also discussed in the *Emergency Services* and *Quality of Provider Performance* indicators.

- In case 23, the patient saw the TTA nurse for extremely elevated blood pressure and headache. The provider ordered laboratory tests, an intravenous line, medications, and four hours of monitoring. The patient refused the medications, but did not refuse any other treatments. The nurse released the patient to housing with a critically high blood pressure (233/146) without discussing the case with the provider and without performing blood pressure monitoring. Two hours later, the provider called back to the TTA to obtain an update on the patient's status, only to discover that the nurse had already released the patient. No immediate harm resulted from this failure. The OIG classified the nurse's actions as an adverse event, unsafe condition.
- In case 25, the patient developed worsening shortness of breath, chest tightness, and wheezes. The nurse treated him with nebulizers, but the patient still did not feel well. The provider did not perform an adequate assessment, did not obtain a chest x-ray, and inappropriately sent the patient back to housing despite the patient's objections. The provider did not review the record and was unaware that the patient had a primary diagnosis of granulomatosis with polyangiitis (Wegener's Syndrome, severe systemic blood vessel inflammation), congestive heart failure, or narrowing of his windpipe with recent lung collapse. Any of these conditions could have contributed to his symptoms. After being returned to his cell, the patient went "man down", and returned to the TTA. Fortunately, this time the provider sent him to the hospital, where he was treated for pneumonia. The poor provider performance was considered an adverse event, near miss. This case is discussed in the *Emergency Services* indicator.

**Summary of Compliance Results:** The compliance component assessed 9 of the 12 primary (clinical) indicators applicable to SAC. Of these nine indicators, OIG inspectors rated one *proficient*, two *adequate*, and six *inadequate*. The results of those assessments are summarized within this section of the report. The test questions used to assess compliance for each indicator are detailed in *Appendix A*.

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## ***ACCESS TO CARE***

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

***Case Review Rating:***

*Adequate*

***Compliance Score:***

*Adequate  
(82.4%)*

***Overall Rating:***

*Adequate*

### ***Case Review Results***

The OIG clinicians reviewed 401 provider, nursing, specialty, and outside hospital events that required a follow-up appointment, and found 34 deficiencies relating to access to care. Fifteen of the deficiencies were considered more likely than not to cause patient harm if not rectified. Due to the relatively low frequency of problems in this area, the *Access to Care* indicator was rated *adequate*.

#### **Provider-to-Provider Follow-up Appointments**

The institution performed adequately with provider-ordered follow-up appointments. These are among the most important aspects of the *Access to Care* indicator. Failure to accommodate provider-ordered appointments can often result in lapses in care where patients experience delays or are completely lost to follow-up. A moderate pattern of problems was identified in this area. Provider-ordered appointments did not occur or were late in cases 2, 15, 21, 23, 26, and 32. This deficiency was infrequent and only moderately affected the rating of this indicator.

#### **RN Sick Call Access**

When sick call nurses did perform an evaluation, they demonstrated good ability to schedule patients with prompt access. Unfortunately, sick call nurses often failed to perform nursing evaluations when necessary. Poor sick call nursing performance is further discussed in the *Quality of Nursing Performance* indicator, and did not negatively affect the *Access to Care* indicator.

#### **RN-to-Provider Referrals**

Any properly functioning health care system must allow nurses to refer a patient for a provider evaluation if the patient's medical needs are beyond the nurse's scope of practice. SAC performed well, with most nurse-to-provider referrals resulting in an appointment. Problems in this area were uncommon, but were identified in cases 50, 56, and 74.

## **RN Follow-up Appointments**

SAC providers and nurses often referred patients for nursing follow-up appointments. OIG clinicians identified a strong pattern of errors in this area. RN line appointments did not occur in cases 31, 44, 60, 68, 73, and the following:

- In case 18, the patient had swelling in one leg. Concerned about the possibility of a blood clot, the provider ordered laboratory tests and a nurse follow-up in two days. The appointment did not occur. Fortunately, the diagnosis was eventually found to be a benign condition.
- In case 19, the patient had persistent cough and resultant chest discomfort. The provider ordered a nurse follow-up within three days, but it did not occur.
- In case 35, the patient was being treated for a bladder problem. The provider ordered the nurse to perform a bladder catheterization, but the appointment was never scheduled.

## **Provider Follow-up After Specialty Services**

SAC provided patients with a provider follow-up after specialty services. The OIG clinicians reviewed 74 diagnostic and consultative specialty services and found only one instance in which the provider follow-up did not occur or was delayed.

## **Intra-System Transfers**

The OIG clinicians reviewed 20 transfer-in events, 13 of which resulted in referrals for follow-up appointments. SAC did not provide the follow-up appointments in cases 9, 17, and 29.

## **Follow-up After Hospitalization**

The institution did well at ensuring that providers followed up with patients after they returned from an outside hospital or an emergency department. OIG clinicians reviewed 18 hospitalization and outside emergency events, and found no delays in provider follow-up.

## **Follow-up After Urgent/Emergent Care**

SAC did not always provide follow-up appointments for patients who were evaluated in the TTA. Most of these patients had a change in medical status, and were at higher risk for medical complications. This deficiency was identified in the following cases:

- In case 2, the patient had recently returned from the hospital after being treated for collapsed lungs and a hemopneumothorax (abnormal collection of blood in the chest cavity). He complained of shortness of breath and chest pain. The TTA nurse did not refer the patient to a provider, but instead planned for the patient to see the provider the next morning. The appointment never occurred. Fortunately, the patient's symptoms spontaneously resolved and he suffered no harm from the error.

- In case 26, the patient was treated in the TTA for an eyebrow laceration and confusion. The patient refused neurological monitoring, and the provider ordered a nurse follow-up the following day. The appointment did not occur.
- In cases 23 and 31, the TTA provider did not order appropriate follow-ups.

### **Specialized Medical Housing**

The institution performed well with provider access during and after admission to the correctional treatment center (CTC) or the outpatient housing unit (OHU). The OIG clinicians reviewed six CTC or OHU admissions with 42 provider encounters. A provider usually rounded on the CTC or OHU patients at appropriate intervals, with one exception:

- In case 23, the patient was admitted to the OHU for persistent and severely elevated blood pressures, the OHU provider examined the patient only three times during the two months of the patient's admission, made no intervention, and maintained minimal documentation.

### **Specialty Access and Follow-up**

SAC performed well in this area. Access to specialty services is discussed in the *Specialty Services* indicator.

### **Diagnostic Results Follow-up**

Providers reviewed diagnostic results and utilized the Notification of Diagnostic Test Results form (CDCR Form 7393) to indicate if a follow-up appointment was necessary. SAC providers usually provided adequate follow-up after they received abnormal diagnostic test results. Errors were identified in cases 20, 25, and 32.

### **Clinician Onsite Inspection**

At the onsite inspection, the OIG clinicians tried to determine what problems hampered SAC's ability to provide reliable access to care for its patients. The schedulers reported no significant provider or nurse backlogs. The chief physician and surgeon spent many hours each week rearranging schedules and appointments in order to keep the institution's access to care metrics in an acceptable range. However, this task had become increasingly challenging due to the lack of providers. At the time of the inspection, SAC had four vacant positions. Line providers described the situation as untenable. Providers rescheduled appointments repeatedly because there were often too many patients scheduled. Providers also complained that they were often interrupted during the day because they covered the entire yard's population by themselves. They were also responsible for covering emergent/urgent situations because of the lack of a dedicated TTA provider.

## Clinician Summary

SAC demonstrated marginally adequate ability to provide access to care. The OIG clinicians found adequate performance in most areas, but some areas were more problematic. Whether ordered by a nurse or a provider, the institution had difficulty providing patients follow-up nurse appointments. Continuity of appointments for patients who transferred into SAC was also unreliable. SAC did not reliably provide follow-up appointments for patients who were seen in the TTA. Medical provider managers at SAC stated the lack of providers negatively affected the ability to maintain medical services for patients. Despite these potentially serious problems, the OIG clinicians rated this indicator *adequate*.

## Compliance Testing Results

The institution received an *adequate* compliance score of 82.4 percent in the *Access to Care* indicator, scoring within the *proficient* range in the following tests:

- Patients had access to Health Care Services Request forms (CDCR Form 7362) at all six housing units inspected (MIT 1.101).
- Inspectors sampled 35 request forms submitted by patients across all facility clinics, and found nursing staff reviewed all requests the same day they were received (MIT 1.003). In addition, nursing staff timely completed a face-to-face encounter for 34 out of 35 patients (97 percent) within one business day of reviewing the request form. For the remaining patient, the nurse conducted the visit five days late (MIT 1.004).
- Of the seven patients whom nursing staff referred to a provider and for whom the provider subsequently ordered a follow-up appointment, six (86 percent) received their appointments timely. One patient received his appointment one day late (MIT 1.006).
- Among 14 health care services requests sampled on which nursing staff referred the patient for a provider appointment, 12 of the patients (86 percent) timely received their appointment. One patient did not receive an appointment at all, and another patient was seen 21 days late (MIT 1.005).

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

- Inspectors reviewed recent appointments for 40 patients who suffered with one or more chronic care conditions; 32 (80 percent) had received or had timely refused follow-up appointments. Four patients received their follow-up appointments from one to 11 days late, two patients received their follow-up appointments from 23 to 39 days late, and two patients received their follow-up appointments 3 to 4 months late (MIT 1.001).



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

- Only 10 of 22 patients sampled who transferred into SAC from other institutions and were referred to a provider for a routine appointment based on nursing staff's initial health care screening of the patient were seen timely (45 percent). For eight patients, provider appointments were held between one and 16 days late, three patients were seen from three to four months late, and for one patient, there was no evidence a timely follow-up appointment occurred (MIT 1.002).
- Among 25 sampled patients who received a specialty service, only 19 (76 percent) received a timely follow-up appointment with a provider. Six patients received their appointments from one to 14 days late; for two other patients, there was no evidence that the follow-up appointment occurred (MIT 1.008).
- Among 28 sampled patients who were discharged from community hospital, 20 (71 percent) received a timely follow-up appointment with a provider. Three patients received their appointments from two to seven days late; for five other patients, inspectors did not find evidence that the follow-up appointment occurred (MIT 1.007).

### ***Recommendations***

No specific recommendations.

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## ***DIAGNOSTIC SERVICES***

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

***Case Review Rating:***

*Inadequate*

***Compliance Score:***

*Inadequate*

*(73.2%)*

***Overall Rating:***

*Inadequate*

### ***Case Review Results***

The OIG clinicians reviewed 174 diagnostic events and found 26 deficiencies, 16 of which related to health information management, and 10 of which were diagnostic tests that were ordered but not completed.

Diagnostic tests not being completed is a serious system deficiency that can lead to significant lapses in care. SAC performed the majority of diagnostic tests in a timely manner. However, test completion was unreliable when SAC nursing was involved in the test collection. SAC relied on nurses to collect urine or stool samples, which was an area in which SAC did not perform adequately. These significant errors were identified in cases 28, 32, 41, and the following:

- In case 6, nurses obtained blood and urine samples during an emergency event in the TTA, but those samples were never sent to the laboratory for processing.
- In case 26, the provider ordered urine toxicology tests many times. SAC nurses failed to perform the test on at least three occasions.
- In case 35, the provider ordered stool samples multiple times. SAC nurses failed to collect the samples on at least two occasions.
- In case 38, the provider ordered a urine test that was not performed until seven weeks later.

The institution also performed poorly with retrieving radiology reports and scanning them into the eUHR. Failure to retrieve radiology reports increased the risk of a lapse in care by increasing the chance that a provider could overlook a seemingly missing report. Even if the ordering provider initially reviewed the report, it would still not be readily available to any subsequent medical staff. Any nurse or provider caring for the patient in the coming months or years would face a tremendous barrier when attempting to review radiology reports that were missing from the eUHR. At the onsite inspection, SAC leadership explained that they had stopped scanning radiology reports into the

eUHR based on a directive from CCHCS headquarters. Failure to retrieve and scan radiology reports into the eUHR was identified in cases 21, 23, 24, 26, 27, 35, 36, 38, 85, and the following:

- In case 32, SAC providers had not followed up on the patient's pulmonary nodules that had been seen on a CT scan three years prior. The abnormal CT scan was not scanned into the eUHR. The barriers created by the decision to stop scanning radiological reports into the eUHR may have contributed to this lapse in care.

The institution did well with retrieving laboratory reports and scanning them into the eUHR. The vast majority of laboratory reports were found in the eUHR.

Providers generally reviewed diagnostic test results in a timely manner. Delays in test review were rare.

### **Clinician Onsite Inspection**

At the onsite inspection, SAC providers reported that diagnostic services were generally adequate, with two major exceptions. The providers stated that SAC had no way of tracking pathology reports. They had little confidence that an abnormal pathology report would be properly retrieved and forwarded to them for review. The second problem was that in the spring of 2016, the SAC radiological technologist went on an extended absence without backup coverage. During the absence, providers had no access to x-ray services, and were discouraged from sending patients out of the facility for routine x-rays.

### **Clinician Summary**

Most radiology and laboratory tests were completed in a timely manner. However, urine and stool tests were not performed with acceptable reliability. Retrieval of radiology reports was problematic. Failure to place radiology reports into the main medical record presented a significant and ongoing risk of harm to patient care. The lack of available x-ray services for an extended period and the lack of adequate pathology report retrieval and forwarding system demonstrated serious flaws in this area. The OIG clinicians rated this indicator *inadequate*.

### ***Compliance Testing Results***

The institution received an *inadequate* compliance score of 73.2 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**

- Eight of the nine radiology services sampled (89 percent) were timely performed. For one patient, the radiology service was provided 14 days late (MIT 2.001). Providers properly evidenced their review of the radiology results for eight of the ten patients reviewed (80 percent). For two patients, there was no evidence the provider reviewed the report

(MIT 2.002). However, all ten of the radiology services sampled were timely communicated to the patients (MIT 2.003).

### **Laboratory Services**

- Laboratory services were completed within the time frame specified in the provider's order for nine of the ten patients sampled (90 percent). One patient's laboratory service was performed 12 days late (MIT 2.004). Providers properly evidenced their review of the laboratory test results for nine of those ten patients (90 percent). One report was reviewed by the provider one day late (MIT 2.005). Providers timely communicated the test results to eight of the ten sampled patients (80 percent). For one patient, inspectors did not find evidence in the eUHR that the patient received notification of the test results, and one other patient was notified one day late (MIT 2.006).

### **Pathology Services**

- SAC received nine of the ten (90 percent) final pathology reports timely. Only one diagnostic report was received six days late (MIT 2.007). With regard to providers' review and communication of the pathology results, SAC scored poorly. Providers evidenced review by initialing and dating zero out of ten sampled final pathology reports. (MIT 2.008). Further, providers communicated pathology results timely to only four of the ten patients who received the service (40 percent). For five patients, the provider communicated the results between 4 to 25 days late. For one additional patient, inspectors did not find evidence in the eUHR that the patient received notification of the test results (MIT 2.009).

### ***Recommendation for CCHCS***

The OIG recommends that CCHCS revisit its directive issued to their institutions to stop scanning radiology reports into the eUHR. This directive continues to present a serious risk of patient harm.

### ***Recommendations for SAC***

The OIG recommends that SAC develop a pathology report process that ensures timely retrieval and provider review.

The OIG recommends that SAC develop an effective backup plan to prevent prolonged lapses in health care services due to the absence of any single employee.

The OIG recommends that SAC scan all future radiology reports into the eUHR until the automated electronic health record system (EHRS) is implemented, and that SAC retrieve all radiology reports that had not been scanned and scan them into the eUHR.

## ***EMERGENCY SERVICES***

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.

***Case Review Rating:***

*Inadequate*

***Compliance Score:***

*Not Applicable*

***Overall Rating:***

*Inadequate*

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 74 urgent/emergent events and found 84 deficiencies with various aspects of emergency care. The OIG clinicians considered 36 of the 86 deficiencies significant, posing serious risk of patient harm.

#### **CPR Response**

The OIG clinicians found serious delays in SAC's emergency response. One delay was attributed to custody performance.

- In case 13, the patient became unresponsive shortly after custody was summoned and arrived at the cell front. Custody staff did not begin CPR until 12 minutes after the start of the emergency event, and 7 minutes after the arrival of medical staff. The subsequent autopsy determined the death was due to an accidental overdose and, therefore, not preventable. The OIG clinicians nevertheless considered this an adverse, sentinel event due to the severely delayed CPR.

#### **Provider Performance**

SAC providers demonstrated a pattern of inadequate emergency assessment. These problems were identified in cases 19, 23, 29, and the following:

- In case 3, first medical responders found the patient non-responsive on the floor. The patient had constricted pupils, shallow breathing, and a weak pulse. The provider had previously started the patient on chronic opioid therapy, but did not consider the possibility of opioid

overdose and did not order naloxone (an opioid antidote). The provider also inappropriately delayed the emergency response by downgrading the ambulance priority.

- In case 22, the patient complained of severe abdominal pain and bloody diarrhea. The patient was brought to the TTA in a wheelchair as he was no longer able to walk. The provider did not perform an evaluation and inappropriately sent the patient back to housing. Later that evening, this time on a gurney, the patient returned to the TTA for the same symptoms. The provider again sent the patient back to housing without an evaluation. The following day, despite the patient's severe abdominal pain and clothes soiled from bloody diarrhea, the provider allowed the patient to wait in the TTA for at least five hours before deciding to send the patient to a higher level of care. Fortunately, the patient suffered no permanent harm as he was treated for his condition successfully in the hospital.
- In case 25, the patient developed worsening shortness of breath, chest tightness, and wheezing. The nurse treated him with nebulizers, but the patient still did not feel well. The provider did not perform an adequate assessment, did not obtain a chest x-ray, and inappropriately sent the patient back to housing despite the patient's objections. The provider did not review the record and was unaware that the patient had a primary diagnosis of polyangiitis (Wegener's Syndrome, severe systemic blood vessel inflammation), congestive heart failure, and narrowing windpipe with recent lung collapse. Any of these conditions could have contributed to his symptoms. After being returned to his cell, the patient went "man down" and returned to the TTA. Fortunately, this time the provider sent him to the hospital, where he was treated for pneumonia.

Providers demonstrated extremely poor documentation of emergent encounters. Providers often failed to document anything at all, even when they saw patients face-to-face. Since the providers delivering emergent care rarely documented these encounters, it was nearly impossible for SAC to transmit needed health information to the primary care provider and team that were tasked with follow-up care. This problem was widespread, and was identified in cases 19, 22, 23, 25, 26, 31, 35, and the following:

- In case 1, the patient was stabbed in the chest. The patient's emergency care was appropriate, but the provider failed to document a progress note or physician orders.
- In case 5, the provider treated the patient's rapid heartbeat with a potentially dangerous medication (adenosine). The intervention itself was appropriate. However, because the medication could have serious side effects, the provider should have documented the assessment and intervention. The provider did not document the assessment in a progress note.
- In case 24, the provider treated the patient in the TTA for hypoglycemia (low blood sugar) over several hours, but did not document a progress note.

## Nursing Performance

Nursing performance during medical emergencies demonstrated significant deficiencies in the timeliness of emergency response, nursing assessments, nursing interventions, and provider notifications. Nursing documentation was also incomplete and sometimes did not show a clear and detailed record of the nursing care provided.

- In case 2, the patient had a recent severe trauma, which required insertion of a chest tube for hemopneumothorax (presence of blood and air in the chest cavity). Shortly after the tube was removed, the patient complained of difficulty breathing. The TTA nurse did not notify the on-call provider and sent the patient back to housing. The nurse ordered the patient to follow-up with the TTA provider the following morning, but the follow-up appointment did not occur. The patient was transferred to another facility without ever being re-evaluated for his breathing. Fortunately, the patient's symptoms resolved on their own. This was considered an adverse event, unsafe condition. This case is also discussed in the *Medical Inspection Results, Adverse Events* section beginning on page 12, and in the *Access to Care* indicator.
- In cases 6, 13, and 16, the TTA nurses failed to perform nursing interventions as described in the CCHCS nursing protocols.
- In case 19, the patient went to the TTA repeatedly for chest pain and dizziness.
  - On one occasion, the nurse did not respond to the scene of the emergency but instead waited for the patient to walk to the TTA.
  - On multiple occasions, the TTA nurses failed to adequately assess and monitor the patient.
  - TTA nurses failed to contact the provider and administered medications without an order.
  - On several occasions, nurses released the patient to housing without notifying the provider.
- In case 23, there were significant delays in transferring the patient with headache and severe high blood pressure to the TTA. Severe delays persisted in the TTA, including with the administration of medication and with notification of the provider.
  - Nursing staff repeatedly failed to notify the provider of severely elevated blood pressures.
  - On more than one occasion, the TTA nurses released the patient back to housing against provider's orders and despite extremely high blood pressure readings.

- Because there was no RN in the OHU, the nurse notified the TTA RN when the patient's blood pressure became extremely high. The TTA RN did not instruct the OHU nurse to send the patient to the TTA for further assessment and monitoring.
- In case 25, the patient was brought to the TTA for worsening shortness of breath, chest tightness, and wheezing. The TTA nurse performed inadequate assessments and gave incomplete information to the on-call provider, which may have led to the inappropriate decision to return the patient to his housing prematurely.
- In case 26, the patient had a seizure and a medical alarm was activated. The nurse did not respond to the scene of the medical emergency, and caused a delay in the emergency medical response. The TTA nurse also failed to perform an adequate assessment and notify the provider before releasing the patient to housing.

### **Nursing Documentation**

Nurses must document all critical information chronologically during an emergency medical response. Complete documentation identifies the quality of assessment and care provided to the patient and the timeliness and coordination of emergency response. In cases 1, 24, 26, and the following bulleted example, nursing staff did not complete a First Medical Responder form, as required by CCHCS policy. Incomplete nursing documentation was also identified in cases 6, 19, 23, and 26.

- In case 17, the nurse did not document the telephone orders received from the provider and whether the medication ordered was administered.

### **Emergency Medical Response Review Committee**

The EMRRC reviewed emergency medical responses on a regular basis and generally identified the deficiencies in staff performance during medical emergency and documentation issues.

### **Clinician Onsite Inspection**

SAC was divided into three widely separated main yards, which made it challenging to respond quickly to medical emergencies. Another challenge was the different security levels present in the institution, which further complicated SAC's ability to provide timely urgent/emergent services out of a single, centralized TTA. To help ameliorate these difficulties, SAC set up an area in each main clinic equipped for medical emergencies. On weekdays and during business hours, the clinic RNs and providers worked double duty in both clinic and TTA areas. SAC providers complained that they were often pulled in many directions, attending to multiple patient needs simultaneously. The providers suspected that many of the documentation and assessment deficiencies identified were due to severe provider understaffing. This compromised their ability to devote sufficient time and attention to each patient.



## **Clinician Summary**

The institution demonstrated delayed emergency response, delayed CPR, unreliable TTA follow-up, poor provider and nurse performance, and poor documentation. Many adverse events were attributable to poor emergency performance. The OIG clinicians rated this indicator *inadequate*.

## ***Recommendations***

No specific recommendations.

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## ***HEALTH INFORMATION MANAGEMENT (MEDICAL RECORDS)***

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

***Case Review Rating:***

*Inadequate*

***Compliance Score:***

*Inadequate  
(55.5%)*

***Overall Rating:***

*Inadequate*

### ***Case Review Results***

The OIG clinicians reviewed 1,210 events and found 176 deficiencies related to health information management, of which 16 were significant (four in case 35; three in case 38; two each in cases 21, 33, and 36; and one each in case 19, 24, and 85).

### **Interdepartmental Transmission**

Deficiencies in most categories were in fact due to poor communication. While not included in the 16 significant health information management deficiencies, the following did affect this indicator's rating:

- In cases 6 and 28, laboratory tests were not performed because the laboratory never received the orders.
- In cases 18 and 24, the patient did not receive needed medications because the pharmacy never received the provider's orders.
- In case 18, the medication nurses never received a stop order, and the nurses continued to administer a medication that a provider had discontinued.
- In case 31, the patient had poorly controlled blood sugar. The on-call provider ordered a follow-up with the RN the next day. The order was not transmitted properly between the TTA nurses, and the patient was not seen.

Providers rarely documented their TTA encounters. Because of this widespread failure, it was nearly impossible for the emergent medical care documentation to be communicated to the follow-up members of the clinic primary care team. This is also discussed in the *Emergency Services* indicator.

## **Hospital Records**

The institution did well with retrieving emergency department (ED) physician reports and hospital discharge summaries. The OIG clinicians reviewed 5 outside ED events and 13 community hospital events. ED reports and hospital discharge summaries were retrieved and scanned in a timely manner in all cases.

SAC performed poorly with having the ED physician report or the hospital discharge summary reviewed and initialed by a provider. Initials or dates were missing on the outside hospital reports in cases 2, 3, 5, 6, 23, 25, 26, 27, and 36.

## **Specialty Services**

The OIG clinicians found problems in the review of specialty reports. These findings are discussed in detail in the *Specialty Services* indicator.

## **Diagnostic Reports**

The institution did poorly with retrieving radiological reports, but did well with retrieving laboratory reports. These findings are discussed further in the *Diagnostic Services* indicator.

## **Urgent/Emergent Records**

Providers did poorly with documenting their TTA encounters, for both telephone encounters and in-person evaluations. Nurses also did not properly document their emergency responses. These findings are discussed further in the *Emergency Services* indicator.

## **Scanning Performance**

SAC had problems with missing documents, mostly medication administration records (MARs), identified in cases 19, 20, 33, 65, 71, and 84. In addition, the OIG clinicians identified mistakes in the document scanning process as either mislabeled or misfiled documents. Erroneously scanned documents can create delays or lapses in care by hindering providers' ability to find relevant clinical information. Mislabeled (scanned with the wrong category or date) or misfiled (into the wrong chart) documents were common and widespread. The OIG clinicians found mislabeled or misfiled documents in the eUHR in cases 19, 20, 23, 33, 48, 63, 72, 84, and 88.

Scanning times for all documents were generally good.

## **Legibility**

Nurses' documentation was often illegible.

## **Clinician Onsite Inspection**

The OIG clinicians observed clinical information transmission during the daily morning huddles. They interviewed health care staff regarding how the information was handled, especially if clinical care occurred outside of the clinic or afterhours. SAC followed a standardized huddle script, which ensured that patients seen outside of normal clinic hours had an appropriate follow-up appointment. In most huddles, the discussion regarding individual patients was superficial, which showed that teams were not very familiar with their patients. Patients with exceptionally poor dietary or medication compliance, poor diabetic control, or abnormal laboratories were mentioned in passing, without meaningful discussion or planning.

## **Clinician Summary**

The institution did well with the retrieval of outside ED reports and hospital discharge summaries. Scanning time frames were acceptable, but scanning accuracy was poor. Missing, misfiled, or mislabeled documents were common throughout the case reviews. SAC had significant difficulty with having outside ED and hospital discharge summaries initialed or signed by a provider. There were also significant problems with the handling of radiological and specialty reports. Errors in transmission occurred regularly and caused a variety of problems. Morning huddles were superficial, with primary care teams demonstrating insufficient familiarity with their patients and shallow discussion regarding problematic patients. The OIG clinicians rated this indicator *inadequate*.

## ***Compliance Testing Results***

The institution received an *inadequate* compliance score of 55.5 percent in *the Health Information Management (Medical Records)* indicator and showed room for improvement in the following areas:

- The institution scored zero in its labeling and filing of documents scanned into patients' eUHR files; some documents were mislabeled, such as pathology reports that were scanned and labeled as hospital admission reports, MARs scanned in the wrong patient file, refusal forms scanned under optometry progress notes, and a nursing assessment protocol that was missing from the eUHR. For this test, once the OIG identifies 12 mislabeled or misfiled documents, the maximum points are lost and the resulting score is zero. For this inspection, inspectors identified a total of 16 documents with errors, four more than the maximum allowable number of errors (MIT 4.006).
- Inspectors tested 11 chronic care dictated progress notes to determine if staff scanned the documents within five days of the patient encounter date; only one was timely (9 percent). Ten dictated progress notes were scanned from one to 12 days late (MIT 4.002).

- Medical administrative staff did not always timely scan MARs into patients' eUHR files, scanning only 4 of 20 sampled documents (20 percent) within the required time frames. Staff scanned the other 16 MARs between one and 30 days late (MIT 4.005).
- Among 28 sampled hospital discharge reports or treatment records for patients whom the institution sent to the hospital for a higher level of care, 12 (43 percent) were complete and reviewed by a SAC provider within three days of the patient's discharge. For 11 patients, providers reviewed the hospital discharge reports between one and six days late. For five other patients, no evidence was found in the eUHR to show when the provider reviewed the reports (MIT 4.008).

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

- SAC staff scanned all 20 sampled specialty service consultant reports into the eUHR within five days of the date the specialty service was performed (MIT 4.003).
- SAC's medical records staff timely scanned miscellaneous non-dictated documents, such as provider progress notes, nursing initial health screening forms, and patient requests for health care services. Specifically, 19 of the 20 documents sampled (95 percent) were timely scanned into the patient's eUHR within three days of the patient's encounter. For one patient, a document was scanned two days late (MIT 4.001).
- SAC timely scanned 25 of the 28 sampled community hospital discharge reports or treatment records into patients' eUHR (89 percent); three reports were scanned from one to 11 days late (MIT 4.004).
- When the OIG reviewed various medical documents, including hospital discharge reports, Initial Health Screening forms (CDCR Form 7277), MARs, and specialty service reports to ensure that clinical staff legibly documented their names on the forms, 28 of 32 samples (88 percent) were compliant (MIT 4.007).

### ***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 patient visits, and the sufficiency of facility infrastructure to conduct comprehensive medical examinations. Rating of this component is based entirely on the compliance testing results from the visual observations inspectors make at the institution during their onsite visit.

***Case Review Rating:***

*Not Applicable*

***Compliance Score:***

*Inadequate  
(65.5%)*

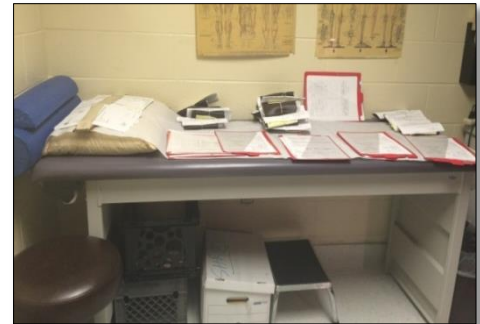
***Overall Rating:***

*Inadequate*

### ***Compliance Testing Results***

The institution received an *inadequate* compliance score of 65.5 percent in the *Health Care Environment* indicator, scoring poorly in the following test areas:

- The OIG inspected various exam rooms in 21 of the institution's clinics, observing patient encounters and interviewing clinical staff to determine if they had appropriate space, configuration, supplies, and equipment to perform a proper clinical examination. The exam rooms or treatment spaces in only one of the 21 applicable clinics (5 percent) were sufficient. For 20 applicable clinics, exam areas were unacceptable for multiple reasons. Exam rooms in 18 clinics had confidential medical records designated for shredding that were easily accessible to inmate porters; staff explained that the documents were removed once the box was full or once per month for shredding, not daily as CCHCS policy requires. Five clinics had exam tables with torn or ripped vinyl covering that could harbor infectious agents. Three clinics did not provide visual privacy for patients during clinical encounters. Two clinics had exam tables that impeded clinician's access to the patient. One clinic had a staff member's personal bag stored on top of the emergency medical response bag (EMRB); another clinic's exam table was used as counter space (*Figure 1*). At one other clinic, a patient's medication blister pack was discarded in an open trashcan, and the patient's identifying information had not been removed (*Figure 2*) (MIT 5.110).



*Figure 1: Exam table used as counter space*



*Figure 2: Confidential medical records discarded in trash*

- Inspectors examined emergency response bags to determine if they were inspected daily and inventoried monthly and whether they contained all essential items. Emergency response bags were compliant in only two of the ten clinical locations where they were stored (20 percent). One or more of the following deficiencies emerged at eight locations: in five locations, there was no documentation indicating that an inventory of the EMRB had been completed in the previous 30 days; one location's EMRB log was missing one entry evidencing staff verified the bag's compartments were sealed and intact. In two locations, the EMRB was missing some blood pressure cuffs; another location was missing a non-rebreather oxygen mask. At two locations, the EMRB oxygen tanks were less than fully charged (MIT 5.111).
- Only 8 of the 21 clinics inspected (38 percent) had all essential core medical equipment and supplies. The remaining 13 clinics had one or more deficiencies. Exam rooms in eight clinics lacked various items such as hemocult cards and a developer, lubricating jelly, tongue depressors, an oto-ophthalmoscope, and tips for the otoscope device. Five clinics had Snellen charts with distance lines measured at less than the standard 20 feet. Exam rooms in three clinics lacked biohazard waste receptacles or bags. Two clinics had non-operational oto-ophthalmoscopes. One clinic was missing an exam table, and another clinic retained an oto-ophthalmoscope with an outdated calibration and a broken charger base (MIT 5.108).
- OIG inspectors observed clinician encounters with patients in 16 clinics. Clinicians followed good hand hygiene practices in only seven clinics (44 percent). At nine clinic locations, clinicians failed to wash their hands before or after patient contact or before applying gloves (MIT 5.104).
- Only 14 of the 21 clinics inspected followed adequate medical supply storage and management protocols (67 percent). Medical supplies at four clinics were not orderly or clearly identifiable, and in one clinic, staff's personal items were stored in the same area as medical supplies. In one clinic, germicidal disposable cloths were stored together with medical supplies. In another clinic, a provider expressed concerns about low-quality medical supplies such as gowns and gloves (MIT 5.107).

The institution received an *adequate* score in the following area:

- Clinic common areas at 16 of the 21 clinics (76 percent) had environments conducive to providing medical services. Three clinics lacked wheelchair mobility access; another two clinics could not provide auditory privacy during nebulization treatments and vital signs and triage assessments (MIT 5.109).

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

- Staff appropriately disinfected, cleaned, and sanitized all 20 sampled clinics (MIT 5.101).

- Based on the OIG’s inspection of the institution’s non-clinic storage area for bulk medical supplies and responses from the warehouse manager and the CEO, the medical supply management process appropriately supported the needs of the medical program. As a result, SAC scored 100 percent on this test (MIT 5.106).
- Clinical health care staff at 18 of the 19 applicable clinics (95 percent) ensured that reusable invasive and non-invasive medical equipment was properly sterilized or disinfected. One clinic did not maintain a medical equipment sterilization log (MIT 5.102).
- At 19 of the 21 clinics inspected (90 percent), proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste were followed. In the receiving and release (R&R) clinic, nursing staff did not have efficient access to personal protective equipment such as disposable gowns. In another clinic’s exam room, a sharps container was found not affixed to a permanent object (MIT 5.105).
- Eighteen of the 21 clinics inspected had operable sinks and sufficient quantities of hand hygiene supplies in clinical areas (86 percent). In two locations, the staff restroom did not have disposable towels. In another location, the patients restroom did not have disposable towels or soap (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 was not scored. When OIG inspectors interviewed health care managers, they did not have concerns about the facility’s infrastructure or its effect on the staff’s ability to provide adequate health care. However, as noted below, the institution had five master infrastructure projects underway, which management staff felt would facilitate the provision of care at SAC. Specifically, the institution was building a new primary care clinic for the psychiatric segregation and administrative segregation units, and renovating the primary care clinic for general population patients on A yard. The institution was building a new central health services building to also include a TTA, and the existing pharmacy was undergoing a minor renovation for new fixtures and counter space. Lastly, SAC was renovating the medication distribution room on A, B, and C Yards. The institution broke ground on these projects starting in June 2015, with projected completion for all projects by April 2017 (MIT 5.999).

### ***Recommendations***

No specific recommendations.



## ***INTER- AND INTRA-SYSTEM TRANSFERS***

This indicator focuses on the management of 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 patients received from other CDCR facilities and patients transferring out of SAC 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 patients who transfer out of the facility, the OIG evaluates the ability of the institution to document transfer information that includes pre-existing health conditions, pending appointments, tests and requests for specialty services, medication transfer packages, and medication administration prior to transfer. The OIG clinicians also evaluate the care provided to patients returning to the institution from an outside hospital and check to ensure appropriate implementation of the hospital assessment and treatment plans.

***Case Review Rating:***

*Inadequate*

***Compliance Score:***

*Adequate*  
(84.7%)

***Overall Rating:***

*Adequate*

In this indicator, the OIG case review and compliance review processes yielded different results, with the case review giving an *inadequate* rating and the compliance testing an *adequate* score. The OIG's internal review process considered the factors leading to both scores and ultimately rated this indicator *adequate* based on two key factors. The case reviews identified problems with medication continuity and follow-up care provided to patients upon their return from the hospital; however, during their onsite review in September 2016, the case review clinicians learned that SAC had already identified some transfer process deficiencies and improved in those areas. Also, while case review identified many deficiencies regarding medication continuity for transfer patients, those issues were more directly related to the *Pharmacy and Medication Management* indicator and were weighted heavily in that indicator's overall rating. In addition, compliance testing for the patients sampled showed that the institution performed adequately in providing newly arrived patients their existing medication orders from their prior institutions. As a result, the compliance review rating of *adequate* was deemed a more appropriate overall rating for the *Inter- and Intra-System Transfers* indicator.

### ***Case Review Results***

The OIG clinicians reviewed 53 inter- and intra-system transfer events, including information from both the sending and receiving institutions. These included 18 hospitalization and outside emergency room events, each of which resulted in a transfer back to the institution. There were 11 significant deficiencies (cases 4, 5, 12, 17, 22, 24, 29, 68, and three times in case 20).

## Transfers In

The OIG clinicians reviewed 15 patients and 24 events in which the patient transferred into SAC from another institution or agency. The OIG clinicians identified 13 deficiencies, 8 of which were significant. SAC had problems maintaining access to providers and demonstrated poor nursing performance in this area. As discussed in the *Access to Care* indicator, SAC did not reliably provide follow-up appointments in the following cases.

- In cases 9 and 17, nurses ordered provider appointments at the time the patient transferred into SAC. In both cases, the appointments never occurred. In case 17, the patient's entire medical care was dropped completely until the patient's death, eight months later.
- In case 9, the pending specialty appointment was delayed.
- In case 29, the specialty appointment was dropped after transfer.

For patients transferring into SAC, nurses had problems with performing initial health screenings, completing documentation, and referring patients appropriately to a provider.

- In case 5, the R&R nurse failed to complete an interview with the patient, failed to ask relevant questions regarding his medical and mental health conditions, and failed to document the information on the initial health screening form.
- In case 9, the R&R nurse failed to assess the patient for tuberculosis signs and symptoms and to document the assessment on the initial health screening form.
- In case 20, on several occasions when the patient returned from court, the nurse failed to obtain vital signs or a blood sugar reading. The patient had multiple chronic medical conditions, including hypertension and diabetes, was taking several medications, and used a cane to walk. The nurse, however, wrote that the patient was not under a doctor's care, was not taking any medications, and did not have any health care appliances.
- In case 68, the nurse did not refer the newly arrived patient for mental health evaluation when the patient reported feeling depressed in the last two weeks.

## Transfers Out

The OIG clinicians reviewed 8 patients and 11 events in which the patient transferred out of SAC to another CDCR institution. The OIG clinicians identified four deficiencies, one of which was significant (case 12).

- In case 2, the nurse failed to recognize that the provider appointment scheduled for the previous day did not occur, and failed to document it on the transfer form to ensure continuity of care.

- In case 11, the nurse did not send the patient’s medications to the receiving institution.
- In case 12, the nurse did not send the patient’s heart medications to the receiving institution.
- In case 90, the nurse did not complete the health care transfer information form.

## **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 OIG clinicians reviewed 18 cases and 33 events in which patients returned to SAC from an offsite hospital or emergency department. The OIG clinicians found 17 deficiencies, of which only 2 were significant. SAC nurses performed adequate assessments upon patients’ return from the hospital, with thorough medication reconciliations, and ensured that the correct medications were ordered each time. Despite the good nursing performance, there remained problems with medication continuity for patients returning from an outside hospital.

- In case 4, the patient returned from an outside hospital with orders to continue intravenous antibiotics and contact isolation. When the patient arrived, SAC was completely unprepared for those needs. The case demonstrated poor care coordination prior to the transfer back to the institution.
- In case 22, the patient returned from the hospital with important medications for worsening inflammatory bowel disease. Despite appropriate medication orders, SAC did not provide the medications until two days later.
- In case 24, the patient returned from the hospital with important medications to treat his intestinal ulcer. Despite appropriate medication orders, institution staff did not provide the medication until a month later.

## **Clinician Onsite Inspection**

The R&R had adequate space for conducting initial health screenings. There was one RN assigned to each watch during each business day. Transfer notifications were generally received weekly, and the R&R nurse completed the health care transfer information forms. During interviews, the R&R nurses demonstrated sufficient knowledge of the transfer process. The OIG clinicians discussed many of the transfer deficiencies with SAC medical managers. They had already identified some of the transfer process deficiencies, and had changed some of their processes to ensure better medication continuity. For example, SAC had recently changed its transfer-out process to ensure that medications were sent with the patient to the next institution.

## Clinician Summary

SAC did not perform well with transfers into the institution. There were problems with access to providers and specialty appointments after patients arrived. Nurses did not perform adequate initial health screenings. For transfers out of the institution, SAC performed adequately; the only exception was that SAC did not ensure that medications were sent with the patient to the next institution. Regarding hospitalizations, SAC nurses did very well assessing the patients' health needs and properly reconciling discharge medications. However, there were problems with maintaining medication continuity for those patients returning from the hospital. Despite evidence of good transfer care in some areas, the institution earned an *inadequate* rating in this indicator.

## Compliance Testing Results

The institution obtained an *adequate* compliance score of 84.7 percent in the *Inter- and Intra-System Transfers* indicator, and performed in the *proficient* range in the following areas:

- Inspectors observed scheduled transfers of four patients being transferred out of the institution. All four applicable transfer packages included required medications and support documentation (MIT 6.101).
- For 29 of the 30 sampled patients who transferred into SAC (97 percent), nursing staff timely completed the assessment and disposition sections of the initial health screening form on the same day that they performed the patient's initial health screening. The one exception was when a nurse did not provide an answer to the question regarding TB signs or symptoms (MIT 6.002).

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

- Of the 30 sampled patients who transferred into SAC, 22 had an existing medication order that required nursing staff to issue or administer medications upon arrival. Eighteen of the 22 patients (82 percent) received their medications timely. Four patients received their directly observed medication (DOT) one day late (MIT 6.003).
- The OIG tested 30 patients who transferred into SAC from other CDCR institutions to determine whether they received a complete initial health screening assessment from nursing staff on their day of arrival. Although nursing staff timely prepared the screening forms, they neglected to answer all applicable questions for six patients, resulting in a score of 80 percent (MIT 6.001).

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

- The OIG sampled 20 patients who transferred out of SAC to other CDCR institutions to determine whether their pending specialty service appointments were listed on the transfer forms. The institution identified the previously approved and still pending appointments for 13 patients (65 percent), but failed to do so for the 7 remaining patients (MIT 6.004).

### ***Recommendations***

No specific recommendations.

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## ***PHARMACY AND MEDICATION MANAGEMENT***

This indicator is an evaluation of the institution's ability to provide appropriate pharmaceutical administration and security management, encompassing the process from the written prescription to the administration of the medication. By combining both a quantitative compliance test with case review analysis, this assessment identifies issues in various stages of the medication management process, including ordering and prescribing, transcribing and verifying, dispensing and delivering, administering, and documenting and reporting. Because effective medication management is affected by numerous entities across various departments, this assessment considers internal review and approval processes, pharmacy, nursing, health information systems, custody processes, and actions taken by the prescriber, staff, and patient.

***Case Review Rating:***

*Inadequate*

***Compliance Score:***

*Inadequate*

*(63.0%)*

***Overall Rating:***

*Inadequate*

### ***Case Review Results***

The OIG clinicians evaluate pharmacy and medication management as secondary processes as they relate to the quality of clinical care provided. Compliance testing is a more targeted approach and is heavily relied on for the overall rating of this indicator. The OIG clinicians evaluated 50 events related to medications, and found 35 deficiencies, 21 of which were significant.

### ***Medication Continuity***

Medication continuity was a significant problem for the patients transferring into the institution, transferring out to other institutions, returning from a community hospital, or receiving monthly chronic care medications. In cases 11 and 12, the nurse did not send the patient's medication to the receiving institution. These cases were also mentioned in the *Inter- and Intra-System Transfers* indicator. In cases 3, 18, 19, 20, 31, 33, and the following, SAC allowed important outpatient medications to expire, causing significant breaks in medication continuity:

- In case 15, the patient's medications were dropped for several months prior to his death.
- In case 17, the patient's medication expired soon after he transferred into SAC. While some medications were renewed, the patient's chronic medications were not administered up to the patient's death eight months later. This case is also discussed in the *Inter- and Intra-System Transfers* indicator and the *Medical Inspection Results, Adverse Events* section.

In cases 22 and 24, upon the patients' return from the hospital, no provider ordered or continued discharge medications. These cases are further discussed in the *Inter- and Intra-System Transfers* indicator.

### ***Medication Administration***

In the majority of cases reviewed, patients received their medications timely and as prescribed. However, medication administration errors were frequent enough to establish a pattern of deficiencies. SAC nurses did not administer medications as prescribed in cases 11, 20, 23, 35, and the following:

- In case 7, SAC nurses did not administer the patient's insulin.
- In case 33, on two occasions, SAC nurses did not administer the patient's injectable medication.
- In case 86, the patient spent nearly a month in the CTC waiting for approval of a new multiple sclerosis medication. While waiting, the patient's symptoms progressed, and the patient was hospitalized once again for his condition.

### **Pharmacy Errors**

There were some cases in which medication orders were delayed or not acted upon at all. At the onsite inspection, SAC leadership postulated that poor transmission of health care information resulted in some of these errors.

- In cases 18 and 24, the patient did not receive needed medications because the pharmacy never received the provider's orders. These cases were also discussed in the *Health Information Management* indicator.
- In case 18, the medication nurses never received a stop order, so the nurses continued to administer a medication that a provider had discontinued. This case was also discussed in the *Health Information Management* indicator.
- In case 32, the provider increased the patient's diabetic medication. The order was not implemented until two weeks later.

### **Clinician Summary**

SAC had tremendous difficulty ensuring medication continuity for patients transferring into the institution, transferring out to other institutions, returning from a community hospital, or receiving monthly chronic care medications. SAC nurses also had problems consistently administering medications exactly as prescribed. On several occasions, provider medication orders were significantly delayed, or not acted upon at all. The OIG clinicians rated this indicator *inadequate*.

### ***Compliance Testing Results***

The institution performed in the *inadequate* range with a compliance score of 63.0 percent in the *Pharmacy and Medication Management* indicator. For discussion purposes below, this indicator is

divided into three sub-indicators: medication administration, observed medication practices and storage controls, and pharmacy protocols.

### **Medication Administration**

In this sub-indicator, the institution received an *inadequate* score of 66.9 percent, performing poorly in the following areas:

- Nursing staff administered medications without interruption to three out of ten patients who were en route from one institution to another with a temporary layover at SAC (30 percent). There was no documented eUHR evidence that six patients received their medications while temporarily housed at the institution. One patient refused one of his medications, and nursing staff did not properly document the refusal on the front or back of the MAR (MIT 7.006).
- SAC timely provided hospital discharge medications to 15 of 27 patients sampled (56 percent). Nursing staff provided discharge medications one to five days late for six patients; for six other patients, no evidence was found in the eUHR that DOT or keep-on-person (KOP) medications were provided. For one of those six, no evidence was found that the patient received his newly prescribed KOP nitroglycerin after being discharged from the hospital. Subsequently, two days later the patient was returned to the hospital for chest pain. Per CCHCS severity guidelines, this was a Level 4 medication error. The institution's pharmacist in charge confirmed a medication error report had not been completed. This medication error is also discussed in MIT 7.998, *Non-Scored Tests* (MIT 7.003).
- Among 30 sampled patients, 20 (67 percent) timely received chronic care medications. For two patients, the nurse documented on the MAR that the patient was a no show, but did not document any efforts to contact custody or ducat the patient to the medication line. A refusal was indicated on the MAR for one patient; however the refusal was not properly documented per CCHCS policy. Two other patients missed one or more doses of their DOT medication and did not receive provider counseling. Three patients did not receive their KOP medication for 30 or more days, and two other patients received their DOT and KOP medications one to nine days late (MIT 7.001).

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

- Of the 40 patients sampled, 37 (93 percent) timely received their new medication orders. Two patients received their medication one and 19 days late, and for one other patient there was no evidence found in the eUHR that the medication was received (MIT 7.002).
- OIG inspectors sampled 30 patients who had transferred from one housing unit to another within the institution; 27 (90 percent) received their prescribed medications without interruption. One patient did not receive his medication by the next dosing interval after the



transfer occurred. One patient received his medication 16 days late, and for one other patient no evidence was found in the eUHR that the medication was received (MIT 7.005).

### **Observed Medication Practices and Storage Controls**

In this sub-indicator, the institution received an *inadequate* score of 49.5 percent, showing room for improvement in the following areas:

- Non-narcotic medications requiring refrigeration were properly stored at only one of the 17 applicable clinics and medication line locations (6 percent). At 16 locations, staff did not have a designated return-to-pharmacy area for refrigerated medications. At 4 of those 16 locations, temperature logs showed recorded refrigerator temperature readings that were out of range; one location's medication refrigerator was found unlocked at the time of the inspection, and another location's medication refrigerator contained a previously opened multi-dose medication vial without a date-opened label (MIT 7.103).
- The institution employed strong medication security controls over narcotic medications at only 2 of the 12 applicable clinics and medication line locations where narcotics were stored (17 percent). Ten were noncompliant; at nine of those locations, the narcotics logbook was not counter-signed by two nursing staff at every shift change. Also, three of those nine locations' narcotics logbooks were missing counter-signatures for destruction of controlled substances. At one other location, nursing staff logged out narcotics and documented the reconciliation count without physically removing the narcotics from the locker, which prevented an accurate spontaneous count (MIT 7.101).
- SAC properly stored non-narcotic medications not requiring refrigeration in 7 of the 19 applicable clinic and medication line storage locations (37 percent). In 12 locations, one or more of the following deficiencies were observed: the medication area lacked a designated area for return-to-pharmacy medications; external and internal medications were not properly separated when stored; medication rooms and cabinets were unlocked; multi-use medication was not labeled with the date it was opened; medication was stored beyond its expiration date; and a personal water bottle was stored in the same area as liquid medication (MIT 7.102).
- Inspectors observed the medication preparation and administration processes at eight applicable medication line locations. Nursing staff were compliant regarding proper hand hygiene and contamination control protocols at five locations (63 percent). At three locations, not all nursing staff washed or sanitized their hands when required, such as prior to putting on gloves, before re-gloving, or after physical contact with patients (MIT 7.104).

SAC received an *adequate* score in the following test:

- Inspectors observed the medication distribution process at eight applicable medication line locations and determined that six of them (75 percent) demonstrated appropriate

administrative controls and protocols. In one location, nursing staff did not verify the patient's identity with picture identification, and did not properly administer medication by crushing and floating it as ordered. At another medication line location, nursing staff failed to immediately update the MAR after administering medication (MIT 7.106).

The institution received a score of 100 percent in the following area:

- Clinical staff employed appropriate administrative controls and followed proper protocols during medication preparation at all eight medication preparation and administration locations observed (MIT 7.105).

### Pharmacy Protocols

In this sub-indicator, the institution received an *adequate* score of 75.3 percent, and scored in the *proficient* or *adequate* range in the following tests:

- SAC's main pharmacy properly followed general security, organization, and cleanliness management protocols; properly stored refrigerated medications; and properly accounted for narcotic medications (MIT 7.107, 7.109, 7.110).
- The institution's pharmacist in charge (PIC) followed required protocols for 23 of the 30 medication error reports and monthly statistical reports reviewed (77 percent). For three medication error reports, the PIC completed corresponding medication error follow-up reports from 4 to 28 days late. Two monthly medication error statistic reports were submitted to the chief of pharmacy services six and seven days late; and another two monthly medication error statistic reports were not submitted to the chief of pharmacy services at all (MIT 7.111).

The institution performed poorly in the following test area:

- In its main pharmacy, SAC did not properly store non-refrigerated medication. Inspectors found medication boxes stored on the floor of the pharmacy (*Figure 3*) (MIT 7.108).



*Figure 3: Medications stored on floor of pharmacy*

## Non-Scored Tests

Throughout the inspection process, the OIG identified instances in which medication errors occurred. The OIG followed up on medication errors classified in the severity Level 4 to Level 6 range to determine whether the errors were properly reported. These findings were not scored.

- During the case review and compliance testing for SAC, the OIG's chief physician and surgeon (CP&S) identified one medication error as a Level 4 (resulting in a need for additional treatment with another drug or hospitalization) and one medication error as a Level 6 (having possibly contributed to or resulted in death). The PIC at SAC did not receive a medication error report for either error. Consequently, the PIC did not complete the CDCR Medication Error Follow-up Report, did not include it on the monthly medication error statistic report, and did not determine if an adverse/sentinel event report was needed. The Level 6 medication error (case 17) is discussed in the case review results section of this indicator, the *Inter- and Intra-System Transfers* indicator, and the *Medical Inspection Results* introduction, *Adverse Events* section, pages 12 to 14. The Level 4 medication error is discussed in the compliance testing results in this indicator MIT 7.003 (MIT 7.998).
- The OIG tested patients in isolation units to determine if they had immediate access to their prescribed KOP asthma rescue inhalers and nitroglycerin medications. Inspectors interviewed 26 applicable patients; 23 had possession of their prescribed rescue medications, but three patients indicated they did not. Following the OIG's notification to the CEO, all three patients received their rescue inhalers (MIT 7.999).

## Recommendations

No specific recommendations.

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## ***PREVENTIVE SERVICES***

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

***Case Review Rating:***  
*Not Applicable*  
***Compliance Score:***  
*Inadequate*  
*(62.2%)*  
***Overall Rating:***  
*Inadequate*

The OIG rates this indicator entirely through the compliance testing component; the case review process does not include a separate qualitative analysis for this indicator.

### ***Compliance Testing Results***

The institution performed in the *inadequate* range in the *Preventive Services* indicator, with a compliance score of 62.2 percent. SAC showed room for improvement in the following areas:

- The institution scored poorly for monitoring of patients on TB medications. For 9 of 10 patients sampled, the institution either failed to complete monitoring at all required intervals, failed to document weight monitoring, or failed to scan the monitoring form into the patient's eUHR in a timely manner (10 percent) (MIT 9.002).
- OIG inspectors sampled 30 patients to determine whether they received a TB screening within the last year. Half of the sampled patients (15) 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). Overall, only 10 of 30 patients sampled (33 percent) had an adequate TB screening (MIT 9.003):
  - Nurses timely screened only 2 of the 15 sampled Code 34 patients, with 11 incidents in which the nurses did not properly complete the history section of the Tuberculin Testing/Evaluation Report (CDCR Form 7331). For two other patients, there was no evidence that a TB screening was completed.
  - For sampled Code 22 patients, only 8 of the 15 received properly completed nurse screenings; LVNs or licensed psychiatric technicians (LPTs) reviewed skin test results instead of RNs, public health nurses, or providers, as CCHCS policy required at the time of the inspection. This deficiency occurred in 6 of the 15 applicable samples, and one patient was not screened for TB in the last year.
- SAC scored 60 percent for timely administration of TB medications. Of ten patients sampled, six received all required doses of TB medication for the most recent three-month

period. There was no evidence found in the eUHR that three patients received their medication on one or more separate occasions. For one other patient, the nurse documented on the MAR that he refused his medication, but no evidence was found in the eUHR that he received a referral and counseling from a provider as required (MIT 9.001).

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

- The OIG sampled 24 patients with various types of chronic medical conditions to determine if the institution offered them recommended vaccinations; 20 patients were timely offered vaccinations for influenza, pneumonia, and hepatitis (83 percent). Four patients had no record that they received, or that the institution offered, the recommended pneumococcal and hepatitis A and B immunizations within the required time frame (MIT 9.008).

SAC scored in the *proficient* range in the following tests:

- The institution timely offered 29 of the 30 patients sampled an influenza vaccination for the most recent influenza season (97 percent). No evidence was found in the eUHR that one patient received or refused the influenza vaccination (MIT 9.004).
- Of 30 patients sampled for colorectal cancer screening, 27 either had a normal colonoscopy within the last ten years or had been offered a colon cancer screening in the last year (90 percent). For three patients, there was no evidence in the eUHR that they received, refused, or were offered a colon cancer screening in the last year (MIT 9.005).

### ***Recommendations***

No specific recommendations.

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## ***QUALITY OF NURSING PERFORMANCE***

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

***Case Review Rating:***

*Inadequate*

***Compliance Score:***

*Not Applicable*

***Overall Rating:***

*Inadequate*

### ***Case Review Results***

The OIG clinicians reviewed 525 nursing encounters, of which 247 were outpatient nursing encounters. Most outpatient nursing encounters were for sick call requests, walk-in visits, and RN follow-up visits. In all, there were 104 deficiencies identified related to nursing care performance, 20 of which were significant. When patients submitted sick call requests with urgent symptoms, the clinic nurses often failed to perform immediate face-to-face assessments. They also failed to perform adequate patient assessments or formulate appropriate plans of care. Nurses often referred patients to the provider with significant delays. The nurses also failed to carry out providers' orders and displayed numerous documentation deficiencies, such as the complete failure to document some nursing encounters. While many of the patients ultimately received care, the pattern of nurses' failure to see patients immediately, to perform adequate assessments, and to appropriately refer patients to the provider increased the potential for patient harm. The OIG clinicians rated this indicator *inadequate*.

## Nursing Sick Call

The institution's nurses often demonstrated improper triage, poor assessment, inadequate intervention, and incomplete or illegible documentation, as evidenced in the following examples:

- In case 23, the patient had severely elevated blood pressure and was seen numerous times by clinic nursing staff. The nurses failed to perform an adequate assessment and document the reasons why medication and monitoring orders were obtained; failed to inform the provider of the patient's severely elevated blood pressure readings; did not carry out the provider's order to notify the TTA nurse or provider of the patient's status; failed to administer medications, take vital signs, and recheck blood pressure as ordered by the provider; and failed to obtain specific blood pressure reading parameters for provider notification.
- In case 39, the patient reported facial numbness and abdominal pain, but the nurse did not see the patient that same day. When the patient was seen the following day, the nurse did not adequately assess the patient. More than one month later, the patient submitted a sick call request for blurry vision. The nurse did not perform a visual acuity check and did not assess the patient's eyes. Six weeks later, the patient submitted another sick call request for worsening vision problems and facial numbness. The nurse again did not assess the patient's eyes or check visual acuity. The nurse also failed to refer the patient to the provider for further evaluation of these neurological symptoms.
- In case 63, the patient submitted several sick call requests for clogged ears, neck and knee pain, and hematuria (blood in the urine). The nurse did not see the patient face-to-face to examine his ears but merely scheduled an ear irrigation. At the ear irrigation visit, the nurse did not document the nursing encounter. The patient reported neck pain but was not seen by the nurse. Instead, the nurse deferred to the provider appointment on the same day but did not address the patient's complaint. Two months later, the patient reported decreased hearing due to ear wax and requested to have his ears irrigated again. The nurse did not examine the patient's ears, did not utilize the nursing protocol, and did not provide eardrops solution for earwax impaction.
- Also in case 63, on a different occasion, a staff member notified the TTA nurse and assisted the patient in completing a sick call request form for hematuria, nausea, and abdominal tenderness. The nurse did not see the patient on the same day but instead scheduled the patient in the nurse clinic after a three-day weekend. When the nurse saw the patient, the nurse did not obtain a history, complete an adequate assessment, or perform a urine analysis for the presence of proteins, blood, glucose, or infection. A month later, the patient complained of knee pain, but the nurse did not see the patient face to face.

- In case 68, the patient with multiple chronic medical conditions arrived at the institution. More than two weeks later, the patient submitted a sick call request for swollen and painful ankles. The nurse did not see the patient face to face and merely noted that a provider appointment was already scheduled in one week. Five weeks later, the patient submitted another sick call request for swollen and painful ankles, but the nurse did not see the patient on the same day. When the patient was seen, the nurse did not perform an adequate assessment of the lower extremities or provide appropriate education. A week later, the nurse saw the patient for earwax build up. The nurse performed an inadequate assessment, but did provide eardrop medication and did schedule the patient for ear irrigation the following week. The appointment did not occur. Three weeks later, the patient submitted another sick call request for clogged ears with difficulty hearing, and he was eventually seen by the clinic nurse.

### **Nursing Sick Call Triage Deficiencies**

CCHCS policy requires an RN to review every sick call request on the day it is received. The purpose of this stringent policy is to identify symptoms that may result in patient harm if not addressed on a same-day, urgent basis. The RN can see all other less urgent requests the next business day. The OIG clinicians identified serious deficiencies regarding SAC nurses' review of sick call requests. They often failed to recognize the need for same-day RN assessments or provider evaluations.

- In case 22, on several occasions, the nurse did not see the patient with urgent medical symptoms on the same day. The patient submitted a sick call request for bloody stools, diarrhea, and severe abdominal pain. Three days later, the patient reported that he was still bleeding a lot, but the nurse merely scheduled him for the next clinic appointment. Fortunately, the TTA RN saw the patient the following day and contacted the on-call provider. Two months later, the patient submitted another sick call request for severe pain and rectal bleeding, but the nurse did not see him that day. More than a week later, the nurse reviewed a sick call slip for chest pain and shortness of breath but, again, failed to see the patient that day.
- In case 51, the patient was having difficulty breathing and had asthma. The nurse did not see him that day.
- In case 52, the patient submitted two sick call requests for severe facial pain and swelling. On both occasions, the nurse did not see him that day.
- In case 57, the nurse did not see a patient with fever and stomach pain on day of his request. Instead, the patient was scheduled for the RN clinic after a three-day weekend.



- In case 64, the nurse did not see a patient with chest pain on the same day the sick call request was reviewed. Two days later, a medical alarm was activated and the patient was brought to the TTA for chest pain.
- In case 65, the patient submitted one sick call request for wrist and knee pain and another, three weeks later, for swollen ankles. The nurse did not see the patient for same-day, face-to-face assessment for any of these requests.
- In case 66, the patient reported he had a urinary tract infection and back pain. The nurse did not see the patient that day.
- In case 78, the patient fell and hurt his back; the nurse did not see the patient for same-day, face-to-face assessment.
- In case 79, the patient submitted a sick call request for respiratory symptoms, vomiting, and body aches. The nurse noted that the patient was seen by the provider for the same complaints the previous day and scheduled the patient for the RN clinic in three days. However, there was no evidence that the patient was seen by the provider since there was no appointment scheduled and no provider progress note found in the eUHR. The nurse should have seen the patient that day.

Patients with urgent medical symptoms were also not seen on the same day in cases 2, 20, 27, 44, 52, 67, 69, 72, 74, 81, and 83.

In cases 18 and 62, the nurse did not assess the patient face to face within the required one business day after the sick call request was reviewed.

### **Inadequate Nursing Assessment**

The OIG clinicians could not determine if the nurses in many cases asked important questions, examined pertinent areas of the body, or performed necessary measurements. Nurses also failed to document the presence or absence of common accompanying signs and symptoms. These deficiencies were found in cases 2, 19, 45, 48, 52, 62, 65, 69, 80, 88, and the following:

- In case 4, the patient was seen in the outpatient clinic for complaints of neck pain and requests for pain medications and nutritional supplements. The nurse did not assess the patient's neck.
- In case 20, the patient had mouth pain after a biopsy procedure. The nurse did not assess the patient's mouth for any swelling, bleeding, or signs and symptoms of infection.
- In case 40, the patient said he reinjured his neck and had increased pain. The nurse did not assess the patient's neck.

- In case 44, the patient saw the nurse for abdominal pain and urinary symptoms. The nurse did not obtain a history or perform a focused assessment of the patient's complaints. The nurse also failed to perform a urinalysis.
- In case 46, the nurse saw the patient for swelling of the hands and legs. The nurse did not obtain adequate history or perform an adequate assessment of the hands and legs.

### **Failure to Refer or Inappropriate Referral to the Provider**

- In case 17, the patient saw the nurse for allergies. He arrived at SAC two months before but had not seen a provider for his chronic medical conditions. The nurse failed to recognize this lapse in care and did not refer him to the provider.
- In case 19, the nurse released the patient with chest pain back to his housing without contacting the provider.
- In case 29, the patient submitted a sick call request stating that his pain medication was not effective and that he wanted to see the provider. The patient's scheduled appointment was more than two months in the future. The nurse should have referred the patient to the provider as a routine appointment (within 14 days).
- In cases 31 and 32, the nurse did not notify the provider when the patient's blood sugar reading was elevated.
- In case 69, the patient was assaulted about two weeks before and said that he was in pain and could not see anything from the right eye. The nurse referred the patient to the provider in two weeks, but the referral should have been urgent since there was a change in vision.
- In case 74, the patient saw the nurse for abdominal pain, diarrhea for one week, headaches, and diminished urinary output. The nurse made a routine referral to the provider rather than an urgent referral as warranted by the patient's symptoms.
- In case 88, the patient had swelling and lesions on his legs. The nurse did not refer the patient to the provider and did not obtain a wound care order.

### **Failure to Follow Provider Orders**

- In case 14, the provider ordered fasting blood sugar checks in the morning and afternoon. The nurses did not check morning blood sugar at all and did not start monitoring the afternoon blood sugar until 16 days later.
- In case 27, blood pressure checks were not completed as ordered by the provider.
- In case 88, the nurses did not perform wound care as ordered.

## **Nursing Documentation**

SAC nurses often failed to document or incompletely documented important clinical information. The OIG found numerous deficiencies in this area.

- In case 19, the patient was brought to the TTA for intravenous fluid infusion. The clinic RN did not document the nursing assessment and telephone contact with the provider prior to the order to transport the patient to the TTA.
- In case 25, the clinic RN referred the patient to the TTA provider for worsening shortness of breath but did not document the events leading to the referral.
- Failure to document or incomplete documentation of pertinent information was also found in cases 2, 3, 13, 18, 24, 27, 63, 64, and 68.

## **Care Management**

A care manager is defined by CCHCS as a primary care RN who develops, implements, and evaluates patient care services and care plans for an assigned patient panel. The care manager provides direction for the assigned patient panel; collaborates with the patient one on one to develop and maintain the treatment plan; interfaces with and refers patients to other services as appropriate; reviews data and coordinates patient care activities and education; and directs the members of the care coordination team to ensure that the patients receive necessary health care services in a safe, timely, and medically appropriate manner.

SAC had one RN care manager assigned in each of the main clinics (Yards A, B, and C). In the cases reviewed, RN care management was not evident at all. The patients were usually seen by the provider for their chronic care management and by the primary care RN only for their episodic illnesses and health care needs. At the time of the OIG clinicians' visit, it was apparent that SAC had not utilized its care managers effectively. During interviews, the care managers said that their responsibilities were to back up nursing sick call, assist with urgent/emergent events, periodically follow up on provider or primary care RN referrals, perform chart reviews, and assist the nursing supervisor with nursing audits. The care managers did not have their own care management program to monitor their patients' health care needs and direct their patients to services commensurate with their needs and clinical risks.

## **Specialty Services**

The OIG clinicians reviewed 27 nursing encounters when patients returned from their specialty appointments and found only minor nursing deficiencies. Most of the telemedicine nurses' progress notes were documented on a pre-printed form. Patients returning from offsite specialty appointments were processed in the TTA and the receiving and release area. See the *Specialty Services* indicator for specific findings.

## **Emergency Services**

The OIG clinicians reviewed 74 urgent/emergent events and found 45 deficiencies related to nursing performance. The TTA nurses showed patterns of delayed emergency response, inadequate assessment and intervention, and failure to notify the provider. See the *Emergency Services* indicator for specific findings.

## **Specialized Medical Housing**

The nursing care provided in the CTC and OHU was adequate. The OIG clinicians reviewed 129 nursing encounters and found 48 deficiencies. See the *Specialized Medical Housing* indicator for specific findings.

## **Medication Administration**

The OIG clinicians found a pattern of nursing deficiencies in medication administration. See the *Pharmacy and Medication Management* indicator for specific findings.

## **Inter- and Intra-System Transfers**

There were nursing deficiencies in the transfer process, including delays in primary care provider referrals, delays in scheduling of specialty appointments, problems with medication continuity, and inadequate nurse screenings. The nursing deficiencies found for transfers out were generally related to the nurses' failure to include significant medical information on the transfer forms. See the *Inter- and Intra-System Transfers* indicator for specific findings.

## **Clinician Onsite Inspection**

The OIG clinicians attended the morning huddles on both days in the outpatient clinics. At the Yard C clinic, the supervising RN facilitated the huddle, which was attended well by the providers, primary care nurses, medication and provider line nurses, schedulers, and custody staff. In the Yards A and B clinics, the RN care manager directed the huddle. All staff members participated in the team discussion and provided information as outlined in the huddle script. The huddle topics included TTA visits, hospital admissions and discharges, new patients, specialty appointments, significant diagnostic reports, medication issues, staffing, supplies, and custody issues. However, the information provided was generally superficial, and there was no meaningful discussion of the plan of care to address patients' conditions or health care needs.

There were a total of ten outpatient care RNs assigned in the outpatient clinics and three RN care managers. The OIG clinicians visited the various clinic areas and interviewed the staff about the nursing sick call and care management processes. On an average day, each clinic received about ten sick call requests, six of which included symptom complaints. The outpatient RN generally saw about ten patients daily, including walk-ins. At the time of the OIG onsite inspection, there was no backlog in the nursing sick call. The nurses did not have problems communicating with the provider

throughout the day. RNs were also aware of the performance monitoring conducted monthly by nursing supervisors, and regularly received feedback.

The OIG clinicians visited several clinical areas and spoke with various nursing staff, including nurses in specialty services, telemedicine, utilization management, TTA, CTC, OHU, R&R, outpatient clinics, and administrative segregation units. The nursing staff verbalized having no major barriers in communication with supervisors, providers, and custody officers to meet patient care needs.

The nursing education program at SAC provided staff with the required annual training, policy update reviews, and skills improvement. Examples of these were medication administration competency, nursing protocols, and effective communication trainings. The OIG clinicians also reviewed supervisory files and found only a few staff performance issues.

### ***Recommendations***

The OIG recommends that SAC provide nurses with additional training on recognizing cases that require same-day assessment.

Care managers have a crucial role in directing and coordinating the health care services needed by the patient. The OIG recommends that SAC expand their care manager responsibilities so that they are expected to provide full and comprehensive care management as outlined by the CCHCS policy.

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## ***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:***

*Inadequate*

***Compliance Score:***

*Not Applicable*

***Overall Rating:***

*Inadequate*

### ***Case Review Results***

The OIG clinicians reviewed 256 medical provider encounters and identified 119 deficiencies related to provider performance, 39 of which were significant. Of the 30 detailed, physician-reviewed cases, 3 were *proficient*, 14 were *adequate*, and 13 were *inadequate*.

### **Assessment and Decision-Making**

Although there was evidence that SAC providers were capable of adequate assessments and sound decisions, there remained many errors in this area. Providers frequently performed poorly. Inadequate assessment or decision-making was found in cases 14, 19, 27, 28, 30, 31, 36, 37, and the following cases:

- In case 15, the provider inexplicably increased the patient's blood pressure medications, even though medical staff had not checked the patient's blood pressure in the past four months. The provider did so without seeing the patient or discussing the changes with the patient. This placed the patient at risk of drug toxicity when the patient was inadvertently administered two similar medications within a few days of the medication change.
- In case 18, the patient had right leg swelling, which may have been due to a life-threatening blood clot. The provider did not treat the patient or obtain the appropriate test until ten days later. This delay placed the patient at high risk of harm. Fortunately, the patient did not have a blood clot, and no harm occurred.
- In case 20, the provider did not assess the patient's chronic kidney disease and allowed the patient's blood pressure medication, which protected the kidneys, to expire.
- In case 22, the patient had ulcerative colitis (inflammatory bowel disease). He complained several times of continued bloody diarrhea and abdominal pain despite already taking the maximum dose of oral medicine. Even though the patient's oral treatment was failing to control the illness, the clinic provider did not consider sending the patient to the hospital for intensive intravenous treatment. During a sick call visit, the nurse informed the provider that

the patient had persistent symptoms and a fast heart rate. Despite these findings suggesting a serious systemic infection, the provider failed to perform a repeat examination and did not consider hospitalization. The patient was eventually transferred to an outside hospital, but only after experiencing a severe delay in emergency care. This case is further discussed in the *Emergency Services* indicator and the *Medical Inspection Results, Adverse Events* section.

- In case 29, the patient had right leg swelling, which also may have been due to a life-threatening blood clot. The provider did not provide precautionary treatment while the patient was waiting for test results. The provider did not obtain the appropriate test until three days later, which confirmed the presence of a blood clot. This delay of treatment placed the patient at high risk of harm. Fortunately, no harm occurred.

### **Review of Records**

A serious pattern of inadequate record review was identified in cases 3, 18, 19, 20, 22, 29, 31, and the following:

- In case 32, the patient had a history of pulmonary nodules, of which specialists had recommended biopsy three years prior. SAC providers failed to adequately review the chart, so they never ascertained that the biopsy never occurred. This issue was completely overlooked. One factor that may have contributed to this error was that the CT scan report showing the abnormalities was never scanned into the eUHR. The radiology report problem is also mentioned in the *Diagnostic Services* indicator.
- In case 37, providers did not recognize or address abnormal laboratory findings of high iron levels or high glucose levels.
- In case 38, the patient had Crohn's Disease (another type of inflammatory bowel disease), and the specialist requested an imaging test to confirm that the disease was in remission. The provider did not review the specialist's recommendations, and did not order the test. This caused a delay in care.
- In case 44, laboratory tests showed that the patient had blood in his urine. The provider did not review the abnormal results during the appointment and did not address the problem.

### **Opioid Prescribing**

SAC providers demonstrated a strong pattern of questionable opioid prescribing practices. Problems with pain management were identified in cases 3, 29, 36, and the following:

- In case 18, the pain management committee decided that opioid medications were not indicated or appropriate for the patient. However, a provider prescribed potent opioid

medications, directly counter to the committee's recommendations. Furthermore, the provider did so without performing an evaluation or appropriate physical examination.

- In case 30, the patient misrepresented his physical condition, was caught in his deception, and was found to have no need for an assistive device. Despite the patient's dishonesty and extensive substance abuse, the provider continued to prescribe opioid medications.
- In case 31, the patient had a severe substance abuse history, including methamphetamine and cocaine overdose. The provider at the institution diagnosed the patient with heroin withdrawal. The provider did not have a license to treat addiction. Nevertheless, the provider treated the withdrawal with a potent opioid medication. The provider subsequently prescribed the same medication for chronic pain. The prescription of opioid medications in this case was inappropriate.
- In case 35, the patient likely abused analgesics. The neurology specialist recommended limiting or decreasing the analgesic. Despite the diagnosis and recommendation, the provider increased the opioid instead.

Throughout the review, the pain management committee never documented its evaluations, decisions, or recommendations in patients' medical records. This poor practice left large gaps in the records.

### **Emergency Care**

TTA providers demonstrated poor emergency performance. This is further discussed in the *Emergency Services* indicator.

### **Chronic Care**

Providers performed adequately with respect to chronic care. Warfarin was managed well; laboratory monitoring and medication adjustments were performed appropriately. There was one case that demonstrated that providers did not always adequately consider overall anticoagulation management beyond warfarin medication:

- In case 29, soon after he was diagnosed with a blood clot, the patient's warfarin levels fell. After confirming the low warfarin levels with repeat tests, the provider did not start the patient on bridging heparin (another anticoagulant) therapy to lower the risk of blood clot complications.

Diabetic management performance was marginal. Providers sometimes failed to review finger stick blood glucose or order adequate follow-up intervals. When on-call providers were notified about severely out-of-control blood sugar readings, the on-call providers did not order appropriate follow-up with the primary care provider.



- In case 14, the provider did not increase the statin (cholesterol medication) when the triglycerides (blood fat often related to elevated blood glucose) were elevated. Instead, the provider prescribed gemfibrozil, which could potentially interact with the statin and increase the risk for serious side effects, such as muscle inflammation. The provider ordered a lengthy six-month follow-up interval, despite the patient's diabetes not being at goal.
- In case 31, the provider ordered follow-up intervals that were too long on three occasions. The on-call provider was notified on four occasions regarding out-of-control diabetes, but did not order a primary care provider follow-up. During one visit, the provider did not adequately review the chart, and did not adjust the insulin when needed.
- In case 32, the provider ordered follow-up intervals that were too long on four occasions. The on-call provider was notified once for out-of-control diabetes, but did not order a provider follow-up. In this case, the provider made good medication adjustments.

### **Specialized Medical Housing**

SAC providers performed adequately with CTC or OHU care. This is further discussed in the *Specialized Medical Housing* indicator.

### **Specialty Services**

SAC providers referred patients for specialty care when necessary. SAC providers generally ordered specialty services within appropriate time frames. When providers saw patients for follow-up after specialty services, they sometimes overlooked the reports. Examples of these errors were discussed earlier in this indicator, where providers often did not perform an adequate review of records.

### **Documentation Quality**

Provider emergency event documentation was extremely poor and is further discussed in the *Emergency Services* indicator. Outpatient provider documentation was much better. Nevertheless, inadequate or missing outpatient documentation was identified in cases 19, 29, 31, and 46.

### **Provider Continuity**

Provider continuity was problematic, and poor continuity was identified in cases 21, 22, 29, 34, and 37.

### **Clinician Onsite Inspection**

The institution had a high number of patients with serious mental health care needs and special security considerations. For much of 2016, only four full-time, clinic providers provided the majority of the medical care at SAC. There had been an average of four full-time physician positions vacant since October of 2014. SAC had been providing medical care with little more than half of its provider positions filled. SAC providers expressed very low morale due to the severe

provider understaffing and high stress levels. They felt overworked and did not believe they could continue providing care much longer under the current conditions. They complained that they were pulled in many directions at once, and could not dedicate sufficient consideration to each individual case. During an interview with an OIG clinician, one provider was interrupted five times for patient care questions within a span of only one hour. Providers admitted to taking clinical shortcuts, such as not documenting their telephone encounters, and not taking sufficient time to carefully review patient charts. Providers felt that their chief physician and surgeon (CP&S) was fair and knowledgeable, but only rarely aided the group by seeing patients. Given that they were severely shorthanded, providers felt that the CP&S could have provided more support by performing additional clinical work. Providers felt that the new chief medical executive (CME) was invested and was trying hard to improve their situation. Unfortunately, there had not been any tangible improvement in the provider staffing situation in the seven months since the CME had assumed the position.

The CP&S and CME described severe provider recruitment problems. SAC made at least seven employment offers to various physicians over the most recent year, but had not been able to recruit and retain a single provider. According to the CP&S, these problems with recruitment were unprecedented, and had never occurred at SAC since installment of the receivership.

The CME and CP&S explained that with the changes in retirement benefits since the California Public Employees' Pension Reform Act in 2013, total compensation packages for newly hired physicians were no longer competitive with those in the community. SAC providers confirmed that this was one major reason physicians were reluctant to join State service.

SAC providers also explained that another major obstacle for joining the prison health service was the risk of litigation. Providers felt that a complete absence of a risk management unit left providers vulnerable to litigious patients. Providers pointed out that every major health provider or hospital had a risk management unit, but that there was none in any institution. Providers did not feel at all reassured when they were informed that most of these lawsuits were frivolous and had a low probability of tainting their records. Providers felt that the combination of low retirement benefits and increased litigation risk were the primary reasons for the extreme recruitment difficulty. They also contributed to their own plans to leave the prison health care system if those concerns were not quickly addressed.

### **Clinician Summary**

The OIG clinicians found a strong pattern of errors in provider assessment and decision-making, review of records, emergency care, and pain management. Providers performed marginally in chronic care, and adequately in the CTC and OHU. Provider continuity was problematic. At the onsite inspection, the OIG clinicians identified a severe physician shortage due to serious problems with physician recruitment and retention. This shortage undoubtedly contributed to many of the errors identified. SAC providers felt that the CP&S could have provided better support by seeing more patients. As a whole, the care provided by SAC medical providers was *inadequate*.

***Recommendations***

No specific recommendations.

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

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

***Case Review Rating:***  
*Adequate*  
***Compliance Score:***  
*Proficient*  
*(100.0%)*  
***Overall Rating:***  
*Adequate*

In this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance testing resulting in a *proficient* score. After considering both case review and compliance testing results, the OIG inspection team determined the final overall rating was *adequate*. While each area's results are discussed in detail below, the result variance is due to the different testing approaches. The key factors were that the case review contained a more detailed review and focused on the quality of care provided. As a result, the case review results were deemed a more accurate reflection of the appropriate overall indicator rating.

### ***Case Review Results***

The institution had 2 medical CTC beds and 24 CTC beds dedicated to mental health. SAC also had 20 OHU beds. There were two designated negative pressure rooms, which were designed to minimize the spread of airborne infection. The OIG clinicians reviewed 14 CTC and OHU patients, including 42 provider and 129 nursing encounters. They identified 72 deficiencies, of which 12 were significant (eight instances in case 23 and once each in cases 4, 5, 85, and 86).

### ***Provider Performance (CTC, OHU)***

Provider performance was generally adequate. In the majority of cases, providers performed sufficient chart review upon patients' admission to the CTC or OHU. While providers usually performed adequate record review, occasionally they made errors in this area. Inadequate record review was identified in three cases.

CTC and OHU providers saw their patients at clinically appropriate intervals. Providers made sound assessments and decisions. Provider documentation was marginal. The OHU provider, who was also the CME, often composed scant and barely adequate documentation. The CTC provider's documentation was adequate, but it also often seemed to be cloned. Insufficient documentation was identified in four cases.

## **Nursing Performance (CTC, OHU)**

The institution's CTC nurses reported that their policy required documentation of at least two patient assessments each shift. For OHU patients, the nurses were required to document all clinical interactions and changes in level of care. Among the 14 CTC and OHU cases reviewed, there were instances of inadequate nursing assessment and intervention. In several cases, the nurses failed to complete an assessment upon the patient's admission as required by CCHCS policy. Incomplete and illegible documentation was also identified. While nursing performance in the CTC and OHU was adequate, the following cases demonstrated deficiencies:

- In case 4, the patient was admitted to the CTC for mental health placement. The patient also had fever and diarrhea. The provider gave an order to monitor the patient's vital signs, but the nurses did not check his temperature until more than ten hours later.
- In case 23, the patient was admitted to the OHU for frequent elevated blood pressure readings. The nurse did not perform an assessment upon his admission to the OHU, and the nursing care was generally poor. When the provider gave a one-time medication order to address the patient's elevated blood pressure, the nurse documented the events that led to the order. After the medication was given, the nurse did not recheck the patient's blood pressure as ordered by the provider. Nursing documentation did not reflect any nursing care or intervention performed while the patient was in the OHU. The nurses repeatedly failed to notify the provider when the patient's blood pressure readings were extremely elevated.
- In case 86, the patient returned from the hospital and required CTC care. The nurse did not inform the provider of the patient's return or obtain an order to admit the patient to the CTC. The patient was housed in the CTC without the admission order. The admission assessment form was also incomplete. One month later, the patient complained of weakness and upset stomach. The nurse did not perform an adequate assessment. The nurse also failed to monitor and assess the patient's condition for the next four hours prior to the patient's transfer back to the hospital.
- In case 89, the patient arrived at SAC and was admitted to the OHU. The nurse did not complete an admission assessment. One week later, the patient reported spitting up blood and having dizziness and chest pain. The nurse did not perform an adequate assessment and check if the medication given was effective. The provider ordered orthostatic vital signs, but the patient refused. The nurse failed to notify the provider of the patient's refusal.

Incomplete or illegible documentation was identified in eight cases.

## **Clinician Onsite Inspection**

At the time of the OIG onsite inspection, both CTC medical beds and 19 of the 20 OHU beds were filled. There was at least one RN, a medication nurse, and a certified nursing assistant assigned during each shift in the CTC. Nursing staff had immediate access to patients, and adequate custody

staff was present. During interviews, the nursing staff demonstrated knowledge of CTC policies and their specific responsibilities. The policies and procedures manual was readily accessible to staff. In the OHU, there was one RN assigned during second watch, while licensed vocational nurses (LVNs) were assigned during the first and third watches. The institution's policy required nursing documentation only when there was a clinical interaction or a change in condition. Nurses performed a complete assessment of each patient's body systems at least once per day. This was better than that required by policy, which called for an assessment of only the body system pertinent to the patient's medical problem.

### **Clinician Summary**

Provider performance in the CTC and OHU was adequate, with occasional deficiencies in documentation and insufficient review of records. Nursing performance was also adequate, with occasional deficiencies in assessment and nursing intervention. Nurses also demonstrated a pattern of incomplete and illegible documentation. The OIG clinicians rated this indicator *adequate*.

### ***Compliance Testing Results***

The institution received a *proficient* compliance score of 100 percent in the *Specialized Medical Housing* indicator, which focused on the institution's CTC and OHU.

- For the one patient for whom this test applied, nursing staff timely completed an initial assessment on the day the patient was admitted to the CTC. A provider evaluated the patient within 24 hours of his admission, and completed a history and physical within 72 hours (MIT 13.001, 13.002, 13.003).
- Inspectors tested the working order of the institution's two CTC patient room call buttons and found that one call button was working properly. Although one call button was not operational, buttons were clearly labeled and identified and a local operating procedure was in place to document 30-minute welfare checks. Staff also confirmed that staff conducted 30-minute welfare checks in the OHU. According to knowledgeable staff who regularly worked in the CTC and OHU, during an emergent event, responding staff were able to access a patient's room in less than one minute, which SAC's management believed to be reasonable. As a result, SAC received a score of 100 percent (MIT 13.101).

### ***Recommendations***

No specific recommendations.

## ***SPECIALTY SERVICES***

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

**Case Review Rating:**  
*Adequate*  
**Compliance Score:**  
*Inadequate*  
(58.6%)  
**Overall Rating:**  
*Inadequate*

In 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 those factors that led to both scores and ultimately rated this indicator *inadequate*. The compliance review identified a large number of deficiencies in five of the seven test areas. Specifically, patients' high-priority specialty services were not timely provided, and specialists' reports for both high-priority and routine specialty services were not timely reviewed by the institution's providers. These types of deficiencies, particularly regarding high-priority services, pose a high risk of negatively affecting a patient's health care. After considering the results for both compliance and case review, the OIG inspection team concluded that the compliance rating of *inadequate* was a more appropriate overall rating of this indicator.

### ***Case Review Results***

The OIG clinicians reviewed 129 events related to *Specialty Services*, which included 74 specialty consultations and procedures, 27 nursing encounters, and 13 warfarin clinic encounters. There were 33 deficiencies in this category, of which 25 were related to specialty report handling and 4 were related to nursing services. Despite a moderately high number of deficiencies in this category, only 4 of the 33 deficiencies were significant.

### ***Access to Specialty Services***

SAC performed very well with access to specialty services. Out of 74 specialty consultations and procedures, the OIG clinicians identified only one deficiency in this area. SAC performed equally well with both routine and high-priority specialty referrals. However, case review acknowledges that compliance testing found deficiencies with timely specialty appointments, specifically high-priority appointments. High-priority appointments are critical to patient care, and the results of compliance testing contributed to the overall *inadequate* score for this indicator.

## **Nursing Performance**

Patients returning from offsite specialty appointments were seen in the TTA. Patients utilizing telemedicine specialty services were assisted by a telemedicine specialty nurse. There were no patterns of deficiencies in nursing services. Nurses performed well in this area.

## **Provider Performance**

The institution's providers performed adequately when ordering specialty services. Providers usually made appropriate referrals for specialty services. They specified the proper priority on the physician request for services form for most diagnostic and consultative requests. However, providers did not provide appropriate care when evaluating patients with possible blood clots. In cases 18, and 29, providers inappropriately delayed needed tests, which placed their patients at high risk of harm. Those cases are discussed further in the *Quality of Provider Performance* indicator.

## **Health Information Management**

The SAC specialty department did well in the retrieval of specialty reports, with all relevant reports retrieved, and nearly all retrieved timely.

Most specialty reports at SAC were scanned into the eUHR without a provider's initials or date of review. This was a relatively minor finding, as SAC providers almost always reviewed the specialty reports timely and documented their review in a progress note. Case review also acknowledges that compliance testing found provider review of specialty documents to be poor, specifically high-priority documents. The compliance results in this area contributed to the overall *inadequate* score for this indicator.

## **Pharmacy and Medication Management**

There were two cases in which the patient did not receive medications that had been recommended by the specialist. These were isolated deficiencies, but were significant:

- In case 18, the ophthalmologist recommended medications for the patient's glaucoma. The provider ordered the medication, but the patient did not receive it.
- In case 86, the neurologist recommended a specialized medication, Tecfidera, which was a disease-modifying medication for multiple sclerosis. The patient spent nearly a month in the CTC waiting for utilization management to make a decision regarding the medication. The patient's symptoms progressed, and the patient was subsequently hospitalized again. This case is also discussed in the *Pharmacy and Medication Management* section.



## ***Compliance Testing Results***

The institution received an *inadequate* compliance score of 58.6 percent in the *Specialty Services* indicator. SAC scored in the *inadequate* range in the following five test areas:

- Providers timely received and reviewed only 4 of the 13 sampled specialty service consultant reports for patients who received a routine specialty service (31 percent). The providers reviewed six patients' reports 2 to 11 days late. There was no evidence that three reports were reviewed by the provider (MIT 14.004).
- When SAC denied a request for specialty services, providers did not always communicate the denial status to the patient within 30 days to provide the patient with alternate treatment strategies. Denials were timely communicated to 8 of the 19 sampled specialty service patients (42 percent). For three of the patients, providers communicated the denials from 4 to 20 days late. There was no evidence in the eUHR that the eight remaining patients were informed of the specialty services denials (MIT 14.007).
- Policy requires that, when patients are approved or scheduled for specialty services appointments at one institution and then transfer to another institution, the receiving institution ensure that the patient's appointment is timely rescheduled or scheduled, and held. Only 10 of the 20 patients sampled (50 percent) received their specialty services appointment timely. One patient received his specialty appointment 15 days late. For the other nine patients, there was no evidence found in the eUHR that the specialty service appointment was received (MIT 14.005).
- For 8 of the 15 patients sampled (53 percent), high-priority specialty services appointments occurred within 14 days of the provider's order. Seven patients received their specialty service appointments from one to 62 days late (MIT 14.001).
- When SAC providers ordered high-priority specialty services for patients, the ordering provider did not always review the specialty report within the required time frame. Providers reviewed 7 of the 13 sampled specialty reports timely (54 percent); the other six reports were reviewed two to ten days late (MIT 14.002).

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

- Among 15 patients sampled, 12 received routine specialty service appointments within 90 days of the provider's order (80 percent). Three patients' specialty service appointments were 7 to 39 days late (MIT 14.003).

SAC scored in the *proficient* range in the following test area:

- When patients did not meet the minimum requirements for a specialty service, the institution timely denied providers' specialty service requests in all 20 sampled incidents (MIT 14.006).

***Recommendations***

No specific recommendations.

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## SECONDARY (ADMINISTRATIVE) QUALITY INDICATORS OF HEALTH CARE

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

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 SAC in July 2016. They also reviewed documents obtained from the institution and from CCHCS prior to the start of the inspection. Of these two secondary indicators, OIG compliance inspectors rated both *inadequate*. The test questions used to assess compliance for each indicator are detailed in *Appendix A*.

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## ***INTERNAL MONITORING, QUALITY IMPROVEMENT, AND ADMINISTRATIVE OPERATIONS***

This indicator focuses on the institution’s administrative health care oversight functions. The OIG evaluates whether the institution promptly processes patient medical appeals and addresses all appealed issues. Inspectors also verify that the institution follows reporting requirements for adverse/sentinel events and patient 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.

***Case Review Rating:***  
*Not Applicable*  
***Compliance Score:***  
*Inadequate*  
*(71.8%)*  
***Overall Rating:***  
*Inadequate*

### ***Compliance Testing Results***

The institution received an *inadequate* compliance score of 71.8 percent in this indicator. The following areas showed room for improvement:

- The institution had not taken adequate steps to ensure the accuracy of its Dashboard data. Although the institution provided substantial evidence of discussion of the methodologies used to conduct periodic data validation and the results of that data validation testing, the QMC meetings did not discuss methodologies used to train staff who collected Dashboard data and, therefore, SAC received a score of zero (MIT 15.004).
- The OIG reviewed data received from the institution to determine if SAC timely processed at least 95 percent of its monthly patient medical appeals during the most recent 12-month period. SAC timely processed only 5 of the 12 months’ appeals reviewed (42 percent). Of the seven months with more than 5 percent of medical appeals in overdue status, the percentages ranged from 6 to 28 percent (MIT 15.001).
- Inspectors reviewed drill packages for three medical emergency response drills conducted in the prior quarter. Only two of the three drill packages were properly completed (67 percent). For one drill package, staff did not complete the Medical Report of Injury or Unusual Occurrence (CDCR Form 7219) (MIT 15.101).
- SAC’s 2015 Performance Improvement Work Plan included sufficient information demonstrating SAC’s improvement or achievement of targeted performance objectives for five of the seven sampled quality improvement initiatives (71 percent) (MIT 15.005).

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

- Inspectors reviewed the last 12 months of SAC's local governing body (LGB) meeting minutes and determined that the LGB met at least quarterly. Although SAC exercised responsibility for the quality management of patient health care each quarter, the meeting minutes for the most recent quarter were not timely approved. As a result, SAC scored 75 percent on this test (MIT 15.006).

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

- Based on a sample of ten second-level medical appeals, the institution's responses addressed all of the patients' appealed issues (MIT 15.102).
- SAC's QMC met monthly, evaluated program performance, and took action when improvement opportunities were identified (MIT 15.003).
- Medical staff promptly submitted the Initial Inmate Death Report (CDCR Form 7229A) to CCHCS's Death Review Unit for all five applicable deaths that occurred at SAC in the prior 12-month period (MIT 15.103).
- The OIG inspected incident review packages for 12 emergency medical response incidents reviewed by SAC's EMRRC during the prior 12-month period. Eleven of the sampled incident packages (92 percent) complied with policy. Only one of the 11 sampled incident packages was not timely reviewed at the next scheduled committee meeting (MIT 15.007).

#### **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 five deaths that occurred during the testing period. As discussed below, CCHCS changed its death review reporting time frames for deaths that occurred on or after November 1, 2015 (MIT 15.996):
  - Prior to November 1, 2015, the DRC was required to complete a death review summary within 30 business days of the patient's death. The OIG allowed five additional business days for that communication. Of the three deaths that occurred at SAC prior to November 1, 2015, one review was provided to the CEO 258 days late (300 days after the death). Another report was provided to the CEO two days late (173 days after the death). For the third death, a final death review summary had not been completed and was untimely as of the time of this report.
  - Beginning November 1, 2015, the DRC is required to complete a death review summary report 60 calendar days after a death occurs for a Level I (unexpected death) Review, or 30 calendar days for a Level II (expected death) Review. The OIG allowed seven

additional calendar days for that communication. Of the two Level I deaths that occurred at SAC on or after November 1, 2015, one review was completed 26 days late (86 calendar days after date of death) but was timely provided to the CEO. For the second Level I death, a final death review summary had not been completed and was untimely as of the time of this report.

- Inspectors met with the CEO to inquire about the institution's protocols for tracking appeals. The health care appeals coordinator provided management staff with weekly routine medical appeal reports tracked by date and number of pending appeals. The reports did not include a listing of appeal subject areas ranked by number of appeals filed. The CEO stated the institution was in the process of developing a system to utilize reports to track potential problem areas as identified within the appeals. During the six months preceding the OIG's inspection, the CEO identified pain medication management as an example of a problem area that was substantiated. Management considered this a critical area and took action to remedy it. Mental health and medical providers met as a team to develop techniques to better manage the use of pain medication (MIT 15.997).
- Informational data regarding SAC's practices for implementing local operating procedures (LOPs) was obtained from the institution's CEO and health program specialist (HPS). The HPS, in collaboration with subject matter experts, was responsible for reviewing new or revised statewide policies and procedures and determining what, if any, impact they had on SAC's existing LOPs, and modifying or developing new LOPs if needed. To ensure the timely communication of new or modified LOPs to all health care staff, they were disseminated via e-mail, posted for review on a shared drive, and discussed at various meetings and morning huddles. Fifteen sampled LOPs were verified. Documentation for each of the LOPs tested was supported by an original signed copy and was approved and operational, with the exception of the Chronic Illness Care and Clinical Guidelines LOPs. At the time of OIG's inspection, SAC had implemented 46 of the 47 applicable stakeholder-recommended LOPs (98 percent) (MIT 15.998).
- The institution's health care staffing resources are discussed in the *About the Institution* section on page 2 (MIT 15.999).

## ***Recommendations***

No specific recommendations.

## ***JOB PERFORMANCE, TRAINING, LICENSING, AND CERTIFICATIONS***

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

***Case Review Rating:***  
*Not Applicable*  
***Compliance Score:***  
*Inadequate*  
*(71.7%)*  
***Overall Rating:***  
*Inadequate*

### ***Compliance Testing Results***

The institution received an *inadequate* compliance score of 71.7 percent in the *Job Performance, Training, Licensing, and Certifications* indicator. The following areas showed room for improvement:

- Inspectors examined nursing supervisors' performance evaluation reviews conducted for five nurses during May 2016. In four of the five nurse reviews, the supervisor did not document aspects of nursing care that were done well. Of those four, three did not include summarized aspects needing improvement. For the remaining one of five nurse reviews, the supervisor did not complete the monthly audit tool. As a result, SAC scored zero on this test (MIT 16.101).
- The OIG tested provider, nursing, and custody staff records to determine if the institution ensured that those staff members had current emergency response certifications. SAC's provider and nursing staff were all compliant with the exception of one provider who was placed in a non-patient care status due to an expired ACLS certification. Custody staff did not always have current certifications. Four officers were not current with their CPR certifications. In addition, managerial custody officers above the rank of captain did not have current certifications. While California Penal Code exempts custody managers who primarily perform managerial duties from medical emergency response certification training, CCHCS policy does not allow for such an exemption. As a result, the institution received a score of 33 percent in this inspection area (MIT 16.104).
- Two of the five providers had a proper clinical performance appraisal completed (40 percent). For two providers, the reviewing supervisor did not date the most recent performance evaluation. For one other provider, the required Unit Health Record Clinical Appraisals and the 360 Degree and Core Competency Evaluations were not completed (MIT 16.103).

SAC scored 100 percent in the following tests:

- All providers at the institution were current with their professional licenses. Similarly, all nursing staff and the pharmacist in charge were current with their professional licenses and certification requirements (MIT 16.001, 16.105).
- All ten nurses sampled who administered medications possessed current clinical competency validations, and all nursing staff hired within the last year timely received new employee orientation training (MIT 16.102, 16.107).
- All pharmacy and providers who prescribed controlled substances had current Drug Enforcement Agency registrations (MIT 16.106).

### ***Recommendations***

The OIG recommends the institution ensure that all providers have a current ACLS certification, and all custody officers above the rank of captain have a current CPR certification.

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## **POPULATION-BASED METRICS**

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

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

### ***Methodology***

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

### ***Comparison of Population-Based Metrics***

For California State Prison, Sacramento, nine HEDIS measures were selected and are listed in the following *SAC 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. SAC performed well in the management of diabetes.

When compared to health care organizations in California, SAC outperformed Medi-Cal in all five diabetic measures selected, and outperformed Kaiser Permanente (both Northern and Southern California regions) in all diabetic measures except blood pressure control and eye exams. When compared nationally, SAC outperformed Medicaid and commercial health plans in each of the five diabetic measures listed. In addition, SAC outperformed Medicare and the U.S. Department of Veterans Affairs (VA) in all applicable diabetic measures except eye exams.

### **Immunizations**

Comparative data for immunizations was only fully available for the VA and partially available for Kaiser Permanente, Medicare, and commercial entities. Regarding the administration of influenza vaccinations to younger adults, SAC scored lower than all other health care organizations. However, this was largely due to a refusal rate of 50 percent for sampled patients. For administering influenza vaccinations to adults aged 65 and older, the institution scored lower than Medicare and the VA by 9 and 13 percentage points, respectively. The 37 percent refusal rate negatively affected the institutions score. With regard to administering pneumococcal vaccines to older adults, SAC scored higher than Medicare but lower than the VA by 22 percentage points. A possible reason for the lower score may have been a result of 23 percent of the patients were never offered the pneumococcal vaccination.

### **Cancer Screening**

For colorectal cancer screening, SAC's scores were lower than the scores of Kaiser and the VA by 13 and 15 percentage points. SAC outperformed commercial entities and matched Medicare in this measure. The 28 percent patient refusal rate for colorectal cancer screening negatively affected the institutions score for this measure.

### **Summary**

Overall, SAC's performance as measured by population-based metrics reflects an adequate chronic care program. Patients refusing to receive the services significantly affected the institution's scores for immunizations for influenza vaccinations and for cancer screenings. SAC has an opportunity to improve its scores by making interventions to lower the rate of patient refusals by education patients on the benefits of immunizations and cancer screenings.

## SAC Results Compared to State and National HEDIS Scores

Clinical Measures	California				National			
	SAC Cycle 4 Results <sup>1</sup>	HEDIS Medi- Cal 2015 <sup>2</sup>	Kaiser (No.CA) HEDIS Scores 2015 <sup>3</sup>	Kaiser (So.CA) HEDIS Scores 2015 <sup>3</sup>	HEDIS Medicaid 2015 <sup>4</sup>	HEDIS Com- mercial 2015 <sup>4</sup>	HEDIS Medicare 2015 <sup>4</sup>	VA Average 2014 <sup>5</sup>
<b>Comprehensive Diabetes Care</b>								
HbA1c Testing (Monitoring)	100%	86%	95%	94%	86%	91%	93%	99%
Poor HbA1c Control (>9.0%) <sup>6,7</sup>	9%	39%	18%	24%	44%	31%	25%	19%
HbA1c Control (<8.0%) <sup>6</sup>	77%	49%	70%	62%	47%	58%	65%	-
Blood Pressure Control (<140/90)	80%	63%	84%	85%	62%	65%	65%	78%
Eye Exams	63%	53%	69%	81%	54%	56%	69%	90%
<b>Immunizations</b>								
Influenza Shots - Adults (18–64)	48%	-	54%	55%	-	50%	-	58%
Influenza Shots - Adults (65+)	63%	-	-	-	-	-	72%	76%
Immunizations: Pneumococcal	71%	-	-	-	-	-	70%	93%
<b>Cancer Screening</b>								
Colorectal Cancer Screening	67%	-	80%	82%	-	64%	67%	82%

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

2. HEDIS Medi-Cal data was obtained from the California Department of Health Care Services 2015 *HEDIS Aggregate Report for 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](http://www.ncqa.org). The results for commercial plans were based on data received from various health maintenance organizations.

5. The Department of Veterans Affairs (VA) data was obtained from the VA’s website, [www.va.gov](http://www.va.gov). For the Immunizations: Pneumococcal measure only, the data was obtained from the *VHA Facility Quality and Safety Report - Fiscal Year 2014*.

6. For this measure, the entire applicable SAC population was tested.

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

## APPENDIX A — COMPLIANCE TEST RESULTS

<b>California State Prison-Sacramento</b> <b>Range of Summary Scores: 55.47%–100%</b>	
<b>Indicator</b>	<b>Compliance Score (Yes %)</b>
<i>Access to Care</i>	82.38%
<i>Diagnostic Services</i>	73.21%
<i>Emergency Services</i>	Not Applicable
<i>Health Information Management (Medical Records)</i>	55.47%
<i>Health Care Environment</i>	65.49%
<i>Inter- and Intra-System Transfers</i>	84.70%
<i>Pharmacy and Medication Management</i>	63.02%
<i>Prenatal and Post-Delivery Services</i>	Not Applicable
<i>Preventive Services</i>	62.22%
<i>Quality of Nursing Performance</i>	Not Applicable
<i>Quality of Provider Performance</i>	Not Applicable
<i>Reception Center Arrivals</i>	Not Applicable
<i>Specialized Medical Housing (OHU, CTC, SNF, Hospice)</i>	100.00%
<i>Specialty Services</i>	58.58%
<i>Internal Monitoring, Quality Improvement, and Administrative Operations</i>	71.83%
<i>Job Performance, Training, Licensing, and Certifications</i>	71.67%

Reference Number	<i>Access to Care</i>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
1.001	<b>Chronic care follow-up appointments:</b> Was the patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter?	32	8	40	80.00%	0
1.002	<b>For endorsed inmate-patients received from another CDCR institution:</b> 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?	10	12	22	45.45%	8
1.003	<b>Clinical appointments:</b> Did a registered nurse review the inmate-patient's request for service the same day it was received?	35	0	35	100.00%	0
1.004	<b>Clinical appointments:</b> Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed?	34	1	35	97.14%	0
1.005	<b>Clinical appointments:</b> 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?	12	2	14	85.71%	21
1.006	<b>Sick call follow-up appointments:</b> If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified?	6	1	7	85.71%	28
1.007	<b>Upon the inmate-patient's discharge from the community hospital:</b> Did the inmate-patient receive a follow-up appointment within the required time frame?	20	8	28	71.43%	0
1.008	<b>Specialty service follow-up appointments:</b> Do specialty service primary care physician follow-up visits occur within required time frames?	19	6	25	76.00%	5
1.101	<b>Clinical appointments:</b> Do inmate-patients have a standardized process to obtain and submit health care services request forms?	6	0	6	100.00%	0
<b>Overall Percentage:</b>					<b>82.38%</b>	

Reference Number	<i>Diagnostic Services</i>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
2.001	<b>Radiology:</b> Was the radiology service provided within the time frame specified in the provider's order?	8	1	9	88.89%	1
2.002	<b>Radiology:</b> Did the primary care provider review and initial the diagnostic report within specified time frames?	8	2	10	80.00%	0
2.003	<b>Radiology:</b> 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	<b>Laboratory:</b> Was the laboratory service provided within the time frame specified in the provider's order?	9	1	10	90.00%	0
2.005	<b>Laboratory:</b> Did the primary care provider review and initial the diagnostic report within specified time frames?	9	1	10	90.00%	0
2.006	<b>Laboratory:</b> Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	8	2	10	80.00%	0
2.007	<b>Pathology:</b> Did the institution receive the final diagnostic report within the required time frames?	9	1	10	90.00%	0
2.008	<b>Pathology:</b> Did the primary care provider review and initial the diagnostic report within specified time frames?	0	10	10	0.00%	0
2.009	<b>Pathology:</b> Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	4	6	10	40.00%	0
<b>Overall Percentage:</b>					<b>73.21%</b>	

<i>Emergency Services</i>	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.	<b>Not Applicable</b>

Reference Number	<i>Health Information Management (Medical Records)</i>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated progress notes, initial health screening forms, and health care service request forms scanned into the eUHR within three calendar days of the inmate-patient encounter date?	19	1	20	95.00%	0
4.002	Are dictated / transcribed documents scanned into the eUHR within five calendar days of the inmate-patient encounter date?	1	10	11	9.09%	0
4.003	Are specialty documents scanned into the eUHR within the required time frame?	20	0	20	100.00%	0
4.004	Are community hospital discharge documents scanned into the eUHR within three calendar days of the inmate-patient date of hospital discharge?	25	3	28	89.29%	0
4.005	Are medication administration records (MARs) scanned into the eUHR within the required time frames?	4	16	20	20.00%	0
4.006	During the eUHR review, did the OIG find that documents were correctly labeled and included in the correct inmate-patient's file?	0	12	12	0.00%	0
4.007	Did clinical staff legibly sign health care records, when required?	28	4	32	87.50%	0
4.008	<b>For inmate-patients discharged from a community hospital:</b> Did the preliminary hospital discharge report include key elements and did a PCP review the report within three calendar days of discharge?	12	16	28	42.86%	0
<b>Overall Percentage:</b>					<b>55.47%</b>	

Reference Number	<i>Health Care Environment</i>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
5.101	<b>Infection Control:</b> Are clinical health care areas appropriately disinfected, cleaned and sanitary?	20	0	20	100.00%	2
5.102	<b>Infection control:</b> Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	18	1	19	94.74%	3
5.103	<b>Infection Control:</b> Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	18	3	21	85.71%	1
5.104	<b>Infection control:</b> Does clinical health care staff adhere to universal hand hygiene precautions?	7	9	16	43.75%	6
5.105	<b>Infection control:</b> Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	19	2	21	90.48%	1
5.106	<b>Warehouse, Conex and other non-clinic storage areas:</b> Does the medical supply management process adequately support the needs of the medical health care program?	1	0	1	100.00%	0
5.107	<b>Clinical areas:</b> Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	14	7	21	66.67%	1
5.108	<b>Clinical areas:</b> Do clinic common areas and exam rooms have essential core medical equipment and supplies?	8	13	21	38.10%	1
5.109	<b>Clinical areas:</b> Do clinic common areas have an adequate environment conducive to providing medical services?	16	5	21	76.19%	1
5.110	<b>Clinical areas:</b> Do clinic exam rooms have an adequate environment conducive to providing medical services?	1	20	21	4.76%	1
5.111	<b>Emergency response bags:</b> Are TTA and clinic emergency medical response bags inspected daily and inventoried monthly, and do they contain essential items?	2	8	10	20.00%	12
<b>Overall Percentage:</b>					<b>65.49%</b>	



Reference Number	<i>Inter- and Intra-System Transfers</i>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
6.001	<b>For endorsed inmate-patients received from another CDCR institution or COCF:</b> Did nursing staff complete the initial health screening and answer all screening questions on the same day the inmate-patient arrived at the institution?	24	6	30	80.00%	0
6.002	<b>For endorsed inmate-patients received from another CDCR institution or COCF:</b> 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	<b>For endorsed inmate-patients received from another CDCR institution or COCF:</b> If the inmate-patient had an existing medication order upon arrival, were medications administered or delivered without interruption?	18	4	22	81.82%	8
6.004	<b>For inmate-patients transferred out of the facility:</b> Were scheduled specialty service appointments identified on the Health Care Transfer Information Form 7371?	13	7	20	65.00%	0
6.101	<b>For inmate-patients transferred out of the facility:</b> Do medication transfer packages include required medications along with the corresponding Medication Administration Record (MAR) and Medication Reconciliation?	4	0	4	100.00%	2
<b>Overall Percentage:</b>					<b>84.70%</b>	

Reference Number	<i>Pharmacy and Medication Management</i>	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?	20	10	30	66.67%	10
7.002	Did health care staff administer or deliver new order prescription medications to the inmate-patient within the required time frames?	37	3	40	92.50%	0
7.003	<b>Upon the inmate-patient's discharge from a community hospital:</b> Were all medications ordered by the institution's primary care provider administered or delivered to the inmate-patient within one calendar day of return?	15	12	27	55.56%	1
7.004	<b>For inmate-patients received from a county jail:</b> 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	<b>Upon the inmate-patient's transfer from one housing unit to another:</b> Were medications continued without interruption?	27	3	30	90.00%	0
7.006	<b>For inmate-patients en route who lay over at the institution:</b> If the temporarily housed inmate-patient had an existing medication order, were medications administered or delivered without interruption?	3	7	10	30.00%	0
7.101	<b>All clinical and medication line storage areas for narcotic medications:</b> Does the institution employ strong medication security controls over narcotic medications assigned to its clinical areas?	2	10	12	16.67%	18
7.102	<b>All clinical and medication line storage areas for non-narcotic medications:</b> Does the institution properly store non-narcotic medications that do not require refrigeration in assigned clinical areas?	7	12	19	36.84%	11
7.103	<b>All clinical and medication line storage areas for non-narcotic medications:</b> Does the institution properly store non-narcotic medications that require refrigeration in assigned clinical areas?	1	16	17	5.88%	13
7.104	<b>Medication preparation and administration areas:</b> Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes?	5	3	8	62.50%	22
7.105	<b>Medication preparation and administration areas:</b> Does the institution employ appropriate administrative controls and protocols when preparing medications for inmate-patients?	8	0	8	100.00%	22
7.106	<b>Medication preparation and administration areas:</b> Does the institution employ appropriate administrative controls and protocols when distributing medications to inmate-patients?	6	2	8	75.00%	22
7.107	<b>Pharmacy:</b> Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and satellite pharmacies?	1	0	1	100.00%	0

Reference Number	<i>Pharmacy and Medication Management</i>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.108	<b>Pharmacy:</b> Does the institution's pharmacy properly store non-refrigerated medications?	0	1	1	0.00%	0
7.109	<b>Pharmacy:</b> Does the institution's pharmacy properly store refrigerated or frozen medications?	1	0	1	100.00%	0
7.110	<b>Pharmacy:</b> Does the institution's pharmacy properly account for narcotic medications?	1	0	1	100.00%	0
7.111	<b>Pharmacy:</b> Does the institution follow key medication error reporting protocols?	23	7	30	76.67%	0
7.998	<b>For Information Purposes Only:</b> 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	<b>For Information Purposes Only:</b> Do inmate-patients in isolation housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications?	Information Only				
<b>Overall Percentage:</b>					<b>63.02%</b>	

<b><i>Prenatal and Post-Delivery Services</i></b>	<b>Scored Answers</b>
This indicator is not applicable to this institution.	<b>Not Applicable</b>

Reference Number	<b><i>Preventive Services</i></b>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
9.001	<b>Inmate-patients prescribed TB medications:</b> Did the institution administer the medication to the inmate-patient as prescribed?	6	4	10	60.00%	0
9.002	<b>Inmate-patients prescribed TB medications:</b> Did the institution monitor the inmate-patient monthly for the most recent three months he or she was on the medication?	1	9	10	10.00%	0
9.003	<b>Annual TB Screening:</b> Was the inmate-patient screened for TB within the last year?	10	20	30	33.33%	0
9.004	Were all inmate-patients offered an influenza vaccination for the most recent influenza season?	29	1	30	96.67%	0
9.005	<b>All inmate-patients from the age of 50 through the age of 75:</b> Was the inmate-patient offered colorectal cancer screening?	27	3	30	90.00%	0
9.006	<b>Female inmate-patients from the age of 50 through the age of 74:</b> Was the inmate-patient offered a mammogram in compliance with policy?	Not Applicable				
9.007	<b>Female inmate-patients from the age of 21 through the age of 65:</b> 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?	20	4	24	83.33%	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				
<b>Overall Percentage:</b>					<b>62.22%</b>	

<i>Quality of Nursing Performance</i>	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.	<b>Not Applicable</b>

<i>Quality of Provider Performance</i>	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.	<b>Not Applicable</b>

<i>Reception Center Arrivals</i>	Scored Answers
This indicator is not applicable to this institution.	<b>Not Applicable</b>

Reference Number	<b>Specialized Medical Housing (OHU, CTC, SNF, Hospice)</b>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	<b>For all higher-level care facilities:</b> 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?	1	0	1	100.00%	0
13.002	<b>For OHU, CTC, &amp; SNF only:</b> Did the primary care provider for OHU or attending physician for a CTC & SNF evaluate the inmate-patient within 24 hours of admission?	1	0	1	100.00%	0
13.003	<b>For OHU, CTC, &amp; SNF only:</b> Was a written history and physical examination completed within 72 hours of admission?	1	0	1	100.00%	0
13.004	<b>For all higher-level care facilities:</b> 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?	Not Applicable				1
13.101	<b>For OHU and CTC Only:</b> 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?	4	0	4	100.00%	0
<b>Overall Percentage:</b>					<b>100.00%</b>	

Reference Number	<i>Specialty Services</i>	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?	8	7	15	53.33%	0
14.002	Did the PCP review the high priority specialty service consultant report within the required time frame?	7	6	13	53.85%	2
14.003	Did the inmate-patient receive the routine specialty service within 90 calendar days of the PCP order?	12	3	15	80.00%	0
14.004	Did the PCP review the routine specialty service consultant report within the required time frame?	4	9	13	30.77%	2
14.005	<b>For endorsed inmate-patients received from another CDCR institution:</b> 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?	10	10	20	50.00%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	20	0	20	100.00%	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?	8	11	19	42.11%	1
<b>Overall Percentage:</b>					<b>58.58%</b>	

Reference Number	<i>Internal Monitoring, Quality Improvement, and Administrative Operations</i>	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?	5	7	12	41.67%	0
15.002	Does the institution follow adverse/sentinel event reporting requirements?	Not Applicable				1
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)?	5	2	7	71.43%	2
15.006	<b>For institutions with licensed care facilities:</b> 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?	11	1	12	91.67%	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?	2	1	3	66.67%	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?	5	0	5	100.00%	0
15.996	<b>For Information Purposes Only:</b> Did the CCHCS Death Review Committee submit its inmate death review summary to the institution timely?	Information Only				
15.997	<b>For Information Purposes Only:</b> Identify the institution's protocols for tracking medical appeals.	Information Only				
15.998	<b>For Information Purposes Only:</b> Identify the institution's protocols for implementing health care local operating procedures.	Information Only				
15.999	<b>For Information Purposes Only:</b> Identify the institution's health care staffing resources.	Information Only				
<b>Overall Percentage:</b>					<b>71.83%</b>	



Reference Number	<i>Job Performance, Training, Licensing, and Certifications</i>	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
16.001	Do all providers maintain a current medical license?	12	0	12	100.00%	0
16.101	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	0	5	5	0.00%	0
16.102	Are nursing staff who administer medications current on their clinical competency validation?	10	0	10	100.00%	0
16.103	Are structured clinical performance appraisals completed timely?	2	3	5	40.00%	0
16.104	Are staff current with required medical emergency response certifications?	1	2	3	33.33%	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
<b>Overall Percentage:</b>					<b>71.67%</b>	

## APPENDIX B — CLINICAL DATA

<b>Table B-1: SAC Sample Sets</b>	
<b>Sample Set</b>	<b>Total</b>
Anticoagulation	3
CTC/OHU	6
Death Review/Sentinel Events	5
Diabetes	3
Emergency Services – CPR	1
Emergency Services – Non-CPR	5
High Risk	5
Hospitalization	5
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	45
Specialty Services	5
	<b>89</b>

**Table B-2: SAC Chronic Care Diagnoses**

<b>Diagnosis</b>	<b>Total</b>
Anemia	2
Anticoagulation	3
Arthritis/Degenerative Joint Disease	11
Asthma	13
COPD	5
Cancer	6
Cardiovascular Disease	7
Chronic Kidney Disease	10
Chronic Pain	22
Cirrhosis/End-Stage Liver Disease	6
Coccidioidomycosis	1
DVT/PE	4
Deep Venous Thrombosis/Pulmonary Embolism	1
Diabetes	17
Gastroesophageal Reflux Disease	15
HIV	4
Hepatitis C	32
Hyperlipidemia	24
Hypertension	44
Mental Health	25
Migraine Headaches	1
Rheumatological Disease	2
Seizure Disorder	8
Sleep Apnea	1
Thyroid Disease	9
	<b>273</b>

**Table B-3: SAC Event — Program**

<b>Program</b>	<b>Total</b>
Diagnostic Services	176
Emergency Care	87
Hospitalization	33
Intra-System Transfers In	24
Intra-System Transfers Out	11
Outpatient Care	556
Specialized Medical Housing	194
Specialty Services	129
	<b>1,210</b>

**Table B-4: SAC Review Sample Summary**

	<b>Total</b>
MD Reviews Detailed	30
MD Reviews Focused	5
RN Reviews Detailed	20
RN Reviews Focused	57
Total Reviews	112
Total Unique Cases	89
Overlapping Reviews (MD & RN)	23

## APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

California State Prison-Sacramento			
Quality Indicator	Sample Category (number of samples)	Data Source	Filters
<i>Access to Care</i>			
MIT 1.001	Chronic Care Patients (40)	Master Registry	<ul style="list-style-type: none"> <li>• Chronic care conditions (at least one condition per patient—any risk level)</li> <li>• <b>Randomize</b></li> </ul>
MIT 1.002	Nursing Referrals (30)	OIG Q: 6.001	<ul style="list-style-type: none"> <li>• See <i>Intra-system Transfers</i></li> </ul>
MITs 1.003-006	Nursing Sick Call (5 per clinic) 35	MedSATS	<ul style="list-style-type: none"> <li>• Clinic (each clinic tested)</li> <li>• Appointment date (2–9 months)</li> <li>• <b>Randomize</b></li> </ul>
MIT 1.007	Returns from Community Hospital (28)	OIG Q: 4.008	<ul style="list-style-type: none"> <li>• See <i>Health Information Management (Medical Records)</i> (returns from community hospital)</li> </ul>
MIT 1.008	Specialty Services Follow-up (30)	OIG Q: 14.001 & 14.003	<ul style="list-style-type: none"> <li>• See <i>Specialty Services</i></li> </ul>
MIT 1.101	Availability of Health Care Services Request Forms (6)	OIG onsite review	<ul style="list-style-type: none"> <li>• Randomly select one housing unit from each yard</li> </ul>
<i>Diagnostic Services</i>			
MITs 2.001–003	Radiology (10)	Radiology Logs	<ul style="list-style-type: none"> <li>• Appointment date (90 days–9 months)</li> <li>• <b>Randomize</b></li> <li>• Abnormal</li> </ul>
MITs 2.004–006	Laboratory (10)	Quest	<ul style="list-style-type: none"> <li>• Appt. date (90 days–9 months)</li> <li>• Order name (CBC or CMPs only)</li> <li>• <b>Randomize</b></li> <li>• Abnormal</li> </ul>
MITs 2.007–009	Pathology (10)	InterQual	<ul style="list-style-type: none"> <li>• Appt. date (90 days–9 months)</li> <li>• Service (pathology related)</li> <li>• <b>Randomize</b></li> </ul>

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
<b>Health Information Management (Medical Records)</b>			
MIT 4.001	Timely Scanning (20)	OIG Qs: 1.001, 1.002, & 1.004	<ul style="list-style-type: none"> <li>Non-dictated documents</li> <li>1<sup>st</sup> 10 IPs MIT 1.001, 1<sup>st</sup> 5 IPs MITs 1.002, 1.004</li> </ul>
MIT 4.002	(11)	OIG Q: 1.001	<ul style="list-style-type: none"> <li>Dictated documents</li> <li>First 20 IPs selected</li> </ul>
MIT 4.003	(20)	OIG Qs: 14.002 & 14.004	<ul style="list-style-type: none"> <li>Specialty documents</li> <li>First 10 IPs for each question</li> </ul>
MIT 4.004	(28)	OIG Q: 4.008	<ul style="list-style-type: none"> <li>Community hospital discharge documents</li> <li>First 20 IPs selected</li> </ul>
MIT 4.005	(20)	OIG Q: 7.001	<ul style="list-style-type: none"> <li>MARs</li> <li>First 20 IPs selected</li> </ul>
MIT 4.006	(12)	Documents for any tested inmate	<ul style="list-style-type: none"> <li>Any misfiled or mislabeled document identified during OIG compliance review (12 or more = No)</li> </ul>
MIT 4.007	Legible Signatures & Review (52)	OIG Qs: 4.008, 6.001, 6.002, 7.001, 12.001, 12.002 & 14.002	<ul style="list-style-type: none"> <li>First 8 IPs sampled</li> <li>One source document per IP</li> </ul>
MIT 4.008	Returns From Community Hospital  (28)	Inpatient claims data	<ul style="list-style-type: none"> <li>Date (2–8 months)</li> <li>Most recent 6 months provided (within date range)</li> <li>Rx count</li> <li>Discharge date</li> <li><b>Randomize</b> (each month individually)</li> <li>First 5 patients from each of the 6 months (if not 5 in a month, supplement from another, as needed)</li> </ul>
<b>Health Care Environment</b>			
MIT 5.101-105 MIT 5.107–111	Clinical Areas (22)	OIG inspector onsite review	<ul style="list-style-type: none"> <li>Identify and inspect all onsite clinical areas.</li> </ul>
<b>Inter- and Intra-System Transfers</b>			
MIT 6.001-003	Intra-System Transfers  (30)	SOMS	<ul style="list-style-type: none"> <li>Arrival date (3–9 months)</li> <li>Arrived from (another CDCR facility)</li> <li>Rx count</li> <li><b>Randomize</b></li> </ul>
MIT 6.004	Specialty Services Send-Outs (20)	MedSATS	<ul style="list-style-type: none"> <li>Date of transfer (3–9 months)</li> <li><b>Randomize</b></li> </ul>
MIT 6.101	Transfers Out (6)	OIG inspector onsite review	<ul style="list-style-type: none"> <li>R&amp;R IP transfers with medication</li> </ul>

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
<b>Pharmacy and Medication Management</b>			
MIT 7.001	Chronic Care Medication (40)	OIG Q: 1.001	<ul style="list-style-type: none"> <li>See <i>Access to Care</i></li> <li>At least one condition per patient—any risk level</li> <li><b>Randomize</b></li> </ul>
MIT 7.002	New Medication Orders (40)	Master Registry	<ul style="list-style-type: none"> <li>Rx count</li> <li><b>Randomize</b></li> <li>Ensure no duplication of IPs tested in MIT 7.001</li> </ul>
MIT 7.003	Returns from Community Hospital (28)	OIG Q: 4.008	<ul style="list-style-type: none"> <li>See <i>Health Information Management (Medical Records)</i> (returns from community hospital)</li> </ul>
MIT 7.004	RC Arrivals – Medication Orders <i>N/A at this institution</i>	OIG Q: 12.001	<ul style="list-style-type: none"> <li>See <i>Reception Center Arrivals</i></li> </ul>
MIT 7.005	Intra-Facility Moves (30)	MAPIP transfer data	<ul style="list-style-type: none"> <li>Date of transfer (2–8 months)</li> <li>To location/from location (yard to yard and to/from ASU)</li> <li>Remove any to/from MHCB</li> <li>NA/DOT meds (and risk level)</li> <li><b>Randomize</b></li> </ul>
MIT 7.006	En Route (10)	SOMS	<ul style="list-style-type: none"> <li>Date of transfer (2–8 months)</li> <li>Sending institution (another CDCR facility)</li> <li><b>Randomize</b></li> <li>NA/DOT meds</li> </ul>
MITs 7.101-103	Medication Storage Areas (varies by test)	OIG inspector onsite review	<ul style="list-style-type: none"> <li>Identify and inspect clinical &amp; med line areas that store medications</li> </ul>
MITs 7.104–106	Medication Preparation and Administration Areas (varies by test)	OIG inspector onsite review	<ul style="list-style-type: none"> <li>Identify and inspect onsite clinical areas that prepare and administer medications</li> </ul>
MITs 7.107-110	Pharmacy (1)	OIG inspector onsite review	<ul style="list-style-type: none"> <li>Identify &amp; inspect all onsite pharmacies</li> </ul>
MIT 7.111	Medication Error Reporting (30)	Monthly medication error reports	<ul style="list-style-type: none"> <li>All monthly statistic reports with Level 4 or higher</li> <li>Select a total of 5 months</li> </ul>
MIT 7.999	Isolation Unit KOP Medications (26)	Onsite active medication listing	<ul style="list-style-type: none"> <li>KOP rescue inhalers &amp; nitroglycerin medications for IPs housed in isolation units</li> </ul>
<b>Prenatal and Post-Delivery Services</b>			
MIT 8.001-007	Recent Deliveries <i>N/A at this institution</i>	OB Roster	<ul style="list-style-type: none"> <li>Delivery date (2–12 months)</li> <li><b>Most recent</b> deliveries (within date range)</li> </ul>
	Pregnant Arrivals <i>N/A at this institution</i>	OB Roster	<ul style="list-style-type: none"> <li>Arrival date (2–12 months)</li> <li><b>Earliest</b> arrivals (within date range)</li> </ul>

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
<i>Preventive Services</i>			
MITs 9.001–002	TB Medications (10)	Maxor	<ul style="list-style-type: none"> <li>• Dispense date (past 9 months)</li> <li>• Time period on TB meds (3 months or 12 weeks)</li> <li>• <b>Randomize</b></li> </ul>
MIT 9.003	TB Code 22, Annual TST (15)	SOMS	<ul style="list-style-type: none"> <li>• Arrival date (at least 1 year prior to inspection)</li> <li>• TB Code (22)</li> <li>• <b>Randomize</b></li> </ul>
MIT 9.004	TB Code 34, Annual Screening (15)	SOMS	<ul style="list-style-type: none"> <li>• Arrival date (at least 1 year prior to inspection)</li> <li>• TB Code (34)</li> <li>• <b>Randomize</b></li> </ul>
MIT 9.005	Influenza Vaccinations (30)	SOMS	<ul style="list-style-type: none"> <li>• Arrival date (at least 1 year prior to inspection)</li> <li>• <b>Randomize</b></li> <li>• Filter out IPs tested in MIT 9.008</li> </ul>
MIT 9.006	Colorectal Cancer Screening (30)	SOMS	<ul style="list-style-type: none"> <li>• Arrival date (at least 1 year prior to inspection)</li> <li>• Date of birth (51 or older)</li> <li>• <b>Randomize</b></li> </ul>
MIT 9.007	Mammogram <i>N/A at this institution</i>	SOMS	<ul style="list-style-type: none"> <li>• Arrival date (at least 2 yrs prior to inspection)</li> <li>• Date of birth (age 52–74)</li> <li>• <b>Randomize</b></li> </ul>
MIT 9.008	Pap Smear <i>N/A at this institution</i>	SOMS	<ul style="list-style-type: none"> <li>• Arrival date (at least three yrs prior to inspection)</li> <li>• Date of birth (age 24–53)</li> <li>• <b>Randomize</b></li> </ul>
MIT 9.009	Chronic Care Vaccinations (24)	OIG Q: 1.001	<ul style="list-style-type: none"> <li>• Chronic care conditions (at least 1 condition per IP—any risk level)</li> <li>• <b>Randomize</b></li> <li>• Condition must require vaccination(s)</li> </ul>
MIT 9.009	Valley Fever (number will vary) <i>N/A at this institution</i>	Cocci transfer status report	<ul style="list-style-type: none"> <li>• Reports from past 2–8 months</li> <li>• Institution</li> <li>• Ineligibility date (60 days prior to inspection date)</li> <li>• <b>All</b></li> </ul>



Quality Indicator	Sample Category (number of samples)	Data Source	Filters
<b>Reception Center Arrivals</b>			
MITs 12.001–008	RC <i>N/A at this institution</i>	SOMS	<ul style="list-style-type: none"> <li>• Arrival date (2–8 months)</li> <li>• Arrived from (county jail, return from parole, etc.)</li> <li>• <b>Randomize</b></li> </ul>
<b>Specialized Medical Housing</b>			
MITs 13.001–004	CTC  (1)	CADDIS	<ul style="list-style-type: none"> <li>• Admit date (1–6 months)</li> <li>• Type of stay (no MH beds)</li> <li>• Length of stay (minimum of 5 days)</li> <li>• <b>Randomize</b></li> </ul>
MIT 13.101	Call Buttons CTC (all)	OIG inspector onsite review	<ul style="list-style-type: none"> <li>• Review by location</li> </ul>
<b>Specialty Services Access</b>			
MITs 14.001–002	High-Priority (15)	MedSATS	<ul style="list-style-type: none"> <li>• Approval date (3–9 months)</li> <li>• <b>Randomize</b></li> </ul>
MITs 14.003–004	Routine (15)	MedSATS	<ul style="list-style-type: none"> <li>• Approval date (3–9 months)</li> <li>• Remove optometry, physical therapy or podiatry</li> <li>• <b>Randomize</b></li> </ul>
MIT 14.005	Specialty Services Arrivals (20)	MedSATS	<ul style="list-style-type: none"> <li>• Arrived from (other CDCR institution)</li> <li>• Date of transfer (3–9 months)</li> <li>• <b>Randomize</b></li> </ul>
MIT 14.006-007	Denials (2)	InterQual	<ul style="list-style-type: none"> <li>• Review date (3–9 months)</li> <li>• <b>Randomize</b></li> </ul>
	(18)	IUMC/MAR Meeting Minutes	<ul style="list-style-type: none"> <li>• Meeting date (9 months)</li> <li>• Denial upheld</li> <li>• <b>Randomize</b></li> </ul>

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
<i>Internal Monitoring, Quality Improvement, &amp; Administrative Operations</i>			
MIT 15.001	Medical Appeals (all)	Monthly medical appeals reports	<ul style="list-style-type: none"> <li>Medical appeals (12 months)</li> </ul>
MIT 15.002	Adverse/Sentinel Events (0)	Adverse/sentinel events report	<ul style="list-style-type: none"> <li>Adverse/sentinel events (2–8 months)</li> </ul>
MITs 15.003–004	QMC Meetings (6)	Quality Management Committee meeting minutes	<ul style="list-style-type: none"> <li>Meeting minutes (12 months)</li> </ul>
MIT 15.005	Performance Improvement Work Plans (PIWP) (7)	Institution PIWP	<ul style="list-style-type: none"> <li>PIWP with updates (12 months)</li> <li>Medical initiatives</li> </ul>
MIT 15.006	LGB (4)	LGB meeting minutes	<ul style="list-style-type: none"> <li>Quarterly meeting minutes (12 months)</li> </ul>
MIT 15.007	EMRRC (12)	EMRRC meeting minutes	<ul style="list-style-type: none"> <li>Monthly meeting minutes (6 months)</li> </ul>
MIT 15.101	Medical Emergency Response Drills (3)	Onsite summary reports & documentation for ER drills	<ul style="list-style-type: none"> <li>Most recent full quarter</li> <li>Each watch</li> </ul>
MIT 15.102	2 <sup>nd</sup> Level Medical Appeals (10)	Onsite list of appeals/closed appeals files	<ul style="list-style-type: none"> <li>Medical appeals denied (6 months)</li> </ul>
MIT 15.103	Death Reports (5)	Institution-list of deaths in prior 12 months	<ul style="list-style-type: none"> <li>Most recent 10 deaths</li> <li>Initial death reports</li> </ul>
MIT 15.996	Death Review Committee (5)	OIG summary log - deaths	<ul style="list-style-type: none"> <li>Between 35 business days &amp; 12 months prior</li> <li>CCHCS death reviews</li> </ul>
MIT 15.998	Local Operating Procedures (LOPs) (all)	Institution LOPs	<ul style="list-style-type: none"> <li>All LOPs</li> </ul>

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
<i>Job Performance, Training, Licensing, and Certifications</i>			
MIT 16.001	Provider licenses (12)	Current provider listing (at start of inspection)	<ul style="list-style-type: none"> <li>Review all</li> </ul>
MIT 16.101	RN Review Evaluations (5)	Onsite supervisor periodic RN reviews	<ul style="list-style-type: none"> <li>RNs who worked in clinic or emergency setting six or more days in sampled month</li> <li><b>Randomize</b></li> </ul>
MIT 16.102	Nursing Staff Validations (10)	Onsite nursing education files	<ul style="list-style-type: none"> <li>On duty one or more years</li> <li>Nurse administers medications</li> <li><b>Randomize</b></li> </ul>
MIT 16.103	Provider Annual Evaluation Packets (5)	OIG Q:16.001	<ul style="list-style-type: none"> <li>All required performance evaluation documents</li> </ul>
MIT 16.104	Medical Emergency Response Certifications (all)	Onsite certification tracking logs	<ul style="list-style-type: none"> <li>All staff <ul style="list-style-type: none"> <li>Providers (ACLS)</li> <li>Nursing (BLS/CPR)</li> <li>Custody (CPR/BLS)</li> </ul> </li> </ul>
MIT 16.105	Nursing staff and Pharmacist in Charge Professional Licenses and Certifications (all)	Onsite tracking system, logs, or employee files	<ul style="list-style-type: none"> <li>All required licenses and certifications</li> </ul>
MIT 16.106	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations (all)	Onsite listing of provider DEA registration #s & pharmacy registration document	<ul style="list-style-type: none"> <li>All DEA registrations</li> </ul>
MIT 16.107	Nursing Staff New Employee Orientations (all)	Nursing staff training logs	<ul style="list-style-type: none"> <li>New employees (hired within last 12 months)</li> </ul>

**CALIFORNIA CORRECTIONAL  
HEALTH CARE SERVICES'  
RESPONSE**

March 10, 2017

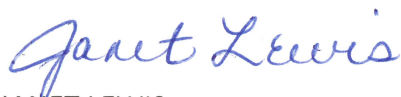
Robert A. Barton, Inspector General  
Office of the Inspector General  
10111 Old Placerville Road, Suite 110  
Sacramento, CA 95827

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 California State Prison, Sacramento (SAC) conducted from July 2016 to September 2016. California Correctional Health Care Services (CCHCS) acknowledges all OIG findings.

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

Sincerely,



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



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