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Inspector General

Office of the Inspector General

Sierra Conservation Center
Medical Inspection Results
Cycle 4

March 2016

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

Office of the Inspector General
SIERRA CONSERVATION CENTER
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Cycle 4

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EXECUTIVE SUMMARY

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

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

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

The OIG performed its Cycle 4 medical inspection at SCC from October to November 2015. The inspection included in-depth reviews of 66 inmate-patient files conducted by clinicians, as well as reviews of documents from 335 inmate-patient files, covering 90 objectively scored tests of compliance with policies and procedures applicable to the delivery of medical care. The OIG assessed the case review and compliance results at SCC using 14 health care quality indicators applicable to the institution, made up of 12 primary clinical indicators and two secondary administrative indicators. To conduct clinical case reviews, the OIG employs a clinician team consisting of a physician and a registered nurse consultant, while compliance testing is done by a team of deputy inspectors general trained in monitoring medical compliance. Of the 12 primary indicators, seven were rated by both case review clinicians and compliance inspectors, three were rated by case review clinicians only, and two were rated by compliance inspectors only; both secondary indicators were rated by compliance inspectors only. See the *Health Care Quality Indicators* table on page ii. Based on that analysis, OIG experts made a considered and measured overall opinion that the quality of health care at SCC was ***adequate***.

Health Care Quality Indicators

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

Overall Assessment: Adequate

Overall Assessment Rating:

Adequate

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

Clinical Case Review and OIG Clinician Inspection Results

The clinicians' case reviews sampled patients with high medical needs and included a review of more than 1,121 patient care events.[1] For the 12 primary indicators applicable to SCC, 10 were evaluated by clinician case review; one was *proficient*, and nine were *adequate*. When determining the overall adequacy of care, the OIG paid particular attention to the clinical nursing and provider quality indicators, as adequate health care staff can sometimes overcome suboptimal processes and programs. However, the opposite is not true; inadequate health care staff cannot provide adequate care, even though the established processes and programs onsite may be adequate. The OIG clinicians identify inadequate medical care based on the risk of significant harm to the patient, not the actual outcome.

Program Strengths — Case Review

- SCC performed very well with nursing sick call access.
- For the sampled patients, SCC consistently provided patients with a primary care provider (PCP) follow-up after they received specialty services, transferred into the institution, returned from the hospital, or were evaluated in the triage and treatment area (TTA).

Program Weaknesses — Case Review

- SCC had significant difficulty ensuring that patients with abnormal labs were scheduled appropriate follow-up appointments when requested by a provider on the Patient Notification of Diagnostic Results (CDCR Form 7393).

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

- SCC often failed to timely retrieve outside emergency room physician and specialty consult reports.

- SCC demonstrated poor provider continuity in the medical clinics and the outpatient housing unit (OHU). Poor provider continuity was associated with many provider errors, such as insufficient medical record review, insufficient documentation, inadequate assessment and decision-making, and inappropriate follow-ups. However, as most patients at SCC were low medical risk, these deficiencies did not place the patient at significant risk of harm.

Compliance Testing Results

Of the 14 total health care indicators applicable to SCC, 11 were evaluated by compliance inspectors.[2] There were 90 individual compliance questions within those 11 indicators, generating 1,072 data points, that tested SCC's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[3] Those 90 questions are detailed in *Appendix A — Compliance Test Results*. The institution's inspection scores for the 11 applicable indicators ranged from 57.1 percent to 98.0 percent, with the primary (clinical) indicator *Health Information Management (Medical Records)* receiving the lowest score, and the primary indicator *Specialized Medical Housing (OHU, CTC, SNF, Hospice)* receiving the highest. Of the nine primary indicators applicable to compliance testing, the OIG rated four *proficient*, four *adequate*, and one *inadequate.* Of the two secondary indicators, which involve administrative health care functions, one was rated *proficient* and one *inadequate*.

Program Strengths — Compliance Testing

As the *SCC Executive Summary Table* on page vii indicates, the institution's compliance ratings were *proficient* for the following four indicators: *Diagnostic Services* (90.8 percent), *Pharmacy and Medication Management* (91.4 percent), *Specialized Medical Housing* (98.0 percent), and *Specialty Services* (87.1 percent). The following are some of SCC's strengths based on its compliance scores for individual questions in all the primary health care indicators:

- Nursing staff timely reviewed patients' requests for health care services and timely completed face-to-face visits with patients.

- For patients referred by nursing staff to a PCP, the PCP saw the patient timely. Providers also conducted timely follow-up appointments with patients who received specialty services.

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

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

- All patients sampled timely received their radiology and laboratory diagnostic services; providers timely reviewed the related diagnostic reports and timely communicated test results to the patients.

- All clinics were appropriately disinfected, cleaned, and sanitary; clinical staff properly sterilized or disinfected reusable medical equipment, properly managed and stored bulk medical supplies, and properly maintained emergency response bags.

- When inmate-patients transferred into SCC from other institutions, nursing staff timely completed their Initial Health Screening forms (CDCR Form 7277).

- Nursing staff timely administered or delivered new medication orders to patients; for patients who transferred from one SCC housing unit to another, nurses ensured their medications were received without interruption.

- In its main pharmacy, SCC followed general security, organization, and cleanliness management protocols; properly stored and monitored non-narcotic medications; and properly accounted for narcotic medications.

- SCC timely provided or offered patients influenza vaccinations and annual colorectal cancer screenings, when required.

- Patients timely received approved high-priority and routine specialty services.

Identified strengths within the secondary indicators related to the following administrative areas:

- The institution promptly processed inmate medical appeals during the most recent 12 months, and SCC addressed all of the patients' appealed issues for sampled second-level medical appeals.

- All providers, nurses, and the pharmacist-in-charge were current with their professional licenses and certifications; all providers, nurses, and custody staff had current medical emergency response certifications; and the pharmacy and authorized providers maintained current Drug Enforcement Agency registrations.

- All nursing staff hired within the most recent 12 months completed the required new employee orientation training, sampled nursing staff received annual clinical competency validations, and nurse supervisors completed required reviews of sampled nursing staff.

Program Weaknesses — Compliance Testing

The institution received scores in the *inadequate* range for the primary indicator *Health Information Management (Medical Records)* (57.1 percent). The institution also received an *inadequate* score in the secondary indicator *Internal Monitoring, Quality Improvement, and Administrative Operations* (57.1 percent). The following are some of the weaknesses identified by SCC's compliance scores for individual questions in all the primary health care indicators:

- Providers did not conduct timely appointments with patients who required a PCP follow-up visit for chronic care conditions; patients who required a PCP sick call follow-up appointment; and patients who had been referred to a PCP by nursing staff upon their transfer to SCC from another institution.

- There were no Health Care Services Request forms (CDCR Form 7362) available for inmate-patients to complete at two of six housing unit locations the OIG inspected.

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

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

- When patients transferred out of SCC with approved pending specialty service appointments, the institution did not always identify the approved services on their health care transfer forms.

- Nursing staff did not always timely administer medications to patients returning to SCC from a community hospital or to patients receiving anti-tuberculosis medication.

- Many sampled patients who transferred into SCC from another institution with an approved specialty service appointment did not receive their services timely after arrival.

Some deficiencies within the secondary indicators related to the following administrative areas:

- Emergency Medical Response Review Committee minutes did not always include all required documentation for incidents discussed at meetings.

- Sampled medical emergency response drill packages did not always include all required documentation applicable to the drill scenario.

The *SCC 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.

SCC Executive Summary Table

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

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

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

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

Overall, SCC performed well in population-based metrics. For comprehensive diabetes care measures, SCC outperformed other State and national organizations in four out of five measures. For blood pressure control, SCC scored in the mid-range, with a higher score than Medi-Cal, Medicaid, Medicare, and commercial entities (based on data obtained from health maintenance organizations), but a lower score than Kaiser and the VA.

With regard to influenza immunizations for younger adults, SCC outperformed Kaiser and commercial entities, and matched the VA score. For older adults, SCC performed better than the VA for administering influenza vaccinations; for administering pneumococcal vaccinations, SCC performed better than Medicare, but not as well as the VA. For colorectal cancer screenings, SCC scored lower than all other entities (Kaiser, commercial, Medicare, and the VA). However, for both influenza vaccinations and cancer screenings, SCC had timely offered the services to all sampled patients, but many of them refused the offers.

Overall, SCC's comparative population-based metrics indicate that its comprehensive diabetes care and preventive services programs are functioning very well in comparison to other State and national health care organizations.

INTRODUCTION

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

Sierra Conservation Center (SCC) was the 13th 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

The primary mission of SCC is to provide housing, programs, and services for minimum- and medium-custody inmates. SCC is one of only two prisons in the State responsible for the training and placement of male inmates in the Conservation Camp Program. SCC administers 20 male camps located from Central California to the California-Mexico border. Inmates placed in camps, are healthy low medical risk patients with infrequent care needs, mostly managed at local community hospitals or with transfer back to the main SCC facility for a higher level of managed care. SCC functions as the center for training staff and inmates in firefighting techniques. The prison is separated into two dormitory-type facilities for minimum and low-medium custody inmates, and a separate high-medium custody facility. SCC operates six medical clinics, at which staff handle non-urgent requests for medical services and specialty services. SCC also conducts screenings in its receiving and release clinical area, treats inmate-patients who need urgent or emergency care in its triage and treatment area (TTA), and treats inmate-patients requiring outpatient health services and assistance with the activities of daily living in the outpatient housing unit (OHU). CCHCS has designated SCC as a "basic" care institution. Basic institutions are located in a rural area away from tertiary care centers and specialty care providers whose services would likely be used frequently by higher-risk patients. Basic institutions have capability to provide limited specialty medical services and consultation for a generally healthy inmate-patient population.

In addition, on August 17, 2014, the institution received national accreditation from the Commission on Accreditation for Corrections. This accreditation program is a professional peer review process based on national standards set by the American Correctional Association.

According to information provided by the institution, SCC's vacancy rate among medical managers, primary care providers, nursing supervisors, and non-supervisory nurses was 5 percent. As of September 2015, SCC had 74.3 budgeted health care positions, of which 70.5 were filled, and eight additional filled health care positions funded under the institution's "blanket" resources.[4] Based on its authorized and filled positions, the institution reported it had 3.8 vacant positions as of September 2015. The eight positions covered under blanket resources included the CEO's position (included in the management category below) and seven nursing staff positions. Prior to September 2015, SCC shared its CEO and other management positions with Deuel Vocational Institution (DVI). Effective September 1, 2015, SCC and DVI were each assigned separate CEO positions; SCC's CEO position was funded under the institution's blanket resources pending the formal budget change to fund the position. The seven nursing staff positions covered under blanket resources included an RN from the institution's pool of intermittent staff who was temporarily filling a vacant permanent RN position, an LVN backfilling the position temporarily vacated by an LVN who was on long-term medical leave, and five certified nurse assistants.

SCC Health Care Staffing Resources as of September 2015

	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff		Totals	
Description	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Authorized Positions	2	3%	8	11%	9.5	13%	54.8	74%	74.3	100%*
Filled Authorized Positions	2	100%	7	86%	9.5	100%	52	95%	70.5	95%
Positions Filled Under Blanket	1						7		8	
Vacancies	0	0%	1	13%	0	0%	2.8	5%	3.8	5%
Recent Hires (within 12 months)	2	100%	0	0%	.5	5%	22	42%	24.5	35%
Staff Utilized from Registry	0	0%	0	0%	0	0%	0	0%	0	0%
Redirected Staff (to Non-Patient Care Areas)	0	0%	0	0%	0	0%	0	0%	0	0%
Staff on Long-term Medical Leave	0	0%	0	0%	0	0%	1	2%	1	1%

Note: SCC Health Care Staffing Resources data was not validated by the OIG.
**Due to rounding, individual percentages for Authorized Positions do not add to exactly 100 percent.*

[4] Blanket resources are those available to the institution from salary savings related to authorized positions that are not currently filled. At management's discretion, blanket resources can be used to temporarily redirect funds from one unit within the institution to another.

As of September 21, 2015, the Master Registry for SCC showed that the institution had 4,395 inmate-patients. Within that total population, 0.6 percent were designated High-Risk, Priority 1 (High 1), and 1.4 percent were designated High-Risk, Priority 2 (High 2). Patients' assigned risk levels are based on the complexity of their required medical care related to their specific diagnoses, frequency of higher levels of care, age, and abnormal labs and procedures. High 1 has at least two high-risk conditions; High 2 has only one. High-risk patients are more susceptible to poor health outcomes than medium- or low-risk patients. High-risk patients also typically require more health care services than do patients with lower assigned risk levels. The chart below illustrates the breakdown of the institution's medical risk levels at the start of the OIG medical inspection.

SCC Master Registry Data as of September 21, 2015

Medical Risk Level	# of Inmate-Patients	Percentage
High 1	25	0.6%
High 2	60	1.4%
Medium	819	18.6%
Low	3,491	79.4%
Total	4,395	100.00%

Commonly Used Abbreviations

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

OBJECTIVES, SCOPE, AND METHODOLOGY

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

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

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

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

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

CASE REVIEWS

The OIG has added case reviews to the Cycle 4 medical inspections at the recommendation of its stakeholders. At the conclusion of Cycle 3, the federal Receiver and the Inspector General determined that the health care provided at the institutions was not fully evaluated by the compliance tool alone, and that the compliance tool was not designed to provide comprehensive qualitative assessments. Accordingly, the OIG added case reviews in which OIG physicians and nurses evaluate selected cases in detail to determine the overall quality of health care provided to the inmate-patients. The OIG's clinicians perform a retrospective chart review of selected patient files to evaluate the care given by an institution's primary care providers (PCPs) 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, SCC Sample Sets*, the OIG clinicians evaluated medical charts for 66 unique inmate-patients. *Appendix B, Table B–4, SCC Case Review Sample Summary*, clarifies that both nurses and physicians reviewed charts for 16 of those patients, for 82 reviews in total. Physicians performed detailed reviews of 30 charts, and nurses performed detailed reviews of 21 charts, totaling 51 detailed reviews. For detailed case reviews, physicians or nurses looked at all encounters occurring in approximately six months of medical care. Nurses also performed a limited or focused review of medical records for an additional 31 inmate-patients. These generated 1,121 clinical events for review (*Appendix B, Table B-3, SCC 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 four chronic care patient records, i.e., four diabetes patients (*Appendix B, Table B–1, SCC Sample Sets*), the 66 unique inmate-patients sampled included patients with 153 chronic care diagnoses, including eight additional patients with diabetes (for a total of 12) (*Appendix B, Table B–2, SCC Chronic Care Diagnoses*). The OIG's sample selection tool evaluated many chronic care programs because the complex and high-risk patients selected from the different categories often had multiple medical problems. While the OIG did not evaluate every chronic disease or health care staff member, the overall operation of the institution's system and staff were assessed for adequacy. The OIG's case review methodology and sample size matched other qualitative research. The empirical findings, supported by expert statistical consultants, showed adequate conclusions after 10 to 15 charts had undergone full clinician review. In qualitative statistics, this phenomenon is known as "saturation." The OIG asserts that the sample size of over 30 detailed reviews certainly far exceeds the saturation point necessary for an adequate qualitative review. With regard to reviewing charts from different providers, the case review is not intended to be a focused search for poorly performing providers; rather, it is focused on how the system cares for those patients who need care the most. Nonetheless, while not sampling cases by

each provider at the institution, the OIG's inspections adequately review most providers. Providers would only escape OIG case review if institutional management successfully mitigated patient risk by having the more poorly performing PCPs care for the less complicated, low-utilizing, and lower-risk patients. The OIG's clinicians concluded the case review sample size was adequate to assess the quality of services provided.

Based on the collective results of clinicians' case reviews, the OIG rated each quality indicator as either *proficient* (excellent), *adequate* (passing), *inadequate* (failing), or *not applicable*. A separate confidential *SCC Supplemental Medical Inspection Results: Individual Case Review Summaries* report details the case reviews OIG clinicians conducted and is available to specific stakeholders. For further details regarding the sampling methodologies and counts, see *Appendix B — Clinical Data, Table B–1; Table B–2; Table B–3;* and *Table B–4*.

COMPLIANCE TESTING

SAMPLING METHODS FOR CONDUCTING COMPLIANCE TESTING

From October to November 2015, deputy inspectors general attained answers to 90 objective medical inspection test (MIT) questions designed to assess the institution's compliance with critical policies and procedures applicable to the delivery of medical care. To conduct most tests, inspectors randomly selected samples of inmate-patients for whom the testing objectives were applicable and reviewed their electronic unit health records. In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed health records for 335 individual inmate-patients and analyzed specific transactions within their records for evidence that critical events occurred. Inspectors also reviewed management reports and meeting minutes to assess certain administrative operations. In addition, during the week of October 5, 2015, field inspectors conducted a detailed onsite inspection of SCC's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,072 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 SCC's plant infrastructure, protocols for tracking medical appeals and local operating procedures, and staffing resources.

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

SCORING OF COMPLIANCE TESTING RESULTS

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

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

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

After compiling the answers to the 90 questions, the OIG derived a score for each primary and secondary quality indicator identified above by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Based on those results, the OIG assigned a rating to each quality indicator of *proficient* (greater than 85 percent), *adequate* (between 75 percent and 85 percent), or *inadequate* (less than 75 percent).

CCHCS DASHBOARD COMPARISON

In the first ten medical inspection reports of Cycle 4, the OIG identified where similar metrics for some of the individual compliance questions were available within the CCHCS Dashboard, which is a monthly report that consolidates key health care performance measures statewide and by institution. However, there was not complete parity between the metrics due to differing time frames for data collecting and differences in sampling methods, rendering the metrics non-comparable. In addition, the OIG specifically identified where the SCC's local process erroneously increased its Dashboard results for one of reported measure. This is further described in the *Access to Care* indicator in this report. The Dashboard information will not be provided in future reports to eliminate confusion. Dashboard data is available on CCHCS's website, www.cphcs.ca.gov.

OVERALL QUALITY INDICATOR RATING FOR CASE REVIEWS AND COMPLIANCE TESTING

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

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

POPULATION-BASED METRICS

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

MEDICAL INSPECTION RESULTS

PRIMARY (CLINICAL) QUALITY INDICATORS OF HEALTH CARE

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

The *SCC Executive Summary Table* on page vii 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 SCC. For these 10 indicators, OIG clinicians rated one *proficient*, and nine *adequate*.

The OIG physicians rated the overall adequacy of care for each of the 30 detailed case reviews they conducted. Of these 30 cases, 24 were *adequate*, and six were *inadequate*. For the 1,121 events reviewed, there were 459 deficiencies (41 percent), of which 64 (6 percent) 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 were two adverse events identified in the case reviews at SCC. The cases were not reflective of the quality of care at SCC.

- In case 31, the patient developed a corneal abrasion, and the provider prescribed eye drops that contained steroid medication. Steroid eye drops were contraindicated, because they increase the risk of worsening the condition. The same error of prescribing the patient steroid eye drops was made by two different providers before the patient was evaluated by an eye specialist. Fortunately, the patient experienced no harm from the provider errors.

- In case 23, the patient was evaluated by a provider for symptoms of chest pain associated with sweating and dizziness, which sometimes occurred at rest. The provider ordered and reviewed an EKG that showed acute abnormalities suggestive of insufficient blood flow to the heart and high risk of a heart attack. The provider did not immediately send the patient to an emergency room. Fortunately, the patient experienced no harm from this provider error, and the severe coronary disease was identified a few months later.

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

ACCESS TO CARE

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

Case Review Rating:
Adequate
Compliance Score:
Adequate
(82.1%)

Overall Rating:
Adequate

Case Review Results

OIG clinicians reviewed 420 provider, nursing, specialty, and outside hospital encounters for which a follow-up needed to be scheduled. Clinicians found 19 deficiencies relating to *Access to Care*. Though the number of deficiencies was low, clinicians considered 9 of the 19 deficiencies more likely than not to cause patient harm if not rectified. Due to the qualitative severity of the deficiencies identified, the OIG could not grant SCC the highest rating for *Access to Care*, so it was thus rated *adequate*.

Provider-to-Provider Follow-up Appointments

SCC performed marginally with provider-ordered follow-up appointments. These are among the most important aspects of the *Access to Care* indicator. Failure to accommodate provider-ordered appointments can often result in lapses in care, or even patients being lost to follow-up. Of the 30 detailed physician-reviewed cases, seven of them contained deficiencies wherein providers ordered a follow-up appointment but SCC did not provide one.

The cause of these deficiencies was a local process used at the institution. Specifically, when providers documented their review of abnormal labs and requested follow-up appointments on the Patient Notification form (CDCR Form 7393), as a deliberate practice, the schedulers did not schedule the follow-up appointments. This practice was intended to prevent duplicate appointments from being made for these patients, who often already had other scheduled appointments. Instead, the result was that many patients did not receive timely appointments to follow up on their abnormal lab results. The OIG clinicians confirmed the existence of this local process during their onsite inspection. This deficiency was the most commonly identified *Access to Care* problem, and was found in cases 26, 31, 33, and the following three cases:

- In case 28, the provider reviewed a lab report indicating that the patient was producing excessive amounts of thyroid hormone, and requested a chronic care follow-up appointment. However, SCC's local process, not scheduling appointments after abnormal

labs, resulted in the patient not receiving a provider visit until nearly six months after the institution received the labs. While there was a severe delay in care, the patient suffered no harm.

- In case 14, the provider reviewed a lab report showing that the patient was producing excessive amounts of thyroid hormone. Despite the provider requesting a follow-up appointment on the CDCR Form 7393, SCC did not expedite the existing appointment, which resulted in another delay in care. However, the patient suffered no harm.

- In case 29, the provider reviewed a lab report indicating that the patient's diabetes was severely out of control, and requested a chronic care follow-up appointment. Because SCC did not schedule a new appointment or expedite existing appointments, the patient experienced a significant delay in diabetic care. However, the patient suffered no harm.

Pure scheduling errors were uncommon and were likely due to oversight or insufficient training of scheduling personnel. Though these errors were rare, when they did occur, they placed the patient at significant risk of harm.

- In case 30, the patient developed bleeding from a wound that had recently required surgical intervention. The nurse was concerned enough to order both a three-day follow-up with the rover provider as well as a 14-day follow-up with the PCP.[5] However, neither of those appointments occurred, greatly increasing the risk of the patient developing a worsening wound. Fortunately, the patient's wound began to heal without medical intervention, and the patient suffered no harm from the scheduling errors.

- In case 28, the patient had diabetes that was severely out of control. The provider laid out a very specific plan of care, including timely lab tests and follow-up appointments. However, the scheduler did not implement the plan as specified, which resulted in a delay in care.

Despite the errors identified above, SCC did perform very well with follow-ups that providers ordered during face-to-face visits.

RN Sick Call Access

SCC performed very well with RN sick call access. OIG clinicians reviewed 117 sick call encounters, and in all instances, the nurse evaluated the patient timely.

RN-to-Provider Referrals

SCC performed adequately with RN-to-provider appointments. OIG clinicians identified 60 instances in which the clinic RN referred the patient to the PCP. In four instances, the PCP

[5] SCC employed a "rover" system, whereby physicians rotated throughout the institution to provide clinical services where there was an excess need for providers. This system is further discussed in the *Quality of Provider Performance* indicator.

appointment did not occur within the requested time frame (cases 13, 14, 30, and 33). In two of those cases, cases 14 and 33, the RN neglected to request the follow-up appointment on the closeout sheet.

Provider Follow-up After Specialty Service

SCC consistently provided patients with a provider follow-up appointment after specialty services. The OIG clinicians reviewed 96 diagnostic and consultative specialty services and found only one deficiency with *Access to Care* in this area.

Intra-System Transfers

Nurses assessed newly transferred patients and always referred them to a provider. Providers always saw the patients timely. The OIG clinicians reviewed ten transfer-in patients and found no deficiencies with *Access to Care* in this area.

Follow-up After Hospitalization

SCC successfully ensured that providers followed up with patients after they returned from an outside hospital or an emergency department. SCC had 28 hospitalization and outside emergency events, and the OIG found no deficiencies with *Access to Care* in this area.

Urgent/Emergent Care

SCC successfully ensured that a PCP followed up on patients after their return from the triage and treatment area (TTA). The OIG clinicians reviewed 29 urgent/emergent encounters, seven of which required a PCP follow-up. Other than provider continuity, which was poor, there were no deficiencies with *Access to Care* in this area.

Specialized Medical Housing

SCC performed adequately with provider access during and after admission to the outpatient housing unit (OHU). A provider saw patients frequently and at appropriate intervals. The OIG clinicians reviewed 13 OHU admissions with 69 OHU provider encounters. The most concerning problem in this area was the lack of provider continuity, which contributed to some errors in care. This is further discussed in the *Specialized Medical Housing* indicator.

Specialty Access

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

Clinician Onsite Inspection

The OIG clinicians discussed the deficiencies above with SCC management during their onsite inspection. In addition to the institution's practice of not scheduling follow-up appointments related

to abnormal labs, the OIG clinicians identified another deficiency in a local SCC process. Specifically, when a patient's original provider appointment was rescheduled, the SCC schedulers failed to adjust the status of the appointment in the Medical Scheduling and Tracking System (MedSATS). As a result, the MedSATS data showed that a provider saw the patient as scheduled. Because MedSATS is used to calculate the data for CCHCS's Dashboard, which is a monthly report that consolidates key health care performance measures statewide and by institution, this local practice erroneously increased SCC's Dashboard results. More importantly, this practice increased the risk of undetected problems in *Access to Care* that accurate data would otherwise have revealed.

Compliance Testing Results

The institution received an *adequate* compliance score of 82.1 percent in the *Access to Care* indicator, but scored in the *proficient* range for the following five indicators:

- Inspectors sampled 32 Health Care Services Request forms (CDCR Form 7362) submitted by inmate-patients across all facility clinics. As documented on the service request form, for 31 patients (97 percent), nursing staff reviewed the request form on the same day they received it. For one patient, the nurse failed to document the nurse's name on the form (MIT 1.003). Nursing staff timely completed a face-to-face patient triage encounter with all 32 patients sampled (MIT 1.004).

- Inspectors sampled 19 patients who had received a specialty service and found that 18 of them (95 percent) received a timely follow-up appointment with a primary care provider (PCP). One patient did not receive a follow-up appointment at all (MIT 1.008).

- For 18 health care service requests sampled where nursing staff referred the patient for a PCP appointment, 17 of the patients (94 percent) received a timely appointment. One patient did not receive a PCP follow-up appointment at all (MIT 1.005).

- The OIG tested nine patients discharged from a community hospital to determine if they received a PCP follow-up appointment within five calendar days of their return to SCC. Eight of the patients (89 percent) received a timely PCP follow-up appointment; one patient received his appointment six days late (MIT 1.007).

The institution has room for improvement in the following areas:

- Only 10 of the 18 patients sampled (56 percent) who transferred into SCC from another institution and were referred to a PCP, based on nursing staff's initial health care screening, were seen timely. Seven inmate-patients were seen from 6 to 16 days late; one other patient never received his PCP appointment at all (MIT 1.002).

- Inmates had access to Health Care Services Request forms (CDCR Form 7362) at four of six (67 percent) housing unit locations inspected. Two housing unit locations did not have the forms available at the time of inspection (MIT 1.101).

- Inspectors tested a sample of seven health care service request forms where nursing staff referred the patient for a PCP appointment, and where the PCP subsequently ordered an additional follow-up appointment. Five of the patients (71 percent) received their subsequent follow-up appointments timely; two patients never received their follow-up appointments at all (MIT 1.006).

- The OIG reviewed recent appointments for 30 patients who suffered with one or more chronic care conditions and found that only 21 of the patients (70 percent) had received timely follow-up appointments. Five patients received their follow-up appointments from three days to six months late; four patients never received a chronic care follow-up appointment at all (MIT 1.001).

Recommendations

The OIG recommends SCC implement a process to promptly schedule provider requested follow-up appointments for patients with abnormal lab results. To avoid scheduling duplicate appointments, require providers to always identify a time frame when the patient's follow-up appointment should occur and, when applicable, change any previously scheduled appointment to fit within that specified time frame. Also, when patients' medical appointments are rescheduled, the schedulers can correctly identify the status of patients' original appointments in MedSATS.

DIAGNOSTIC SERVICES

Case Review Rating:
Adequate
Compliance Score:
Proficient
(90.8%)

Overall Rating:
Adequate

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

For this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance review resulting in a *proficient* score. The OIG's internal review process considered those factors that led to both scores and ultimately rated this indicator *adequate.* The key factors were that the OIG's case review showed that medical staff did not always complete laboratory and other diagnostic testing orders, and failures to retrieve diagnostic reports could have affected the care of patients. As a result, the case review testing results were deemed a more accurate reflection of the appropriate overall rating.

Case Review Results

The OIG clinicians reviewed 144 diagnostic events and found 48 deficiencies. Of those 48 deficiencies, 40 were related to health information management, and eight were related to the non-completion of ordered tests.

Non-completion of diagnostic tests is a serious system deficiency that can potentially lead to significant delays or even lapses in care. SCC demonstrated infrequent but recurring errors wherein the institution did not complete labs as ordered:

- In case 4, on two occasions, the PCP ordered lab tests but SCC did not complete them as ordered. The first time was when the PCP ordered labs for an upcoming chronic care visit, but staff did not complete the labs. The second time was when the PCP evaluated the patient for acute abdominal pain and ordered labs for the following day. SCC did not perform the labs timely.

- In case 13, a provider ordered a phenytoin (seizure medication) level, but staff did not perform the laboratory blood test.

- In case 12, a provider ordered future labs in preparation for an oncology appointment. However, the lab draw was premature, which placed the patient at risk for a lapse in care.

Fortunately, a provider fixed the error by reordering the tests to be redrawn at the appropriate time.

- In case 22, a provider ordered a lung spirometry test, which was not performed.

During their onsite visit, the OIG clinicians asked SCC's lab supervisor why there was a low but recurring rate of non-completed tests. SCC had investigated several of the errors identified, and the most common explanation was the non-receipt of the orders. SCC had recently moved to a scanning system whereby staff scanned orders at the point of care, in addition to scanning the orders after they were processed, in an attempt to mitigate some of the transmission errors. SCC was hopeful that the move to an electronic health record system (EHRS) with computerized provider order entry would eliminate these types of errors and help improve diagnostic performance.

Despite the deficiencies identified, SCC provided the majority of diagnostic services in a timely manner; providers usually reviewed, initialed, and dated test reports timely; and medical records staff scanned those reports into the eUHR timely.

A few patterns of deficiencies related to health information management did emerge during the OIG clinicians' case reviews:

- SCC did not notify patients of their test results after medical staff performed diagnostic EKGs in cases 17, 18, 23, and 26. Also, in case 1, SCC did not notify the patient of the lab test results; in case 21, it did not notify the patient of ultrasound results.

- SCC was tardy in retrieving and processing pathology reports in cases 13, 16, and 29.

- Some SCC providers frequently failed to legibly initial diagnostic reports evidencing their review.

Clinician Summary

SCC generally did well in most aspects of *Diagnostic Services*. However, there was a low but recurring level of test non-completion, which prevented SCC from attaining the highest rating in this category. SCC had difficulty retrieving pathology reports in a timely manner and occasionally had difficulty notifying patients of their diagnostic test results, especially EKG results. However, the institution provided the majority of diagnostic services in a timely manner. Considering all aspects of diagnostic services reviewed, the OIG clinicians rated this indicator *adequate*.

Compliance Testing Results

The institution received a *proficient* compliance score of 90.8 percent in the *Diagnostic Services* indicator, which encompasses radiology, laboratory, and pathology services. For clarity, each diagnostic service type is discussed separately below:

Radiology Services

- For all ten of the radiology services sampled, inspectors found the services were timely performed, the ordering provider timely reviewed the diagnostic report results, and the test results were timely communicated to the patients (MIT 2.001, 2.002, 2.003).

Laboratory Services

- Similarly, SCC performed well with laboratory services. For all ten patients sampled, their laboratory services were timely performed, the ordering provider timely reviewed the diagnostic report results, and the test results were timely communicated to the patients (MIT 2.004, 2.005, 2.006).

Pathology Services

- The institution timely received the final pathology report for only eight of ten patients sampled (80 percent). For two patients, inspectors could not find the reports in their eUHR at all (MIT 2.007). Providers documented sufficient evidence that they timely reviewed the final report results for seven of those eight patients (88 percent); for one patient, the PCP's initials were illegible (MIT 2.008). Providers timely communicated the final pathology test results to only four of the eight patients (50 percent). For three patients, the provider communicated the pathology test results from one to six days late; for another patient, there was no evidence the provider communicated the test results to the patient at all (MIT 2.009).

Recommendations

No specific recommendations.

EMERGENCY SERVICES

Case Review Rating:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

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

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

Case Review Results

The OIG clinicians reviewed 31 urgent or emergent events and found 33 deficiencies in a variety of areas. Most of the deficiencies were minor and did not significantly affect patient care. In general, SCC performed adequately with basic life support (BLS) care and 9-1-1 call activation times. Patients requiring urgent or emergent services received timely and adequate care in the majority of cases reviewed.

Provider Performance

The quality of provider care in this indicator was adequate. Treatment and triage area (TTA) providers generally saw the patients timely and made adequate assessments. The providers made sound triage decisions and sent patients to higher levels of care appropriately. The OIG identified a few instances in which a TTA provider failed to perform an adequate assessment, but nevertheless made an appropriate triage decision. For quality improvement purposes, those cases are discussed below:

- In case 5, the patient presented to the TTA with symptoms of severe shortness of breath and dyspnea on exertion. If the provider had reviewed the medical record, it would have been evident that the patient was being treated for congestive heart failure and had run out of his diuretic medication two weeks prior. However, the TTA provider did not review the medical record, did not obtain a chest x-ray, and diagnosed and treated the patient for chronic obstructive pulmonary disease (COPD) exacerbation, instead of congestive heart failure. In addition, the TTA provider documented a normal lung exam, whereas an outside emergency room physician found the patient to have crackles (indicative of fluid in the lungs) in the lower third of both lungs. Though the TTA provider completely missed the

correct diagnosis, the provider did make the correct triage decision and did send the patient to a higher level of care.

- In case 2, the patient presented to the TTA with complaints of lower abdominal pain and the inability to urinate. The on-call provider correctly ordered the nurse to perform a urinary catheterization, which drained an excessive amount of urine, and sent the patient back to housing with a PCP follow-up in two weeks. While the triage decision to keep the patient at the institution was correct, the follow-up interval was inappropriate. The provider should have ordered a follow-up for the next day to ensure the patient had regained the ability to urinate and, if the patient still could not do so, provided the patient with urgent medical care. As a consequence of this lack of follow-up, on the following day, the patient went "man-down" because of his persistent inability to urinate.

Nursing Performance

The nursing care provided during emergency medical response incidents was generally adequate. However, nursing documentation of some emergency medical response encounters revealed numerous timeline discrepancies, delays in the medical responders' arrival on scene, delays in contacting the provider, and lack of documentation by medical staff eyewitnesses present on scene prior to the arrival of the medical responders. The following examples demonstrate these case review findings:

- In case 2, various delays occurred in three different emergency medical response encounters for this patient, who experienced sharp abdominal pain with a distended bladder from acute urinary retention. The medical responder did not arrive on scene within 8 minutes in two of the three encounters, with on-scene arrival delays of 13 minutes and 15 minutes. The RN medical responder in one encounter did not assess the patient's vital signs until 20 minutes after arrival on scene. All three encounters had delays, 20 minutes, 40 minutes, and 47 minutes, in contacting the provider. In one encounter, the time documented for the medical responders' arrival on scene was the same time as noted for the patient's arrival in the TTA.

- In case 4, the patient had two emergency response encounters. In the first encounter, various nurses provided care for head and face trauma after an altercation. Numerous inconsistent timeline discrepancies occurred throughout the nursing documentation. In the second encounter, the nursing staff provided care for severe abdominal pain and did not contact the provider and initiate the 9-1-1 Emergency Medical Services (EMS) call for more than one hour. The RN administered antacids and other medication for abdominal pain twice without documenting a provider's order.

- In case 5, nursing staff documented numerous inconsistent timeline discrepancies for this patient with shortness of breath and difficulty breathing. The LVN eyewitness on scene initially did not document the incident at all. The TTA nurse did not place this patient on

the monitor until an hour after arrival in the TTA, when the provider ordered an EKG. Although inserting an intravenous line and infusing normal saline are covered under the nursing protocol, this patient was transferred offsite to the hospital for higher level of care without placement of an intravenous line.

- In case 13, the patient had a seizure while in the pill line. The LVN eyewitness initially on scene did not document the incident, and a delay of more than one hour occurred in notifying the provider.

The following case is brought forward for nursing quality improvement purposes:

- In case 13, the day before he was admitted to the OHU, the patient presented to the TTA with a documented episode of true loss of consciousness. The nurse did not notify the physician on call and sent the patient back to housing without any provider input.

Onsite Clinician Inspection

During the onsite visit, OIG clinicians found the patient care environment in the TTA appropriately staffed and containing the necessary supplies and equipment for providing safe patient care. There were two nurses (one medical responder and one TTA RN) present in the TTA during the visit. The RN medical responder went out to the yard for any medical emergencies, while the TTA RN remained in the TTA for the duration of the shift. One RN was assigned to the TTA on first watch (10:00 pm to 6:00 am), and two RNs were assigned on second watch (6:00 am to 2:00 pm) and on third watch (2:00 pm to 10:00 pm).

The TTA was located in the main prison yard, and all yards except C Yard were within close proximity to the TTA. Because inmates on C Yard had special needs yard (SNY) status, they were generally not brought back to the main yard. However, C Yard did not have clinical staff available after office hours or on weekends, and was not equipped with certain emergency medical supplies and equipment. Therefore, when an emergency occurred, medical staff were required to carry emergency response equipment from the TTA and drive a transport vehicle through various security gates to access the yard. The usual travel time from the TTA to C Yard was 15 to 20 minutes.

The emergency medical response delays identified in the case reviews were primarily with patients housed in C Yard. SCC administrators were aware of the factors contributing to delays in emergency medical response on the yard, and were planning strategies to improve emergency medical response times without compromising the safety and security of the inmate-patients. Potential strategies under consideration included setting up a small TTA in C Yard after the current construction project was completed, and creating a new access gate to the yard for faster more direct access from the TTA during emergency medical situations.

Specific examples of case review findings for patients returning through the TTA from hospital discharge and other offsite appointments are discussed in the *Intra- and Inter-System Transfers* indicator.

Clinician Summary

SCC staff provided *adequate* emergency services to their patients. While TTA providers made occasional questionable assessments, their triage decisions were largely appropriate. Nursing staff at SCC generally provided appropriate assessment, intervention, and monitoring during emergency medical responses.

Recommendations

- The OIG recommends that nursing administrators implement training and monitoring strategies to ensure that all nursing staff throughout the institution maintain organized, accurate documentation of urgent or emergent incidents, including nursing assessments, interventions, timelines, contacts, and consistent use of the acceptable CCHCS documentation forms.

- The OIG recommends that SCC implement specific interventions to improve emergency medical access and response times to patients in C Yard.

HEALTH INFORMATION MANAGEMENT (MEDICAL RECORDS)

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(57.1%)

Overall Rating:
Inadequate

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

For this indicator, the OIG case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance review resulting in an *inadequate* score. The OIG's internal review process considered the factors leading to both scores and ultimately rated this indicator *inadequate*. The compliance test results provide a quantitative result for scanning of records and proper labeling of eUHR documents. As a result, the compliance testing results were deemed a more accurate reflection of the appropriate overall rating.

Case Review Results

Inter-Departmental Transmission

- SCC generally had good performance in this area, with only occasional errors found in the transmission of diagnostic orders. This finding is discussed in the *Diagnostic Services* indicator.

Dictated Progress Notes

- Most providers used handwritten progress notes, but occasionally they used dictation, which caused occasional transcription delays. These deficiencies were identified in cases 4, 14, and 17.

Hospital Records

- SCC had difficulty with the retrieval of emergency department (ED) physician reports. The OIG clinicians reviewed eight outside ED events. SCC had not retrieved those reports in cases 2 and 4.

- SCC did very well with the retrieval of hospital discharge summaries. The OIG clinicians reviewed 20 community hospital events. SCC retrieved and scanned all discharge

summaries in a timely manner. However, in cases 3 and 16, a provider did not properly sign the discharge summaries.

Specialty Services

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

Diagnostic Reports

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

Urgent/Emergent Records

- SCC medical staff sometimes did not properly document urgent/emergent encounters. In case 2, the eUHR did not include the First Medical Responder form (CDCR Form 7286). In case 53, institution staff did not scan the same form into the eUHR for six months. In case 13, the TTA flowsheet was not found in the eUHR, resulting in an incomplete evaluation of the nursing assessment, treatment, and interventions provided in the TTA.

Scanning Performance

- 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. The OIG clinicians found mislabeled documents in the eUHR in cases 3, 13, 16, 17, 18, 22, and 53. Documents were filed in the wrong patient's chart in cases 1, 3, 14, and 23.

- Scanning times for all documents were generally good.

Legibility

- Legibility was a significant problem in most cases reviewed. Some providers did not utilize name stamps, which created repeated legibility problems.

- In addition to poor legibility, many health care staff neglected to time stamp their documents as required by policy.

Clinician Summary

SCC had moderate difficulty with the retrieval of outside ED physician reports and the retrieval and review of specialty reports. SCC also had significant difficulty with the proper labelling and filing of documents when scanning them into the eUHR. SCC demonstrated good performance with the

retrieval of hospital discharge summaries and scan times. SCC's retrieval and review of diagnostic reports was adequate. The OIG clinicians rated this indicator *adequate*.

Compliance Testing Results

The institution received an *inadequate* compliance score of 57.1 percent in the *Health Information Management (Medical Records)* indicator and received *inadequate* scores in the following three areas:

- The institution scored a 0 percent in its labeling and filing of documents scanned into inmate-patients' electronic unit health records. The most common errors included incorrectly labeled documents, including progress notes, health screening forms, and other documents (MIT 4.006).

- Inspectors tested three PCP dictated progress notes to determine if institution staff scanned the documents within five calendar days of the patient encounter date, and found staff did not scan any of the documents within the required time frame. SCC staff scanned the three documents one, two, and ten days late (MIT 4.002).

- When the OIG reviewed various medical documents (hospital discharge reports, initial health screening forms, certain medication administration records, and specialty service reports) to ensure that clinical staff legibly documented their names on the forms, only 13 of 28 samples (46 percent) showed compliance (MIT 4.007).

The institution performed in either the *adequate* or *proficient* range for the following test areas:

- SCC medical records staff timely scanned medication administration records (MARs) into the inmate-patient's eUHR files for 18 of the 20 patients sampled (90 percent). For two patients, MARs were scanned 6 and 27 days late (MIT 4.005).

- SCC staff scanned specialty service consultant reports into the inmate-patient's eUHR file within five calendar days for 12 of the 14 reports reviewed (86 percent). Institution staff scanned two of the documents between two and five days late (MIT 4.003).

- The OIG reviewed eUHR files for ten patients sent or admitted to the hospital to determine if an SCC provider reviewed the patients' hospital discharge reports or treatment records within three calendar days of discharge. Providers timely reviewed the records for eight patients (80 percent). The provider reviewed one patient's discharge report two days late; for another patient, the provider did not document that the report was reviewed at all (MIT 4.008). For eight of those ten patients (80 percent), SCC health records staff timely scanned the discharge reports into the patient's eUHR. Two reports were scanned one and seven days late (MIT 4.004).

- Medical records staff timely scanned 15 of 20 sampled non-dictated documents into the patient's eUHR within three calendar days of the patient's encounter (75 percent). These documents included providers' progress notes, patients' initial health screening forms, and health care services request forms. Medical records staff scanned five documents between one and five days late (MIT 4.001).

Recommendations

No specific recommendations.

HEALTH CARE ENVIRONMENT

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

Case Review Rating:
Not Applicable
Compliance Score:
Adequate
(83.8%)

Overall Rating:
Adequate

Compliance Testing Results

The institution scored well in the *Health Care Environment* indicator, with an *adequate* score of 83.8 percent.

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

- The institution appropriately disinfected, cleaned, and sanitized all nine clinics observed; cleaning logs indicated that porters regularly cleaned all clinics as scheduled (MIT 5.101).
- Clinical health care staff in all nine clinics properly sterilized and disinfected reusable invasive and non-invasive medical equipment (MIT 5.102).
- OIG inspectors observed clinicians in eight clinics, all of whom adhered to universal hand hygiene precautions, scoring 100 percent for this test (MIT 5.104).
- Based on 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 supported the needs of the medical health care program. As a result, SCC scored 100 percent for this test (MIT 5.106).
- All nine clinics followed adequate protocols for managing and storing bulk medical supplies (MIT 5.107).
- Inspectors examined emergency response bags to determine if institution staff inspected the bags daily and inventoried them monthly, and whether the bags contained all essential items. Emergency response bags were compliant at all seven applicable clinical locations, resulting in a score of 100 percent for this test (MIT 5.111).
- Eight of the nine clinics (89 percent) inspected had operable sinks and sufficient quantities of hygiene supplies in clinical areas. The only exception was the receiving and release

clinic (R&R), where the inmate restroom did not have antiseptic soap or disposable hand towels (MIT 5.103).

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

- Seven of the nine clinics' common areas (78 percent) had an environment conducive to providing medical services, such as acceptable wheelchair access, adequate patient waiting areas, sufficient clinician work space, and reasonable patient privacy in triage stations. However, at the A and B facilities, the RN clinics lacked a suitable waiting area for patients; patients waited outside and sat on a cement ledge where there was no overhang or shade protection for inclement weather or extreme heat (MIT 5.109).

While SCC performed well in the *Health Care Environment* indicator, the following areas need improvement:

- Six of the nine clinics (67 percent) followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste; three clinics had PCP exam rooms that did not have a sharps container (puncture resistant containers used for expended syringes) (MIT 5.105).

- Only six of the nine clinics observed (67 percent) had appropriate space, configuration, supplies, and equipment to allow clinicians to perform a proper clinical examination. There was no auditory privacy in the OHU exam room, and exam room space in two other clinics did not provide an adequate environment for clinicians to conduct a comprehensive exam. Specifically, the placement of one clinic's exam room table did not allow patients to lie fully extended on the table, and another clinic's exam room did not have sufficient space for a provider and patient to move freely within the room (Figure 1) (MIT 5.110).

Figure 1 – Inadequate exam room space for conducting comprehensive examinations

- Most clinics' common areas and exam rooms were missing one or more core equipment items or essential supplies necessary to conduct a comprehensive exam. As a result, only two of the nine clinics (22 percent) received a passing score for this test. Equipment and supply deficiencies in seven clinics' common areas or exam rooms included the following: four clinics without nebulization units, and one with a nebulization unit not timely calibrated; four without hemoccult cards and developer in provider exam rooms; three

without a medication refrigerator; two without a biohazard waste receptacle; two without a weight scale; one without a Snellen eye chart; and one without sterile tongue depressors (MIT 5.108).

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. The OIG does not score this question. When OIG inspectors interviewed SCC's health care management, staff did not have any significant concerns about the existing infrastructure at the institution or its effect on staff's ability to provide adequate health care. The institution had a system in place to identify and report facility infrastructure problems when they occurred. At the time of the OIG inspection, SCC had five ongoing projects:

Project A: Provide updated medication distribution space in A, B, and C Yards, and in the administrative segregation facility.

Project B: Provide new single-story pharmacy and laboratory buildings.

Project C: Reconfigure and renovate the existing central health services building.

Project D: Construct a new health care administration building outside the secure perimeter.

Project E: Renovate and expand the existing primary care clinic on C Yard.

Recommendations for CCHCS

- Develop a statewide policy to identify required core equipment and supplies for each type of clinical setting, including primary care clinics, specialty clinics, the TTA, the R&R, and inpatient units.

Recommendations for SCC

The OIG recommends the institution develop local operating procedures that help to ensure the following:

- All clinical areas consist of a standardized full complement of core equipment that includes a nebulization unit, medication refrigerator, weight scale, and Snellen eye chart. Each exam room has a biohazard waste receptacle, hemoccult cards and developer (in provider exam rooms), and a supply of sterile tongue depressors.

- All exam settings include rooms that are arranged so that a patient can lie fully extended on the exam table, and the provider and patient can move freely within the room with adequate space for a sufficient exam to be performed.

INTER- AND INTRA-SYSTEM TRANSFERS

Case Review Rating:
Adequate
Compliance Score:
Adequate
(81.2%)

Overall Rating:
Adequate

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

Case Review Results

The OIG clinicians reviewed 21 encounters related to *Inter- and Intra-System Transfers*, including information from both the sending and receiving institutions. Clinicians reviewed 11 encounters for inmates transferring into SCC from other institutions, and ten encounters for inmates transferring out of SCC to other institutions. The OIG also reviewed 46 events related to patients returning to SCC from a community hospital or emergency department.

Transfers In

The OIG clinicians found several minor deficiencies for inmates transferring into SCC from other CDCR institutions, primarily related to incomplete and illegible nursing documentation. However, in one case, the RN did not adequately assess and refer the new arrival for appropriate health care services:

- In case 2, the RN failed to document the patient's history of attempted suicide on the health screening assessment (CDCR Form 7277), when the Transfer Health Care Information form (CDCR Form 7371) indicated the patient had attempted suicide seven years previously. The RN did not make a referral for mental health services. Four days after the patient arrived at SCC, he attempted suicide again, and he was sent out for a higher level of care at a hospital emergency department.

Transfers Out

Similar to transfers in, deficiencies found with inmates transferring out of SCC were largely due to incomplete nursing documentation of significant medical information on the Health Care Transfer Information form (CDCR Form 7371).

- In case 2, the patient was placed in the OHU after a suicide attempt, and later that same month, the patient transferred to another institution. The RN did not document information about the recent suicide attempt on the CDCR Form 7371.

- In case 21, the RN did not document the patient's recent history of chest pain episodes, hospital admissions, or chronic care program appointments for obesity.

- In case 53, the RN did not document that this chemotherapy patient needed maintenance of his portacath (indwelling intravenous access line) with scheduled port flushes.

Hospitalizations

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

TTA nurses processed hospital return patients upon the patients' return to SCC. Although most discharge summaries were retrieved from community hospitals and scanned into the eUHR within acceptable time frames, some ED discharge summaries were not retrieved, and some discharge summaries were not properly signed or dated by a provider (further discussed in the *Health Information Management* indicator). In the majority of cases, RNs appropriately reviewed the discharge medications and the plan of care, and obtained physician orders to implement the plan of care. This adequate performance was attributed to an informal medication reconciliation process in place that was consistently followed by nursing staff (also discussed in the *Pharmacy and Medication Management* indicator).

However, two cases illustrated how a lack of attention to detail can result in transfer errors for patients returning from the hospital. These cases are provided for quality improvement purposes and are not indicative of the general practices at SCC.

- In case 13, the patient returned to SCC after partial thyroidectomy surgery. Although the nurse reviewed the list of discharge medications, the nurse did not review the hospital discharge summary, which stressed the importance of the medication prednisone to prevent nerve degeneration. The provider also did not adequately review the hospital discharge summary and did not order the prednisone. Despite not receiving the medication, the patient suffered no harm.

- In case 5, the patient returned from a hospitalization for congestive heart failure with recommendations to increase critical heart medications. Although the nurse informed the on-call provider of the recommended medication changes, the provider intentionally did not order them. During the onsite inspection, the provider claimed to have been concerned about the patient's blood pressure, which was normal, and intentionally deferred the patient to a different provider the next day. There is no evidence that the on-call provider arranged with the follow-up provider to ensure that the medications were readdressed. In the end, SCC did not implement the medication changes for the patient's heart failure.

Systemwide Transfer Challenges

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

Compliance Testing Results

The institution obtained an *adequate* compliance score of 81.2 percent in the *Inter- and Intra-System Transfers* indicator. SCC performed in the *proficient* range for the tests below:

- For 29 of 30 sampled inmate-patients who transferred into the institution (97 percent), nursing staff completed an Initial Health Screening form (CDCR Form 7277) on the same day the patient arrived. For one patient, the screening nurse did not answer all of the necessary questions on the form (MIT 6.001). For all 30 sampled patients, nursing staff timely completed the assessment and disposition sections of the form on the same day that they performed the patient's screening, scoring 100 percent for this test (MIT 6.002).

- The institution scored 100 percent when the OIG tested transfer packages for three patients who transferred out of SCC during the OIG's onsite inspection and had been prescribed medications. All three transfer packages included the required medications and related documentation (MIT 6.101).

The institution scored within the *inadequate* range for the following two tests:

- Of nine sampled patients who transferred into SCC with an existing medication order, only six (67 percent) continued to receive their medications without interruption. Two patients did not timely receive their KOP medications; one other patient did not receive two nurse-administered medications at the next dosing interval after arrival (MIT 6.003).

- The OIG sampled seven inmate-patients who transferred out of SCC to another CDCR institution to determine whether SCC listed the patients' pending specialty service appointments on their Health Care Transfer Information form (CDCR Form 7371). The institution identified the previously approved and still pending appointments for three of the patients (43 percent), but failed to do so for the four remaining patients (MIT 6.004).

Recommendations

No specific recommendations.

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 PCP prescriber, staff, and patient.

***Case Review Rating**:*
Proficient
***Compliance Score**:*
Proficient
(91.4%)

Overall Rating:
Proficient

Case Review Results

The OIG clinicians evaluate pharmacy and medication management as secondary processes as they relate to the quality of clinical care provided.

Nursing Medication Errors

During the onsite visit, OIG clinicians met with medical, nursing, and pharmacy representatives regarding case review findings. Nursing instruction and monitoring of staff knowledge, skills, and practice regarding medication administration was evident by current records maintained in the individual education and administrative nursing files. The nursing instructor and nursing administrators at SCC had implemented medication administration competency and physical assessment testing as part of the annual training for nursing staff.

Twenty-six medication management nursing events were reviewed in the case reviews, the vast majority of which demonstrated that patients received medications timely and as prescribed. Medication errors found during case reviews were rare. However, the institution can use the following deficiencies for education and quality improvement purposes:

- In case 17, the medication nurse did not document the date keep-on-person (KOP) medications were given to the patient on three KOP medication administration records (MARs) in July and August 2015.

- In case 52, the medication nurses did not initial some of the MARs from April through September 2015. It was unclear whether the patient received some of the essential medications ordered by the provider.

- In case 5, the PCP renewed the prescription for furosemide, but SCC nursing staff did not document administration of the medication to the patient.

Pharmacy Errors

No pharmacy-related errors were identified during the OIG clinician case review.

Medication Continuity

Medication continuity was not a significant problem for the majority of the patients transferring into the institution, returning from a community hospital, or receiving monthly chronic care medications.

Clinician Summary

Pharmacy and medication administration performance was rated *proficient*.

Compliance Testing Results

The institution received a *proficient* compliance score of 91.4 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

For this sub-indicator, the institution received an *adequate* average score of 84 percent. The institution performed well in the following three areas:

- Nursing staff timely administered or delivered new medication orders to 28 of the 30 patients sampled (93 percent). One patient received his KOP medication seven days late, and another never received a newly ordered KOP medication at all (MIT 7.002).

- Among the 30 sampled inmate-patients at SCC who had transferred from one housing unit to another, 28 (93 percent) received their prescribed medications without interruption. Two patients did not receive their nurse-administered medications by the next dosing interval after the transfer occurred (MIT 7.005).

- The institution timely dispensed chronic care medications to 19 of 24 patients sampled, scoring 79 percent for this test. Four patients received refills of their KOP medications from nine days to three months late. In addition, a provider changed one patient's medication from KOP to directly observed therapy (DOT) dosing, but the patient still received a KOP supply of the same medication for one month (MIT 7.001).

The institution could improve in the following medication administration area:

- Clinical staff timely provided new and previously prescribed medications to only seven of ten patients sampled who had been recently discharged from a community hospital and returned to the institution (70 percent). Three patients received their medication from one to three days late (MIT 7.003).

Observed Medication Practices and Storage Controls

For this sub-indicator, the institution received an average score of 89 percent, scoring in the *proficient* range for the following three tests:

- The OIG inspected 12 applicable clinic and medication line storage locations and found that non-narcotic medications that did not require refrigeration were properly stored at all locations, resulting in a score of 100 percent (MIT 7.102).

- SCC nursing staff at all six sampled locations employed appropriate administrative controls and protocols when preparing inmate-patients' medications (MIT 7.105).

- The OIG inspected seven applicable clinic and medication line storage locations and found that non-narcotic medications requiring refrigeration were properly stored at six locations, for a score of 86 percent. At one location, refrigerated medication awaiting return to the pharmacy was not clearly identified or stored separately from other medications (MIT 7.103).

SCC scored in the *adequate* range for the following three tests:

- The OIG interviewed nursing staff and inspected narcotics storage areas at six applicable locations to assess whether strong narcotics security controls existed. Five areas (83 percent) were adequately controlled. At one narcotics storage area, two nurses had access to the narcotics locker key during the same shift (MIT 7.101).

- Nursing staff followed proper hand hygiene contamination control protocols at five of six inspected medication preparation and administration locations (83 percent). At one location, a nurse's hands were not re-sanitized after changing gloves (MIT 7.104).

- Nursing staff followed appropriate administrative controls and protocols during the medication distribution process at five of the six pill lines inspectors observed (83 percent). At one pill line location, there was no overhang to protect waiting patients from inclement weather or extreme heat (MIT 7.106).

Pharmacy Protocols

For this sub-indicator, the institution received a score of 100 percent in each of the following tests:

- In its main pharmacy, the institution followed general security, organization, and cleanliness management protocols; and properly stored and monitored non-narcotic medications that required refrigeration and those that did not. (MIT 7.107, 7.108, 7.109).

- The SCC pharmacist-in-charge (PIC) maintained adequate controls and properly accounted for narcotic medications (MIT 7.110).

- The PIC properly processed all 25 medication error reports the OIG sampled (MIT 7.111).

Non-Scored Tests

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

In another non-scored area, the OIG tested inmate-patients in isolation units to determine if they had immediate access to their prescribed KOP rescue inhalers and nitroglycerin medications. At SCC, there was only one patient applicable to the testing criteria, and he indicated he had possession of his rescue inhaler medication (MIT 7.999).

Recommendations

No specific recommendations.

PREVENTIVE SERVICES

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

Case Review Rating:
Not Applicable
Compliance Score:
Adequate
(82.1%)

Overall Rating:
Adequate

Compliance Testing Results

The institution performed in the *adequate* range in the *Preventive Services* indicator with a compliance score of 82.1 percent. The institution scored in the *proficient* range for the following three tests:

- All 30 inmate-patients the OIG sampled either had a normal colonoscopy within the last 10 years or were offered a colon cancer screening in the last year (MIT 9.005).

- The institution timely offered inmate-patients an influenza vaccination to 29 of 30 sampled inmate-patients, scoring 97 percent for this test (MIT 9.004).

- The OIG tested whether inmate-patients who suffered from a chronic care condition were offered vaccinations for influenza, pneumonia, and hepatitis. At SCC, 15 of the 17 patients sampled (88 percent) received all recommended vaccinations at the required interval. Two patients had no record that they received, or were offered, the recommended pneumonia immunization within the last five years (MIT 9.008).

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

- OIG inspectors sampled 30 inmate-patients to test whether they received an annual tuberculosis screening within the last year. Fifteen of the sampled patients were classified as Code 34 (subject only to an annual signs and symptoms check) and 15 sampled patients were classified as a Code 22 (requiring a tuberculosis skin test in addition to a signs and symptoms check). In total, 23 of the 30 sampled patients (77 percent) timely received these annual tuberculosis screenings. One Code 22 patient did not receive a tuberculosis evaluation within the prior 12-month period. For three other patients, the nurse did not document the time the tuberculosis test was read; therefore, inspectors could not determine if the nurse read the test within the required time frame. For one of those patients, and three other patients, the nurse who performed the screening did not complete the history evaluation section of the tuberculosis report (MIT 9.003).

The institution has room for improvement in the following three areas:

- The institution scored 62 percent for timely administering anti-tuberculosis medication to inmate-patients with tuberculosis. Of the 13 patients sampled, only 8 received all required doses of their medication during the most recent three-month period. Three patients missed one medication dose during the period and did not receive counseling for the missed medication; for two other patients, their MAR indicated they received an extra dose of medication (MIT 9.001).

- When the OIG reviewed the institution's monthly monitoring of sampled patients who received anti-tuberculosis medication, the institution was in compliance for only 9 of those 13 patients (69 percent). Four inmate-patients did not receive monthly monitoring each month during the three-month test period (MIT 9.002).

Recommendations

No specific recommendations.

QUALITY OF NURSING PERFORMANCE

Case Review Rating:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

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

Case Review Results

The OIG evaluated 402 nursing encounters for the SCC case review, of which 217 were outpatient nursing encounters. Of the 217 outpatient nursing encounters reviewed, approximately 170 were for sick call requests (CDCR Form 7362) or primary care clinic nurse follow-up visits, 15 were for RN care management, and 32 were for other outpatient nursing encounters such as public health and specialty care nurses. In general, SCC nursing services performed well. There were 68 deficiencies in outpatient nursing services, but the majority were unlikely to contribute to patient harm. Nevertheless, these deficient areas are clearly established in CCHCS policy as requirements for nursing care and practice and, therefore, are subject to appropriate quality improvement strategies. Three cases (12, 21, and 69) had deficiencies with the potential for adverse outcomes or unnecessary delays in needed health care services for patients presenting in outpatient clinics with medical problems.

Nursing Sick Call

The majority of sick call RNs appropriately assessed complaints and symptoms, and provided necessary interventions for patients presenting with medical issues in the outpatient RN clinics. The

quality of nursing performance was affected by patterns of deficiencies that included assessment, implementation of appropriate interventions based on assessment, and nursing documentation. The following examples demonstrate types of deficiencies found in the sick call process:

- In case 13, the patient had a neck wound and complained of problems chewing and swallowing solid foods during his recent hospitalization for a thyroidectomy, and requested a soft diet. The sick call RN did not contact the provider about ordering a soft diet or provide instruction about appropriate food choices or safe eating methods.

- In case 21, the RN reviewed a sick call request (CDCR Form 7362) submitted by a patient in the administrative segregation unit for lower abdominal pain at level 7 out of 10, but did not assess the patient on the same day. During the onsite visit, nursing administrators stated that an RN was assigned to make daily rounds in the administrative segregation unit. However, there was no documentation found in the eUHR of nursing assessment of this patient.

- In case 69, the sick call RN saw the patient, a new arrival to SCC nine days previously, with a history of colitis and chronic rectal bleeding. The RN did not assess the patient for current rectal bleeding status, contact a provider for consultation, or make an urgent provider referral for this new arrival. The plan of care was to stop ibuprofen (likely due to potential adverse effects related to gastrointestinal irritation and prolonged bleeding), but it was not until 13 days later that the provider discontinued the medication.

- In several cases, the sick call RN did not address each medical complaint or all symptoms per CCHCS nursing protocols (cases 37, 38, and 47).

Other Outpatient Nursing Encounters

- In case 12, the RN case manager did not order a follow-up appointment for this cancer patient even though the plan of care was to monitor him every 30 days. This resulted in the patient being dropped from subsequent RN case management follow-up visits.

- In two cases, nursing staff did not read tuberculosis (TB) skin test results in accordance with the CDC guidelines of between 48 and 72 hours after skin test placement (injection). Errors occurred when TB test results were read prematurely the day after the injection (case 52), and when the date and time of reading the test results were not documented at all, even though the results were signed by nursing staff (case 4).

Medication Administration

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

Clinician Onsite Inspection

During the onsite visit, the OIG found nurses in outpatient clinic settings at SCC to be active participants in the primary care team morning huddles. The huddles started and ended on time and were well attended in all clinics by the providers, sick call nurses, nurse case managers, medication line nurses, mental health staff, schedulers, and others. Sick call nurses facilitated morning reports and discussions about currently hospitalized and newly discharged patients, TTA visits, physician-on-call reports, mental health concerns, and any other issues related to current patients and the day's clinic. All staff members had the opportunity to participate in the team discussions.

The OIG conducted interviews during walking rounds, and the RN and LVN staff verbalized having no major barriers with initiating communication with nursing supervisors, providers, and custody officers regarding patient care needs and providing nursing services to patients. The public health nurse maintained the current inmate population surveillance status of specific patients being monitored. The receiving and release nurse clearly demonstrated knowledge of processes established at SCC to assess the health care status and needs of incoming inmates. The OIG commends the nursing staff at SCC for their knowledge about assigned patients, specific processes and procedures for their individual assignments, and the institution-wide nursing practice policies.

Outpatient nurses and nursing case managers have a crucial role in assessing, facilitating interventions for, and coordinating the needed health care services for patients with chronic and acute care needs. Although case review revealed that the quality of outpatient nursing care was *adequate,* nursing education strategies for ongoing quality improvement are clearly indicated.

Recommendations

The OIG recommends that SCC develop improvement strategies to ensure the proficiency and monitoring of all sick call nurses in the following areas:

- Conducting a focused subjective and objective nursing assessment that is based on both the patient's current complaints and past health history.
- Completing and documenting a focused physical assessment of each medical complaint.
- Documenting accurate legible nursing notes according to subjective, objective, assessment, plan, education (SOAPE) note format requirements, which include the nursing assessment conclusion written in the NANDA[6] taxonomy format, as required by CCHCS nursing protocols.

[6] NANDA International (formerly known as the North American Nursing Diagnosis Association) is an international professional nursing organization that sets industry guidelines for nursing terminologies and nursing diagnosis.

QUALITY OF PROVIDER PERFORMANCE

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

Case Review Rating:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

Case Review Results

The OIG clinicians reviewed 280 medical provider encounters and identified 143 deficiencies related to provider performance at SCC. Despite these numerous deficiencies, the OIG clinicians rated provider performance *adequate* because most of the deficiencies did not pose a significant medical risk to SCC's overwhelmingly low medical complexity patient population.

Assessment and Decision-Making

SCC providers demonstrated inadequate assessment and decision-making in the majority of cases reviewed. Because SCC provider continuity was extremely poor, there were many errors in this category. Provider errors in assessment and decision-making were widespread, and OIG clinicians identified errors in cases 3, 4, 14, 16, 17, 18, 26, 27, 29, 30, 31, 32, 34, 35, and the following four cases:

- In case 5, after initial success managing the patient's congestive heart failure, the PCP intentionally allowed the patient's diuretic medication to expire without an adequate monitoring plan, even though the patient had been requiring daily diuretic medication treatment for the past month. This error contributed to one of the patient's potentially preventable hospitalizations.

- In case 13, the patient required care for a thyroid mass as well as seizures. Providers repeatedly failed to address abnormal laboratory test results for this patient's seizure medication levels. In addition, providers repeatedly inadequately reviewed the patient's hospital records, and did not address the hospital surgeon's recommendations for steroid medication to prevent further nerve damage.

- In case 15, the provider repeatedly ignored elevated blood pressure measurements that staff had documented on the patient's flowsheet for over a year.

- In case 23, the provider evaluated the patient for symptoms of chest pain and obtained an electrocardiogram. The electrocardiogram was abnormal and showed changes that were

suggestive of insufficient blood flow to the heart, which placed the patient at high risk for having a heart attack. Instead of sending the patient to a higher level of care immediately, the provider ordered a routine cardiac stress test.

The examples listed above were illustrative of the types of errors that occurred when SCC cared for a rare patient with moderate to high medical complexity. Fortunately, the vast majority of patients at SCC were of extremely low medical complexity, where similar types of errors were much less likely to cause harm.

- In case 4, the patient was generally healthy with a medical history of only hepatitis C. The patient was involved in an altercation and sustained multiple head and facial traumas. After being cleared by a local emergency room, the patient continued to have symptoms of abdominal pain. The provider did not adequately review the CT scan report, which indicated that the patient may have had pancreatitis, so the provider did not consider the diagnosis. The provider also failed to perform an adequate physical examination or order appropriate urine tests. Because of the general good health of the patient, the likelihood of these more serious conditions was low; the provider errors did not constitute significant risk of harm to the patient. Fortunately, the patient suffered no harm and his symptoms resolved spontaneously.

Since the majority of cases were similar to case 4, i.e., patients with low medical complexity were not exposed to excessive risk of harm despite the provider errors identified, most of the physician-reviewed cases garnered adequate ratings. Many of these errors were associated with poor provider continuity. When the institution provided good provider continuity, SCC did demonstrate the ability to adequately care for patients.

- In case 12, the patient had lymphoma. The regular provider monitored the patient closely after he had completed his chemotherapy for lymphoma. The provider ordered regular lab tests, positron emission tomography (PET) scans, and specialty appointments to ensure that the patient received necessary care. Provider continuity was good in this case.

Provider-Ordered Follow-up Intervals

The OIG clinicians found a pattern in which providers did not order appropriate follow-up for their patients. This error occurred in cases 16, 32, 52, and the following three cases:

- In cases 15 and 29, the patients had poorly controlled diabetes, and the provider ordered a follow-up in four months, with no plans to review the fingerstick glucose logs in the meantime.

- In case 30, the provider was concerned about the possibility of a pseudomonas wound infection, which was potentially extremely serious. However, the provider ordered a

follow-up in 14 days, which was unsafe if indeed the patient truly had a serious wound infection.

Review of Records

SCC providers frequently demonstrated they performed only a cursory review of patients' records. OIG clinicians identified this deficiency in cases 13, 14, 15, 17, 27, 29, 33, 34, 52, and the following three cases:

- In case 16, the patient required management for his chronic conditions of diabetes and hypertension. During two patient encounters, the provider did not review blood sugar logs or recognize that during the patient's recent hospitalization, the patient's blood pressure medications changed. On a later date, the provider did not review the blood pressure checks medical staff had performed weekly for the past eight weeks.

- In case 23, three weeks after a different provider failed to send the patient to a higher level of care for chest pain with electrocardiographic changes, the provider did not review the recent electrocardiograms, despite the patient giving a history of chest pressure and sweating as recent as the previous day.

- In case 26, multiple providers saw this patient with uncontrolled diabetes. On two occasions, providers failed to review important blood sugar logs, which contributed to their lack of appropriate intervention in this case.

While some of the cursory record review was attributed to individual provider skill and work habits, many of the deficiencies were associated with poor provider continuity. Because of poor provider continuity, SCC providers were not adequately familiar with their patients, leading to many of the errors identified in this indicator. Extensive medical record review is time consuming and lowers the number of patients a provider can see in a single workday. Thus, there was a tendency for providers to perform cursory record review and to address only the most pressing issue at the time of the patient encounter. Since the chance for any one patient to consistently see the same PCP was low, this cursory care continued in a self-perpetuating cycle.

Emergency Care

SCC emergency care provider performance was adequate. While assessments and decision-making were sometimes inaccurate and questionable, providers generally made appropriate triage decisions and sent their patients to higher levels of care when needed. This is further discussed in the *Emergency Services* indicator.

Chronic Care

Chronic care performance was adequate. SCC patients were of markedly low medical complexity and did not require any anticoagulation or HIV management. Hepatitis C management at SCC was adequate, though all of the patients reviewed were relatively healthy and did not require treatment for hepatitis C or end-stage liver disease.

Although the management of diabetic patients was initially poor, it improved significantly during the last few months of the review period.

- In case 26, the patient had poorly controlled diabetes. Providers initially did not adequately review blood glucose data, failed to monitor fasting glucose levels even though the patient was on basal insulin, and chronologically ordered follow-up intervals and insulin adjustments too far apart. However, after five months, providers corrected their errors and delivered good diabetic care.

- Similarly, in case 27, providers did not adequately review blood sugars, made insufficient insulin adjustments, and ordered inappropriately long follow-up intervals. The patient's HgbA1c (average blood sugar measurement) levels spiked from 9.6 to 11.4 (poor control is greater than 9.0). However, after three months, providers began to follow the patient closely, reviewed his fingerstick data appropriately, and made appropriate adjustments to his insulin regimen. This resulted in much better diabetic control, as evidenced by the marked reduction in the patient's HgbA1c level from 11.4 in August down to 7.6 by mid-September (the target goal for this patient was below 8).

Specialty Services

SCC providers referred patients for specialty services appropriately. While there were occasional problems where providers delayed the referral or requested the service without the proper priority, most cases demonstrated appropriate specialty services usage.

Documentation Quality

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

- In case 27, a provider did not document a progress note for an encounter that was intended to address out-of-control diabetes and to make a decision whether to prescribe ACE inhibitor (blood pressure) medication therapy. At the time of the encounter, the patient's parole was imminent, and the provider's failure to act resulted in a delay in care.

- In case 31, the patient still had a fever despite having been prescribed antibiotics. The progress note lacked a sufficiently thorough assessment and plan. In addition, the document

did not accurately describe what happened to the patient. In the progress note, the provider had planned to send the patient to an outside hospital emergency room, but the patient was admitted to the OHU instead.

- In case 30, the patient appeared to have a potentially infected wound draining green, purulent discharge. The provider decreased the frequency of dressing changes without documenting the reason, and without evidencing that the provider examined the wound prior to the dressing change order.

Onsite Inspection

At the time of the OIG's inspection, SCC had not yet implemented its primary care home model of health care delivery. The chief medical executive (CME) indicated that there was very little available physical space to place additional health care staff. In fact, SCC had one available physician position open, but the CME had no office space to place the provider, which was one reason the position remained vacant.

Because of the lack of available space, nursing encounters occurred in a separate physical location from the provider encounters. When nurses required communication with providers, they called the provider, but no actual joint visits were provided due to their physical separation. The future Health Care Facility Improvement Project may improve this with increased space.

SCC also utilized a "rover" system, where a rotating physician provided overflow provider services on a daily basis. The rover was responsible for seeing patients in the TTA, evaluating clinic add-on patients, and potentially caring for any acute needs of OHU patients. While this system did serve to relieve pressure on the institution when patients had more acute needs, it also contributed to the poor provider continuity, since SCC rotated the rover responsibility among the providers frequently.

In an attempt to improve continuity of care, the institution assigned patients to an individual provider by the last two digits of their CDCR identification number. Case reviews found this practice to be rarely successful in promoting continuity of care. At the onsite inspection, the OIG clinicians discovered that too often, SCC scheduled patients to see a different provider due to provider time off and scheduling logistics. Of particular concern was provider continuity on C Yard, where SCC held its most medically complex patients. While the entire C Yard patient population was divided among all the SCC providers, essentially only one or two exam rooms were available for provider use on a daily basis. This resulted in each provider rotating into C Yard only once per week, approximately. It was exceedingly difficult, if not impossible, for SCC to maintain adequate provider continuity when each PCP was available for patients only once per week.

The CME explained that the primary care home model was about to be implemented at SCC in the beginning of 2016, which he hoped would improve provider continuity of care. In addition, when the clinic building expansions at SCC were completed and there was adequate physical space, nursing staff could be brought back to the clinic to create a true primary care team. The additional

space could potentially allow providers to attend to their C Yard patients more than once per week. While one or two dedicated C Yard providers would theoretically solve the provider continuity problem, the CME explained that prior experimentation with assigning specific providers to that yard resulted in high levels of provider burnout because C Yard (a special needs yard) was filled with particularly challenging and demanding inmate-patients.

The morning huddle was actually an audio teleconference each morning between the main clinic and the C Yard clinic. This institution-wide teleconference served to keep the primary care providers abreast of any new or outstanding issues with their patients. Case management nurses discussed all patients whose diabetes was out of control or who had concerning blood sugar readings. The CME had recently implemented an administrative review of the master registry and had instructed providers to attend to those patients whose diabetes the registry identified as out of control. This positive change was evident in the case reviews, and resulted in at least two initially inadequate diabetic cases ultimately being rated adequate (cases 26 and 27).

SCC providers felt that morale was good among the provider group, and they generally enjoyed working at SCC. Most providers described the CME as open, compassionate, and fair. The CME was also described as emotional and passionate, occasionally excessively so. Providers felt that their job performance was adequately monitored through various means, such as the annual chart reviews, morning huddle, quality improvement teams, and master registry and population management. Some providers complained of excessive job performance monitoring, including CCHCS headquarters and OIG reviews, but at the same time, complained of receiving only sporadic and insufficient feedback. SCC did not have a chief physician and surgeon. Instead, all provider monitoring and feedback was the responsibility of the CME.

Clinician Summary

SCC provider performance was marginally *adequate*. The case reviews demonstrated strong patterns of deficiencies in assessment and decision-making, insufficient documentation, cursory review of records, and inappropriate follow-up intervals. The majority of these deficiencies were associated with poor provider continuity, rather than provider skill or work ethic. In the few cases reviewed in which SCC did have medically complex patients, SCC providers did not perform adequately due to the poor provider continuity. As most patients at SCC were low medical risk, these deficiencies did not place the patient at significant risk of harm.

Recommendations

The OIG recommends that SCC:

- Expedite the implementation of its primary care home model of health care delivery to improve provider continuity within the institution. Improved provider continuity needs to occur in both the SCC primary care clinics (especially C Yard) as well as the OHU.

- Monitor provider staffing levels, overtime accumulation, and provider time off to minimize their detrimental effects on provider continuity.

- Modify its "rover" provider system to provide more continuity in provider care. Require that patients be seen by their own primary care provider if they develop acute symptoms during their provider's regular working hours. By having the rover provider see all patients who develop acute symptoms, SCC unintentionally increases the number of patient hand-offs that occur and creates discontinuity in provider care.

- Provide better PCP coverage and improve provider continuity of care for patients on C Yard, which is where SCC's most medically complex patients are housed. Dedicate one or two providers specifically to C yard patients, instead of dividing that patient population among all providers.

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

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

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

Overall Rating:
Adequate

For 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. The OIG's internal review process considered those factors that led to both scores and ultimately rated this indicator *adequate.* The key factors were that the case review had a larger sample size, and the case review focused on the quality of care provided. As a result, the case review testing results were deemed a more accurate reflection of the appropriate overall rating.

Case Review Results

At the time of the OIG's inspection, SCC had a ten-bed OHU, of which two beds were designated for mental health patients on one-to-one monitoring. OIG clinicians reviewed a total of 69 provider encounters and 97 nursing encounters in ten cases that included admissions to the OHU for a higher level of supervised medical treatment and monitoring. The OIG clinicians identified deficient areas in both nursing and provider care, as demonstrated by findings in the following case review examples.

Nursing Performance

The OHU nursing performance was generally adequate. Although OIG clinicians identified various practice improvement issues, the majority of nursing encounters reviewed demonstrated appropriate patient-specific nursing assessment, interventions, and documentation. Of the 45 deficiencies identified for nursing services, the majority were unlikely to contribute to patient harm. The examples of the identified deficiencies listed in this report are for educational and quality improvement purposes.

Inadequate Nursing Assessment and Intervention

- In case 13, the patient was admitted to the OHU after returning from thyroidectomy surgery at a community hospital. The RN did not assess or address the patient's complaint of pain, noted there was no pain medication ordered, but did not follow up with the provider for an order for pain medication. The LVN noted the patient only ate 30 percent of his dinner, had problems swallowing, and needed a liquid or soft diet, but did not follow up with the

provider regarding the patient's complaint of difficulty swallowing and the possible need to change his diet.

- Nursing staff did not measure specific oral fluid intake and urinary output amounts every shift as ordered by the provider for patients who were on fluid restriction or experiencing edema (swelling) of the lower extremities (cases 23 and 24).

- Nurses administered pain medication, anti-nausea medication, and insulin, but did not document patient reassessment for effectiveness or response to the intervention (cases 13, 23, 53, and 67).

- In case 53, the medication nurse administered morphine for pain despite blood pressures below 100 systolic, and did not notify the provider about the low blood pressures.

Inadequate Nursing Documentation

- Nurses did not document a discharge nursing assessment, discharge follow-up instructions, or outpatient disposition at discharge from the OHU (cases 22 and 23).

- In case 53, OHU nurses often did not document an assessment of the peripherally inserted central catheter (PICC) intravenous line site regarding signs and symptoms of infection, nor that the line was flushed every 12 hours per nursing protocol. On one occasion, the RN informed the provider there was no blood return when the PICC line was flushed, indicating malfunction, but did not document whether orders were given. The next day, the patient was sent offsite to a community hospital for a higher level of care for PICC line infection.

Provider Performance

SCC did not have a specific provider assigned to OHU care, which resulted in poor provider continuity. Instead, patient care in the OHU was generally delivered by the rover provider, the assignment of whom rotated among the SCC providers on a daily basis. OIG clinicians identified many of the same types of deficiencies associated with poor continuity of care during the case reviews for OHU patients, that were found for ambulatory clinic patients. In institutions where patients have complex medical needs, these types of deficiencies are often associated with inadequate care. However, because the vast majority of SCC patients had remarkably low medical complexity, these deficiencies led the OIG clinicians to rate most OHU cases suboptimal, but still adequate.

Most of the provider deficiencies identified in the OHU were identical to those found in the general SCC ambulatory setting, including the following: inadequate OHU provider assessments in cases 1, 3, 4, 5, and 13; poor provider continuity throughout the OHU case reviews; inadequate record

reviews in cases 5 and 13; and inadequate documentation in cases 3, 13, 24, and 36. In addition, case 3 demonstrated inadequate pain management evaluation.

The following examples are provided for quality improvement purposes only regarding provider continuity of care in the OHU:

- In case 5, the patient submitted a sick call form while in the OHU with complaints of increasing cough and chest pain. The nurse discussed the symptoms with the provider during the morning huddle, and the nurse only ordered a change in the patient's inhaled steroid medication, but did not reevaluate the patient for possible recurrent congestive heart failure. Considering that the patient had severe cardiomyopathy, and the hospital discharged the patient for congestive heart failure only two weeks prior, the OHU provider should have reevaluated the patient the same day the nurse mentioned the symptoms in the huddle. Furthermore, when the patient returned from the hospital, the OHU providers failed to order daily weight checks. Despite documenting that the plan of care was to optimize the patient's medications for congestive heart failure, the providers spent months without adjusting the patient's heart medications at all.

- In case 13, the patient returned from the hospital after his entire thyroid was removed. The OHU provider performed an incomplete assessment, and neglected to address the patient's recent history of uncontrolled seizures and subtherapeutic seizure medication levels.

- Also in case 13, subsequent to the incident above, SCC sent the patient to an emergency room for recurrent seizures. The emergency room recommended a neurology consult. SCC admitted the patient to the OHU upon his return to SCC. The OHU providers did not consider the recommendation for a neurology consult, made no changes to the patient's seizure medications, and discharged the patient from the OHU the next day even though the patient's seizures were still not controlled.

Clinician Summary

SCC provided marginally adequate OHU care to patients, with significant room for improvement. Identified errors related to both nursing and provider care. Nursing errors related to assessment, intervention, and documentation. Provider errors were generally associated with poor continuity of provider care. However, because of the extremely low medical complexity of SCC's patient population, these errors did not result in a significant risk of harm for most cases reviewed.

Compliance Testing Results

The institution received a *proficient* score of 98 percent for the *Specialized Medical Housing* indicator, which focused on the institution's outpatient housing unit (OHU). The institution received a *proficient* score in all of the indicator's test areas, which included the following:

- For all ten patients sampled, nursing staff timely completed an initial assessment on the day a provider admitted the inmate-patient to the OHU (MIT 13.001).

- Providers evaluated all ten sampled patients within 24 hours of admission to the OHU (MIT 13.002).

- Providers completed their subjective, objective, assessment, plan, and education (SOAPE) notes at required 14-day intervals for all ten sampled patients (MIT 13.004).

- SCC had a local operating procedure requiring staff to perform 30-minute welfare checks on patients in the OHU; the OIG found that SCC staff timely documented this monitoring. In addition, according to staff interviewed, custody officers and clinicians were able to access a patient's room in 15 seconds when an emergent event occurred. As a result, the institution received a score of 100 percent for this test (MIT 13.101).

- Providers completed a history and physical (H&P) exam within 72 hours of admission to the OHU for nine of ten patients (90 percent). For one patient, the provider neglected to include all required elements of the H&P exam, including a review of systems for the patient, and the patient's sexual, marriage, and education history (MIT 13.003).

Recommendations

The OIG recommends that SCC:

- Evaluate the current process in the OHU for monitoring nursing performance in basic nursing practice functions, such as PICC line assessment and care, monitoring of fluid intake and output, and nursing assessment after an intervention.

- Establish methods to ensure that nursing staff document nursing assessments and interventions for each patient encounter, that the documentation specifically reflects the patient's status and needs, and that it is thorough and accurate.

- Improve continuity of provider care in the OHU, to lower the frequency of patient hand-offs and reduce oversight errors.

SPECIALTY SERVICES

***Case Review Rating**:*
Adequate
***Compliance Score**:*
Proficient
(87.1%)

Overall Rating:
Adequate

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

For this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance review resulting in a *proficient* score. The OIG's internal review process considered those factors that led to both results and ultimately rated this indicator *adequate.* The key factors were that providers often ordered specialty services as routine when an urgent referral was appropriate and there were frequent delays in specialty report retrieval. As a result, the OIG's inspection team concluded that the appropriate overall rating for this indicator was *adequate*.

Case Review Results

The OIG clinicians reviewed 153 events related to *Specialty Services*, 96 of which were specialty consultations and procedures. The OIG clinicians found 38 deficiencies in this category.

Access to Specialty Services

Specialty services were generally provided within adequate time frames for routine and priority services. Specialty services of an urgent priority were generally marked "routine" by the PCP, with the provider then making an additional handwritten notation of "priority" on the specialty request form. For the cases reviewed, this review process worked well; SCC completed most specialty referrals within acceptable time frames, with only one notable exception: in case 13, the institution significantly delayed performing the patient's radioactive iodine treatment for a thyroid malignancy because the institution was not prepared to perform the procedure.

Nursing Performance

SCC nurses performed adequate assessments for patients being prepared for or returning from specialty appointments. There were only four minor deficiencies in this area.

Provider Performance

SCC providers sometimes delayed the referral or requested the service without the proper priority. While this practice was not common, the institution can use the following examples for quality improvement purposes:

- In case 22, the patient sustained injuries during an inmate riot. SCC providers sent the patient to an outside emergency department, where hospital staff diagnosed him with a fractured eye socket. Recommendations from the emergency room were for the patient to have follow-up with a head and neck surgeon in two weeks as well as an ophthalmology follow-up in three to four weeks. When the patient returned to SCC, the provider ordered the ophthalmology appointment, but neglected to order the head and neck surgeon referral.

- In case 4, the patient had a recent altercation with another inmate, and described seeing "floaters" in one of his eyes. The provider did not assess the patient's visual fields or visual acuity. There was no evidence that the provider considered that the patient may have had a potential retinal detachment. Instead, the provider initiated a specialty referral six days later, and with only routine priority. The provider should have instead ensured that an eye specialist evaluated the patient on an urgent, if not emergent, basis.

Despite the above examples, SCC providers generally initiated referrals when medically needed, and directed them to appropriate specialists.

Utilization Management

The OIG clinicians found no significant problems with SCC's utilization management program.

Health Information Management

There were frequent delays in the retrieval of specialty reports, found in cases 12, 14, 15, 16, 18, 22, 29, and 52. In cases 12 and 22, SCC failed to retrieve some specialty reports altogether. Delays in retrieval or non-retrieval of specialty reports significantly increased the risk of delays or lapses in care.

Onsite OIG Clinician Inspection

SCC management explained that the previous offsite specialty coordinator had fallen ill, and the new coordinator was in the process of steadily improving the performance of specialty report retrieval and ensuring patients obtained timely specialty services. SCC management explained that even though specialty requests were often marked with "routine" priority, providers often wrote a secondary notation of "priority" and sent word-of-mouth transmissions for those services that required expedited processing. Those specialty requests were separated from the routine ones by being placed physically on the desk of the offsite specialty coordinator, ensuring that they were

addressed on a daily basis. While this informal process seemed to work well for the majority of specialty services provided, SCC had no formal priority scheduling system in place.

Clinician Summary

SCC provided adequate specialty services. Providers did a good job of identifying and referring patients appropriately when needed. Specialty access was generally adequate, despite the institution not having a formal method of identifying and tracking specialty requests that fell in between routine and urgent priority time frames. Specialty report handling was only marginally sufficient, with frequent delays in report retrieval. Despite the problems identified, SCC provided patients with needed specialty care. The OIG clinicians thus rated this indicator *adequate*.

Compliance Testing Results

The institution received a *proficient* compliance score of 87.1 percent in the *Specialty Services* indicator. SCC scored in the *proficient* range in the following test areas:

- High-priority specialty service appointments occurred within 14 calendar days of the provider's order for all four patients sampled (MIT 14.001). In addition, all 15 inmate-patients sampled received their routine specialty services appointment within 90 calendar days of the provider's order (MIT 14.003).

- Providers timely received and reviewed the specialists' reports within the required time frames for all four of the sampled patients who received a high-priority specialty service (MIT 14.002).

- The institution timely denied providers' specialty service requests for all 20 sampled patients (MIT 14.006).

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

- Providers received and reviewed the specialists' reports for 12 of the 15 sampled patients who received a routine specialty service (80 percent) within the required time frame. However, providers reviewed three of the reports late by one to six days (MIT 14.004).

- Among 20 patients sampled who had a specialty service denied by the institution's health care management, 15 patients (75 percent) received timely denial notification, which included the provider meeting with the patient within 30 days of the denial to discuss alternate treatment strategies. For two patients, this requirement was not met at all; three other patients received a follow-up visit from 3 to 17 days late (MIT 14.007).

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

- When inmate-patients at one institution have an approved pending or scheduled specialty services appointment and then transfer to a different institution, policy requires that the receiving institution reschedule or provide the patient's appointment within the required time frame. Of 20 sampled patients who transferred to SCC with an approved appointment, only 11 patients (55 percent) timely received their specialty services upon arrival. Of those nine patients who did not receive their services timely, one did not receive his service at all. Eight other patients received their specialty services from 4 to 54 days late (MIT 14.005).

Recommendations

The OIG recommends that SCC:

- Implement a formal tracking system to ensure that all specialty reports are timely retrieved, forwarded to the PCP for review and signature, and scanned into the medical record.

- Implement a formal priority scheduling process that is not dependent on word-of-mouth communication and the specialty coordinator's individual work habits. Require that providers clearly document the number of days within which the service must occur. If it is fewer than 14 days, mark the request with "urgent" priority. If it is more than 14 days, identify the request as "routine." This will aid the specialty coordinator in properly queuing and tracking the requests.

SECONDARY (ADMINISTRATIVE) QUALITY INDICATORS OF HEALTH CARE

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

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 SCC in October 2015. They also reviewed documents obtained from the institution and from CCHCS prior to the start of the inspection. The test questions used to assess compliance for each indicator are detailed in *Appendix A*.

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

INTERNAL MONITORING, QUALITY IMPROVEMENT, AND ADMINISTRATIVE OPERATIONS

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(57.1%)

Overall Rating:
Inadequate

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

Compliance Testing Results

The institution scored within the *inadequate* range in the *Internal Monitoring, Quality Improvement, and Administrative Operations* indicator, receiving a score of 57.1 percent. The low score primarily resulted from the following four tests that scored in the *inadequate* range:

- The institution had not taken adequate steps to ensure the accuracy of its Dashboard data reporting. Specifically, SCC's Quality Management Committee meetings did not discuss methodologies used to conduct periodic validation and testing of Dashboard data, and the committee did not discuss methodologies used to train staff who collect Dashboard data. As a result, SCC received a score of zero for this test (MIT 15.004).

- The SCC's 2014 Performance Improvement Work Plan (PIWP) did not include adequate evidence demonstrating the institution's improvement in achieving targeted performance objectives for any of its nine quality improvement initiatives. In general, the work plan included insufficient progress information to demonstrate that each of its nine performance objectives either improved or reached the targeted level. As a result, SCC received a score of zero for this test (MIT 15.005).

- The OIG inspected documentation for 12 emergency medical response incidents reviewed by the institution's Emergency Medical Response Review Committee (EMRRC) during the prior six-month period and found that 6 of 12 sampled incident packages (50 percent) complied with policy. Five of the packages tested did not include the EMRRC checklist. The EMRRC committee documented one other event as a placeholder because it did not timely receive the incident package and review it; the documentation did not include the medical review form or the checklist (MIT 15.007).

- Emergency response drill packages for two of three medical emergency response drills conducted in the prior quarter contained all required summary reports and related documentation. The second watch drill package did not include the Triage and Treatment Services Flowsheet (CDCR Form 7464); and the Crime/Incident Report (CDCR Form 837), Interdisciplinary Progress Notes (CDCR Form 7230), or Cardiopulmonary Resuscitation Record (CDCR Form 7462), all of which are required when an inmate death occurs during a drill scenario. As a result, SCC received a score of 67 percent for this test (MIT 15.101).

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

- SCC processed inmate medical appeals timely for all 12 of the most recent months (MIT 15.001). In addition, inspectors sampled ten second-level inmate medical appeals and found that all ten of the appeal responses addressed the inmate-patient's initial complaint (MIT 15.102).

- The institution's QMC met monthly, evaluated program performance, and took action when staff identified improvement opportunities in five of the six months tested. The QMC meeting minutes for March 2015 did not provide evidence that the committee evaluated program performance. As a result, SCC received a score of 83 percent for this test (MIT 15.003).

Other Information Obtained from Non-Scored Areas

The OIG gathers non-scored data regarding the completion of death review reports to determine if CCHCS's Death Review Committee sends the final reports to the institutions on a timely basis. However, SCC did not have any inmate deaths during the OIG's 12-month test period ending August 2015 (MIT 15.996).

Inspectors met with the institution's chief executive officer (CEO) to inquire about SCC's protocols for tracking appeals. The CEO and the appeals coordinator reviewed monthly appeals reports together. The reports identify appeals processed and their disposition, and list appealed issues by category. The medical management team worked with the inmates to resolve appeals. Medical staff discussed appeals in QMC meetings, and if the issues were related to a staff member's work, the employee's supervisor ensured the problem was resolved. Medical appeals at SCC were consistently low in number and, in the past six months, management had not had to address any critical issues due to management's ability to identify issues as they arose and quickly resolve problems (MIT 15.997).

Informational data gathered regarding the institution's practices for implementing local operating procedures (LOPs) indicated that the institution had an effective process in place for developing LOPs. The institution's health program specialist (HPS) maintained an internal tracking log that

identified all LOPs, their revision due dates, and the appropriate staff who needed to review each LOP. When CCHCS revised a policy and procedure (P&P), the HPS reviewed the P&P and determined if the institution's current LOP needed revision. If a revision was necessary, the HPS routed the new P&P and revised LOP to stakeholders and then to the QMC committee for review at the next QMC meeting. The HPS made final corrections prior to final approval by the CEO and warden. The final LOP was scanned into the health care share drive, and supervisors were responsible for ensuring staff were aware of the new LOP. At the time of the OIG inspection, the institution had implemented 47 of the 48 applicable stakeholder-recommended LOPs (98 percent) (MIT 15.998).

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

Recommendations

No specific recommendations.

JOB PERFORMANCE, TRAINING, LICENSING, AND CERTIFICATIONS

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

***Case Review Rating**:*
Not Applicable
***Compliance Score**:*
Proficient
(94.6%)

Overall Rating:
Proficient

Compliance Testing Results

The institution received a *proficient* compliance score of 94.6 percent in the *Job Performance Training, Licensing, and Certifications* indicator.

For seven of the indicator's eight tests, the institution scored 100 percent, as follows:

- Nursing supervisors completed proper reviews of staff for all five samples tested (MIT 16.101).
- All ten nurses sampled were current on their clinical competency validations (MIT 16.102).
- All providers were current with their professional licenses (MIT 16.001).
- All active duty providers, nurses, and custody staff were current with their emergency response certifications (MIT 16.104).
- All nurses and the pharmacist-in-charge were current with their professional licenses and certification requirements (MIT 16.105).
- The pharmacy and providers who prescribed controlled substances had current Drug Enforcement Agency registrations (MIT 16.106).
- Finally, all nursing staff hired within the last year timely received new employee orientation training (MIT 16.107).

The institution has room for improvement in the following remaining area:

- OIG reviewed clinical performance evaluation packages for SCC's seven providers and found that only four contained all required documentation (57 percent). For three providers, the physician supervisor did not document whether the Unit Health Record Clinical Appraisals were discussed with the provider being evaluated (MIT 16.103).

Recommendations

No specific recommendations.

POPULATION-BASED METRICS

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

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

Methodology

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

Comparison of Population-Based Metrics

For Sierra Conservation Center, nine HEDIS measures were selected and are listed in the following Table, *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. SCC performed well with its management of diabetes.

When compared statewide, SCC outperformed the Medi-Cal scores in all five diabetic measures selected (diabetic monitoring, diabetics under poor control, diabetics under good control, blood pressure control, and eye examinations). When compared to Kaiser Permanente, SCC outperformed Kaiser in all diabetic measures except blood pressure control. When compared nationally, SCC also outperformed Medicaid, Medicare, and commercial health plans (based on data obtained from health maintenance organizations) in each of the five diabetic measures. Also, SCC outperformed the United States Department of Veterans Affairs (VA) in all applicable measures except blood pressure control, in which SCC scored only 2 percentage points lower.

Immunizations

Comparative data for immunizations was only fully available for the VA (national) and partially available for Kaiser Permanente (statewide) and commercial (national). Regarding the administration of influenza shots to younger adults, SCC outperformed Kaiser and commercial plans and matched the VA's score. For influenza shots to older adults, SCC outperformed the VA, the only other entity for which there was comparable data. However, for influenza immunizations to both younger and older adults, the institution had offered the service to all patients the OIG sampled, but many refused the offer. With regard to pneumococcal immunizations, SCC scored 9 percentage points higher than Medicare, but 14 percentage points lower than the VA.

Cancer Screening

For colorectal cancer screening, SCC scored lower than all of the other entities that reported data (Kaiser, commercial plans, Medicare, and the VA). However, all 39 patients the OIG sampled were offered the screening timely, but 19 subsequently refused it.

Summary

Overall, SCC's HEDIS scores demonstrate a high-performing chronic care program, corroborated by the institution's *adequate* ratings in the *Quality of Provider Performance*, *Quality of Nursing Performance, Access to Care,* and *Preventive Services* indicators. The institution's scores for influenza immunizations and colorectal cancer screenings were significantly affected by patients refusing to receive the services.

SCC Results Compared to State and National HEDIS Scores

Clinical Measures	California				National			
	SCC Cycle 4 Results [1]	HEDIS Medi-Cal 2014 [2]	Kaiser (No.CA) HEDIS Scores 2015 [3]	Kaiser (So.CA) HEDIS Scores 2015 [3]	HEDIS Medicaid 2015[4]	HEDIS Com-mercial 2015[4]	HEDIS Medicare 2015 [4]	VA Average 2012 [5]
Comprehensive Diabetes Care								
HbA1c Testing (Monitoring)	**100%**	83%	95%	94%	86%	91%	93%	99%
Poor HbA1c Control (>9.0%) [6,7]	**10%**	44%	18%	24%	44%	31%	25%	19%
HbA1c Control (<8.0%) [6]	**80%**	47%	70%	62%	47%	58%	65%	-
Blood Pressure Control (<140/90)	**78%**	60%	84%	85%	62%	65%	65%	80%
Eye Exams	**97%**	51%	69%	81%	54%	56%	69%	90%
Immunizations								
Influenza Shots - Adults (18–64) [8]	**65%**	-	54%	55%		50%	-	65%
Influenza Shots - Adults (65+)	**79%**	-	-	-	-	-	-	76%
Immunizations: Pneumococcal	**79%**	-	-	-	-	-	70%	93%
Cancer Screening								
Colorectal Cancer Screening	**51%**	-	80%	82%	-	64%	67%	82%

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

APPENDIX A — COMPLIANCE TEST RESULTS

Sierra Conservation Center Range of Summary Scores: 57.14% - 98.00%	
Indicator	**Compliance Score (Yes %)**
Access to Care	82.07%
Diagnostic Services	90.83%
Emergency Services	Not Applicable
Health Information Management (Medical Records)	57.14%
Health Care Environment	83.84%
Inter- and Intra-System Transfers	81.24%
Pharmacy and Medication Management	91.44%
Prenatal and Post-delivery Services	Not Applicable
Preventive Services	82.06%
Quality of Nursing Performance	Not Applicable
Quality of Provider Performance	Not Applicable
Reception Center Arrivals	Not Applicable
Specialized Medical Housing (OHU, CTC, SNF, Hospice)	98.00%
Specialty Services	87.14%
Internal Monitoring, Quality Improvement, and Administrative Operations	57.14%
Job Performance, Training, Licensing, and Certifications	94.64%

Reference Number	*Access to Care*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
1.001	**Chronic care follow-up appointments:** Was the inmate-patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter?	21	9	30	70.00%	0
1.002	**For endorsed inmate-patients received from another CDCR institution:** If the nurse referred the inmate-patient to a provider during the initial health screening, was the inmate-patient seen within the required time frame?	10	8	18	55.56%	12
1.003	**Clinical appointments:** Did a registered nurse review the inmate-patient's request for service the same day it was received?	31	1	32	96.88%	0
1.004	**Clinical appointments:** Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed?	32	0	32	100.00%	0
1.005	**Clinical appointments:** If the registered nurse determined a referral to a primary care provider was necessary, was the inmate-patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter?	17	1	18	94.44%	14
1.006	**Sick call follow-up appointments:** If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified?	5	2	7	71.43%	25
1.007	**Upon the inmate-patient's discharge from the community hospital:** Did the inmate-patient receive a follow-up appointment within the required time frame?	8	1	9	88.89%	1
1.008	**Specialty service follow-up appointments:** Do specialty service primary care physician follow-up visits occur within required time frames?	18	1	19	94.74%	0
1.101	**Clinical appointments:** Do inmate-patients have a standardized process to obtain and submit health care services request forms?	4	2	6	66.67%	0
Overall Percentage:					**82.07%**	

Reference Number	*Diagnostic Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
2.001	**Radiology:** Was the radiology service provided within the time frame specified in the provider's order?	10	0	10	100.00%	0
2.002	**Radiology:** Did the primary care provider review and initial the diagnostic report within specified time frames?	10	0	10	100.00%	0
2.003	**Radiology:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	10	0	10	100.00%	0
2.004	**Laboratory:** Was the laboratory service provided within the time frame specified in the provider's order?	10	0	10	100.00%	0
2.005	**Laboratory:** Did the primary care provider review and initial the diagnostic report within specified time frames?	10	0	10	100.00%	0
2.006	**Laboratory:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	10	0	10	100.00%	0
2.007	**Pathology:** Did the institution receive the final diagnostic report within the required time frames?	8	2	10	80.00%	0
2.008	**Pathology:** Did the primary care provider review and initial the diagnostic report within specified time frames?	7	1	8	87.50%	2
2.009	**Pathology:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	4	4	8	50.00%	2
Overall Percentage:					**90.83%**	

Emergency Services	Scored Answers
Assesses reaction times and responses to emergency situations.	**Not Applicable**

Reference Number	*Health Information Management (Medical Records)*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated progress notes, initial health screening forms, and health care service request forms scanned into the eUHR within three calendar days of the inmate-patient encounter date?	15	5	20	75.00%	0
4.002	Are dictated / transcribed documents scanned into the eUHR within five calendar days of the inmate-patient encounter date?	0	3	3	0.00%	0
4.003	Are specialty documents scanned into the eUHR within five calendar days of the inmate-patient encounter date?	12	2	14	85.71%	0
4.004	Are community hospital discharge documents scanned into the eUHR within three calendar days of the inmate-patient date of hospital discharge?	8	2	10	80.00%	0
4.005	Are medication administration records (MARs) scanned into the eUHR within the required time frames?	18	2	20	90.00%	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?	13	15	28	46.43%	0
4.008	**For inmate-patients discharged from a community hospital:** Did the preliminary hospital discharge report include key elements and did a PCP review the report within three calendar days of discharge?	8	2	10	80.00%	0
Overall Percentage:					**57.14%**	

Reference Number	*Health Care Environment*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
5.101	**Infection Control:** Are clinical health care areas appropriately disinfected, cleaned and sanitary?	9	0	9	100.00%	0
5.102	**Infection control:** Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	9	0	9	100.00%	0
5.103	**Infection Control:** Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	8	1	9	88.89%	0
5.104	**Infection control:** Does clinical health care staff adhere to universal hand hygiene precautions?	8	0	8	100.00%	1
5.105	**Infection control:** Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	6	3	9	66.67%	0
5.106	**Warehouse, Conex and other non-clinic storage areas:** Does the medical supply management process adequately support the needs of the medical health care program?	1	0	1	100.00%	8
5.107	**Clinical areas:** Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	9	0	9	100.00%	0
5.108	**Clinical areas:** Do clinic common areas and exam rooms have essential core medical equipment and supplies?	2	7	9	22.22%	0
5.109	**Clinical areas:** Do clinic common areas have an adequate environment conducive to providing medical services?	7	2	9	77.78%	0
5.110	**Clinical areas:** Do clinic exam rooms have an adequate environment conducive to providing medical services?	6	3	9	66.67%	0
5.111	**Emergency response bags:** Are TTA and clinic emergency medical response bags inspected daily and inventoried monthly, and do they contain essential items?	7	0	7	100.00%	2
5.999	**For Information Purposes Only:** Does the institution's health care management believe that all clinical areas have physical plant infrastructures sufficient to provide adequate health care services?	Information Only				
Overall Percentage:					**83.84%**	

Reference Number	*Inter- and Intra-System Transfers*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
6.001	**For endorsed inmate-patients received from another CDCR institution or COCF:** Did nursing staff complete the initial health screening and answer all screening questions on the same day the inmate-patient arrived at the institution?	29	1	30	96.67%	0
6.002	**For endorsed inmate-patients received from another CDCR institution or COCF:** When required, did the RN complete the assessment and disposition section of the health screening form; refer the inmate-patient to the TTA, if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening?	30	0	30	100.00%	0
6.003	**For endorsed inmate-patients received from another CDCR institution or COCF:** If the inmate-patient had an existing medication order upon arrival, were medications administered or delivered without interruption?	6	3	9	66.67%	21
6.004	**For inmate-patients transferred out of the facility:** Were scheduled specialty service appointments identified on the Health Care Transfer Information Form 7371?	3	4	7	42.86%	0
6.101	**For inmate-patients transferred out of the facility:** Do medication transfer packages include required medications along with the corresponding Medical Administration Record (MAR) and Medication Reconciliation?	3	0	3	100.00%	5
Overall Percentage:					**81.24%**	

Reference Number	*Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.001	Did the inmate-patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows?	19	5	24	79.17%	6
7.002	Did health care staff administer or deliver new order prescription medications to the inmate-patient within the required time frames?	28	2	30	93.33%	0
7.003	**Upon the inmate-patient's discharge from a community hospital:** Were all medications ordered by the institution's primary care provider administered or delivered to the inmate-patient within one calendar day of return?	7	3	10	70.00%	0
7.004	**For inmate-patients received from a county jail:** Were all medications ordered by the institution's reception center provider administered or delivered to the inmate-patient within the required time frames?	Not Applicable				
7.005	**Upon the inmate-patient's transfer from one housing unit to another:** Were medications continued without interruption?	28	2	30	93.33%	0
7.006	**For inmate-patients en route who lay over at the institution:** If the temporarily housed inmate-patient had an existing medication order, were medications administered or delivered without interruption?	Not Applicable				
7.101	**All clinical and medication line storage areas for narcotic medications:** Does the institution employ strong medication security controls over narcotic medications assigned to its clinical areas?	5	1	6	83.33%	8
7.102	**All clinical and medication line storage areas for non-narcotic medications:** Does the institution properly store non-narcotic medications that do not require refrigeration in assigned clinical areas?	12	0	12	100.00%	2
7.103	**All clinical and medication line storage areas for non-narcotic medications:** Does the institution properly store non-narcotic medications that require refrigeration in assigned clinical areas?	6	1	7	85.71%	7
7.104	**Medication preparation and administration areas:** Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes?	5	1	6	83.33%	8
7.105	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when preparing medications for inmate-patients?	6	0	6	100.00%	8
7.106	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when distributing medications to inmate-patients?	5	1	6	83.33%	8
7.107	**Pharmacy:** Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and satellite pharmacies?	1	0	1	100.00%	0

Reference Number	*Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.108	**Pharmacy:** Does the institution's pharmacy properly store non-refrigerated medications?	1	0	1	100.00%	0
7.109	**Pharmacy:** Does the institution's pharmacy properly store refrigerated or frozen medications?	1	0	1	100.00%	0
7.110	**Pharmacy:** Does the institution's pharmacy properly account for narcotic medications?	1	0	1	100.00%	0
7.111	**Pharmacy:** Does the institution follow key medication error reporting protocols?	25	0	25	100.00%	0
7.998	**For Information Purposes Only:** During eUHR compliance testing and case reviews, did the OIG find that medication errors were properly identified and reported by the institution?	Information Only				
7.999	**For Information Purposes Only:** Do inmate-patients in isolation housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications?	Information Only				
Overall Percentage:					**91.44%**	

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

Reference Number	*Preventive Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
9.001	**Inmate-patients prescribed INH:** Did the institution administer the medication to the inmate-patient as prescribed?	8	5	13	61.54%	0
9.002	**Inmate-patients prescribed INH:** Did the institution monitor the inmate-patient monthly for the most recent three months he or she was on the medication?	9	4	13	69.23%	0
9.003	**Annual TB Screening:** Was the inmate-patient screened for TB within the last year?	23	7	30	76.67%	0
9.004	Were all inmate-patients offered an influenza vaccination for the most recent influenza season?	29	1	30	96.67%	0
9.005	**All inmate-patients from the age 50 through the age of 75:** Was the inmate-patient offered colorectal cancer screening?	30	0	30	100.00%	0
9.006	**Female inmate-patients from the age of 50 through the age of 74:** Was the inmate-patient offered a mammogram in compliance with policy?	Not Applicable				
9.007	**Female inmate-patients from the age of 21 through the age of 65:** Was the inmate-patient offered a pap smear in compliance with policy?	Not Applicable				
9.008	Are required immunizations being offered for chronic care inmate-patients?	15	2	17	88.24%	0
9.009	Are inmate-patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	Not Applicable				
Overall Percentage:					**82.06%**	

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

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

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

Reference Number	*Specialized Medical Housing (OHU, CTC, SNF, Hospice)*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	**For all higher-level care facilities:** Did the registered nurse complete an initial assessment of the inmate-patient on the day of admission, or within eight hours of admission to CMF's Hospice?	10	0	10	100.00%	0
13.002	**For OHU, CTC, & SNF only:** Did the primary care provider for OHU or attending physician for a CTC & SNF evaluate the inmate-patient within 24 hours of admission?	10	0	10	100.00%	0
13.003	**For OHU, CTC, & SNF only:** Was a written history and physical examination completed within 72 hours of admission?	9	1	10	90.00%	0
13.004	**For all higher-level care facilities:** Did the primary care provider complete the Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes on the inmate-patient at the minimum intervals required for the type of facility where the inmate-patient was treated?	10	0	10	100.00%	0
13.101	**For OHU and CTC Only:** Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter inmate-patient's cells?	1	0	1	100.00%	0
Overall Percentage:					**98.00%**	

Reference Number	*Specialty Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	Did the inmate-patient receive the high-priority specialty service within 14 calendar days of the PCP order?	4	0	4	100.00%	0
14.002	Did the PCP review the high priority specialty service consultant report within the required time frame?	4	0	4	100.00%	0
14.003	Did the inmate-patient receive the routine specialty service within 90 calendar days of the PCP order?	15	0	15	100.00%	0
14.004	Did the PCP review the routine specialty service consultant report within the required time frame?	12	3	15	80.00%	0
14.005	**For endorsed inmate-patients received from another CDCR institution:** If the inmate-patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames?	11	9	20	55.00%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	20	0	20	100.00%	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?	15	5	20	75.00%	0
Overall Percentage:					**87.14%**	

Reference Number	*Internal Monitoring, Quality Improvement, and Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.001	Did the institution promptly process inmate medical appeals during the most recent 12 months?	12	0	12	100.00%	0
15.002	Does the institution follow adverse/sentinel event reporting requirements?	Not Applicable				
15.003	Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified?	5	1	6	83.33%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	0	1	1	0.00%	0
15.005	For each initiative in the Performance Improvement Work Plan (PIWP), has the institution performance improved or reached the targeted performance objective(s)?	0	9	9	0.00%	2
15.006	**For institutions with licensed care facilities:** Does the local governing body (LGB), or its equivalent, meet quarterly and exercise its overall responsibilities for the quality management of patient health care?	Not Applicable				
15.007	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	6	6	12	50.00%	0
15.101	Did the institution complete a medical emergency response drill for each watch and include participation of health care and custody staff during the most recent full quarter?	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?	Not Applicable				
15.996	**For Information Purposes Only:** Did the CCHCS Death Review Committee submit its inmate death review summary to the institution timely?	Information Only				
15.997	**For Information Purposes Only:** Identify the institution's protocols for tracking medical appeals.	Information Only				
15.998	**For Information Purposes Only:** Identify the institution's protocols for implementing health care local operating procedures.	Information Only				
15.999	**For Information Purposes Only:** Identify the institution's health care staffing resource.	Information Only				
Overall Percentage:					**57.14%**	

Reference Number	*Job Performance, Training, Licensing, and Certifications*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
16.001	Do all providers maintain a current medical license?	8	0	8	100.00%	0
16.101	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	5	0	5	100.00%	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?	4	3	7	57.14%	0
16.104	Are staff current with required medical emergency response certifications?	3	0	3	100.00%	0
16.105	Are nursing staff and the Pharmacist-in-Charge current with their professional licenses and certifications?	5	0	5	100.00%	1
16.106	Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	1	0	1	100.00%	0
16.107	Are nursing staff current with required new employee orientation?	1	0	1	100.00%	0
Overall Percentage:					**94.64%**	

APPENDIX B — CLINICAL DATA

Table B-1 SCC Sample Sets	
Sample Set	**Total**
CTC/OHU	5
Diabetes	4
Emergency Services - Non-CPR	5
High Risk	8
Hospitalization	6
Intra-system Transfers-In	3
Intra-system Transfers-Out	3
RN Sick Call	25
Specialty Services	7
	66

Table B-2 SCC Chronic Care Diagnoses	
Diagnosis	**Total**
Anemia	1
Arthritis/Degenerative Joint Disease	5
Asthma	9
COPD	6
Cancer	3
Cardiovascular Disease	7
Chronic Kidney Disease	2
Chronic Pain	13
Cirrhosis/End Stage Liver Disease	1
Coccidioidomycosis	1
Diabetes	12
Gastroesophageal Reflux Disease	14
Hepatitis C	22
Hyperlipidemia	11
Hypertension	24
Mental Health	14
Seizure Disorder	4
Sleep Apnea	1
Thyroid Disease	3
	153

Table B-3 SCC Event - Program	
Program	**Total**
Diagnostic Services	142
Emergency Care	46
Hospitalization	46
Intra-system Transfers-In	11
Intra-system Transfers-Out	10
Outpatient Care	500
Specialized Medical Housing	215
Specialty Services	151
	1,121

Table B-4 SCC Case Review Sample Summary	
	Total
MD Reviews Detailed	30
MD Reviews Focused	0
RN Reviews Detailed	21
RN Reviews Focused	31
Total Reviews	82
Total Unique Cases	66
Overlapping Reviews (MD & RN)	16

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

Sierra Conservation Center			
Quality Indicator	**Sample Category (number of patients/samples)**	**Data Source**	**Filters**
Access to Care	Chronic Care (30)	Master Registry	• Chronic care conditions (at least one condition per inmate-patient—any risk level) • **Randomize**
	Nursing Sick Call (min. of 5 per clinic) (32)	MedSATS	• Clinic (each clinic tested) • Appt. date (2–9 months) • **Randomize**
	Returns from Community Hospital (10)	Inpatient Claims Data	• See ***Health Information Management (Medical Records)*** (returns from community hospital)
Diagnostic Services	Radiology (10)	Radiology Logs	• Appt. Date (90 days–9 months) • **Randomize** • Abnormal
	Laboratory (10)	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • **Randomize** • Abnormal
	Pathology (10)	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • **Randomize**
Health Information Management (Medical Records)	Timely Scanning: (20)	OIG Qs: 1.001, 1.002, 1.004	• Non-dictated documents • First 5 inmate-patients selected for each question
	(3)	OIG Q: 1.001	• Dictated documents • First 20 inmate-patients selected
	(14)	OIG Qs: 14.002 & 14.004	• Specialty documents • First 10 inmate-patients selected for each question
	(10)	OIG Q: 4.008	• Community hospital discharge documents • First 20 inmate-patients selected for the question
	(20)	OIG Q: 7.001	• MARs • First 20 inmate-patients selected
	Legible Signatures and Review (28)	OIG Qs: 4.008, 6.001/6.002, 7.001, 12.001/12.002, & 14.002	• First 8 inmates sampled • One source document per inmate-patient
	Complete and Accurate Scanning (all documents)	Documents for any tested inmate	• Any incorrectly scanned eUHR document identified during OIG eUHR file review, e.g., mislabeled, misfiled, illegibly scanned, or missing
	Returns from Community Hospital (10)	Inpatient Claims Data	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • **Randomize** (each month individually) • First 5 inmate-patients from each of the 6 months (if not 5 in a month, supplement from another, as needed)

Quality Indicator	Sample Category (number of patients/samples)	Data Source	Filters
Health Care Environment	Clinical Areas (9)	OIG Inspector Onsite Review	• Identify and inspect all onsite clinical areas.
Inter- and Intra-System Transfers	Intra-System transfers (30)	SOMS	• Arrival date (3–9 months) • Arrived from (another CDCR facility) • Rx count • **Randomize**
	Specialty Service Send-outs (7)	MedSATS	• Date of Transfer (3–9 months) • **Randomize**
Pharmacy and Medication Management	Chronic Care Medication (30)	OIG Q: 1.001	See ***Access to Care*** • (At least one condition per inmate-patient—any risk level) • **Randomize**
	New Medication Orders (30)	Master Registry	• Rx Count • **Randomize** • Ensure no duplication of inmate-patients tested in chronic care medications
	Intra-Facility moves (30)	MAPIP Transfer Data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (high–low)–inmate-patient must have NA/DOT meds to qualify for testing • **Randomize**
	En Route *N/A at this institution*	SOMS	• Date of transfer (2–8 months) • Sending institution (another CDCR facility) • **Randomize** • Length of stay (minimum of 2 days) • NA/DOT meds
	Returns from Community Hospital (10)	Inpatient Claims Data	• See ***Health Information Management (Medical Records)*** (returns from community hospital)
	Medication Preparation and Admin Areas (6)	OIG Inspector Onsite Review	• Identify and inspect onsite clinical areas that prepare and administer medications
	Pharmacy (1)	OIG Inspector Onsite Review	• Identify and inspect onsite pharmacies
	Medication Error Reporting (25)	OIG Inspector Review	• Five reports from five months with high-severity errors
Prenatal and Post-Delivery Services	Recent Deliveries *N/A at this institution*	OB Roster	• Delivery date (2–12 months) • **Most recent** deliveries (within date range)
	Pregnant Arrivals *N/A at this institution*	OB Roster	• Arrival date (2–12 months) • **Earliest** arrivals (within date range)

Quality Indicator	Sample Category (number of patients/samples)	Data Source	Filters
Preventive Services	Chronic Care Vaccinations (17)	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per inmate-patient—any risk level) • **Randomize** • Condition must require vaccination(s)
	INH (13)	Maxor	• Dispense date (past 9 months) • Time period on INH (at least a full 3 months) • **Randomize**
	Colorectal Screening (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • **Randomize**
	Influenza Vaccinations (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • **Randomize** • Filter out inmate-patients tested in chronic care vaccination sample
	TB Code 22, annual TST (15)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (22) • **Randomize**
	TB Code 34, annual screening (15)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (34) • **Randomize**
	Mammogram *N/A at this institution*	SOMS	• Arrival date (at least 2 years prior to inspection) • Date of birth (age 52–74) • **Randomize**
	Pap Smear *N/A at this institution*	SOMS	• Arrival date (at least three years prior to inspection) • Date of birth (age 24–53) • **Randomize**
	Valley Fever *N/A at this institution*	Cocci Transfer Status Report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • **All**
Reception Center Arrivals	RC *N/A at this institution*	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • **Randomize**
Specialized Medical Housing	OHU (10)	CADDIS	• Admit date (1–6 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • **Randomize**

Quality Indicator	Sample Category (number of patients/samples)	Data Source	Filters
Specialty Services Access	High-Priority (4)	MedSATS	• Approval date (3–9 months) • **Randomize**
	Routine (15)	MedSATS	• Approval date (3–9 months) • Remove optometry, physical therapy or podiatry • **Randomize**
	Specialty Service Arrivals (20)	MedSATS	• Arrived from (other CDCR institution) • Date of transfer (3–9 months) • **Randomize**
	Denials (10)	InterQual	• Review date (3–9 months) • **Randomize**
	(10)	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • **Randomize**
Internal Monitoring, Quality Improvement, and Administrative Operations	Medical Appeals (all)	Monthly Medical Appeals Reports	• Medical appeals (12 months)
	Adverse/Sentinel Events *N/A at this institution*	Adverse/Sentinel Events Report	• Adverse/sentinel events (2–8 months)
	QMC Meetings (6)	Quality Management Committee Meeting Minutes	• Meeting minutes (6 months)
	PIWP Medical Initiatives (9)	Performance Improvement Work Plan	• Performance Improvement Work Plan with updates (12 months) • Medical Initiatives
	Local Governing Body *N/A at this institution*	Local Governing Body Meeting Minutes	• Meeting minutes (12 months)
	EMRRC (12)	EMRRC Meeting Minutes	• Meeting minutes (6 months)
	Medical Emergency Response Drills (3)	OIG Inspector Onsite Review	• Most recent full quarter • Each watch
	2nd Level Medical Appeals (10)	OIG Inspector Onsite Review	• Medical appeals denied (6 months)
	Death Reports *N/A at this institution*	OIG Inspector Onsite Review	• Death reports (12 months)
	Local Operating Procedures (all)	OIG Inspector Onsite Review	• Review all

Quality Indicator	Sample Category (number of patients/samples)	Data Source	Filters
Job Performance, Training, Licensing, and Certifications	RN Review Evaluations (5)	OIG Inspector Onsite Review	• Current Supervising RN reviews
	Nursing Staff Validations (10)	OIG Inspector Onsite Review	• Review annual competency validations • **Randomize**
	Provider Annual Evaluation Packets (7)	OIG Inspector Onsite Review	• All required performance evaluation documents
	Medical Emergency Response Certifications (all)	OIG Inspector Onsite Review	• All staff o Providers (ACLS) o Nursing (BLS/CPR) o Custody (CPR/BLS)
	Nursing staff and Pharmacist-in-charge Professional Licenses and Certifications (all)	OIG Inspector Onsite Review	• All licenses and certifications
	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations (all)	OIG Inspector Onsite Review	• All current DEA registrations
	Nursing Staff New Employee Orientations (all)	OIG Inspector Onsite Review	• New employees (within the last 12 months)

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

March 14, 2016

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

Dear Mr. Barton:

The purpose of this letter is to inform you that the Office of the Receiver has reviewed the draft report of the Office of the Inspector General (OIG) Medical Inspection Results for Sierra Conservation Center (SCC) conducted from October 2015 to December 2015. California Correctional Health Care Services (CCHCS) acknowledges all OIG findings.

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

Sincerely,

Janet Lewis

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

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