

California State Prison, Solano Medical Inspection Results Cycle 4



December 2015

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Service ♦ Transparency**

Office of the Inspector General

CALIFORNIA STATE PRISON, SOLANO

Medical Inspection Results

Cycle 4

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December 2015

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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 the OIG found to be providing adequate care still did not meet constitutional standards, depending on the analysis of the underlying data provided by the OIG. Likewise, an institution that has been rated *inadequate* by the OIG could still be found to pass constitutional muster with the implementation of remedial measures if the underlying data were to reveal easily mitigated deficiencies.

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

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

The OIG performed its Cycle 4 medical inspection at California State Prison, Solano, from June to July 2015. The inspection included in-depth reviews of 62 inmate-patient files conducted by clinicians as well as reviews of documents from 485 inmate-patient files conducted by deputy inspectors general, covering 92 objectively scored tests of compliance with policies and procedures applicable to the delivery of medical care. The OIG assessed the case review and compliance results at SOL 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 SOL was *inadequate*.

Health Care Quality Indicators

Fourteen Primary Indicators (Clinical)	All Institutions– Applicability	SOL Applicability
<i>1–Access to Care</i>	All institutions	Both case review and compliance
<i>2–Diagnostic Services</i>	All institutions	Both case review and compliance
<i>3–Emergency Services</i>	All institutions	Case review only
<i>4–Health Information Management (Medical Records)</i>	All institutions	Both case review and compliance
<i>5–Health Care Environment</i>	All institutions	Compliance only
<i>6–Inter- and Intra-System Transfers</i>	All institutions	Both case review and compliance
<i>7–Pharmacy and Medication Management</i>	All institutions	Both case review and compliance
<i>8–Prenatal and Post-Delivery Services</i>	Female institutions only	N/A
<i>9–Preventive Services</i>	All institutions	Compliance only
<i>10–Quality of Nursing Performance</i>	All institutions	Case review only
<i>11–Quality of Provider Performance</i>	All institutions	Case review only
<i>12–Reception Center Arrivals</i>	Institutions with reception centers	N/A
<i>13–Specialized Medical Housing (OHU, CTC, SNF, Hospice)</i>	All institutions with an OHU, CTC, SNF, or Hospice	Both case review and compliance
<i>14–Specialty Services</i>	All institutions	Both case review and compliance
Two Secondary Indicators (Administrative)	All Institutions– Applicability	SOL Applicability
<i>15–Internal Monitoring, Quality Improvement, and Administrative Operations</i>	All institutions	Compliance only
<i>16–Job Performance, Training, Licensing, and Certifications</i>	All institutions	Compliance only

Overall Assessment: Inadequate

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

**Overall Assessment
Rating:**

Inadequate

Clinical Case Review and OIG Clinician Inspection Results

The clinicians’ case reviews sampled patients with high medical needs and included a review of 1,325 patient care events.¹ Of the 12 primary indicators applicable to SOL, ten were evaluated by clinician case review; four were *adequate*, and six were *inadequate*. When determining the overall adequacy of care, the OIG paid particular attention to the clinical nursing and provider quality indicators, as adequate health care staff can sometimes overcome suboptimal processes and programs. However, the opposite is not true; inadequate health care staff cannot provide adequate care, even though the established processes and programs onsite may be adequate. The OIG clinicians identify inadequate medical care based on the risk of significant harm to the patient, not the actual outcome.

Program Strengths—Case Review

- SOL had implemented an innovative RN case management program as an integral part of the primary care home model. Registered nurse case managers regularly saw the highest-acuity patients, including all patients returning from hospitalization. The RN case managers helped coordinate care for patients with complex medical needs and managed anticoagulation with the assistance of the California Correctional Health Care Services (CCHCS) anticoagulation guidelines. They counseled poorly controlled diabetic patients regarding medication and dietary compliance.
- SOL had fully committed to a primary care home model. Provider continuity was excellent, and RN case manager continuity was good. The OIG clinician onsite inspection found well-functioning teams with open lines of communication between providers and nurses.

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

- SOL clinical managers had effectively identified and worked to reduce the impact of poor quality health care staff on patient care. A physician and a pharmacist, both of whom were no longer employed by SOL at the time of the OIG’s inspection, were responsible for some of the most severe deficiencies identified in the case reviews.

Program Weaknesses—Case Review

- For patients returning from an outside hospitalization, there was no process in place to ensure that all hospital discharge summaries were reviewed by the responsible RN case manager and the primary care provider (PCP). The PCPs failed to sign and date any of the hospital discharge summaries to indicate they reviewed these documents. Several patients were lost to follow-up after hospitalization, creating serious lapses in care. SOL also had similar access problems for patients who required follow-up after being evaluated in the triage and treatment area (TTA).
- SOL had severe problems with the processing of specialty reports. These reports were often not retrieved or scanned into the medical record. Even when they were retrieved, they were often retrieved late. This problem markedly increased the risk of lapses in care for those patients receiving specialty services and delayed the care for some patients.
- SOL had severe problems with the processing of laboratory reports. In numerous instances, lab tests were collected and processed, but the corresponding lab reports were not found in the medical records and patients were not notified of their results. With lab studies not processed into the medical record, some patients received inadequate monitoring and diagnosis and delays in care.
- Providers who admitted patients to the SOL correctional treatment center (CTC) often performed grossly inadequate history and physical examinations (H&Ps). Some providers substituted outdated H&Ps from a different institution in lieu of their own independent evaluations. Others performed superficial H&Ps that were insufficient for transmitting adequate health information.
- Most SOL providers used template electronic progress notes, but some of the providers allowed legacy information to persist on the template. This resulted in “cloned” progress notes, which contained outdated information. Providers who heavily relied on these notes sometimes failed to adequately readdress medical conditions when required. This problem was particularly prevalent in the CTC and led to inadequate patient care.

Compliance Testing Results

Of the 14 total indicators of health care applicable to SOL, compliance inspectors evaluated 11.² There were 92 individual compliance questions within those 11 applicable indicators, generating 1,330 data points, that tested SOL's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.³ Those 92 questions are detailed in *Appendix A—Compliance Test Results*. The institution's inspection scores for the 11 applicable indicators ranged from 58.1 percent to 98.0 percent, with the primary (clinical) indicator *Health Information Management (Medical Records)* receiving the lowest score, and the primary (clinical) indicator *Specialized Medical Housing* receiving the highest. For the nine primary indicators applicable to compliance testing, the OIG rated two *proficient*, three *adequate*, and four *inadequate*. For the two secondary indicators, which involve administrative health care functions, one was rated *proficient* and the other *inadequate*.

Program Strengths—Compliance Testing

As the *Executive Summary Table* on page x indicates, the institution's primary indicator compliance scores were in the *proficient* range for the following two indicators: *Inter- and Intra-System Transfers* (91.6 percent), and *Specialized Medical Housing* (98.0 percent). The following are some of the strengths identified based on SOL's compliance scores in the primary health care indicators:

- Nursing staff routinely reviewed patients' service requests timely and completed face-to-face visits with patients within one business day.
- All inmate-housing locations had Health Care Services Request forms (CDCR Form 7362) available and a standard process for submitting requests to medical staff.
- Inmate-patients received radiology services within the required time frame.
- Providers timely reviewed laboratory reports and communicated the results to the patients.
- The institution routinely scanned hospital discharge reports, non-dictated progress notes, initial health screening forms, and health care service request forms into patients' electronic unit health records (eUHRs) within the required time frames.
- The institution's clinics ensured that reusable invasive and non-invasive medical equipment was properly sterilized and disinfected, and clinical staff adhered to universal hand hygiene precautions.

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.

- For inmate-patients newly arriving at SOL from another CDCR institution, nursing staff properly completed the Initial Health Screening form (CDCR Form 7277) by answering all applicable questions, documenting an assessment and disposition, and signing and dating the form on the same day the inmate arrived at the institution.
- Medication packages for inmates who transferred out of SOL included all prescribed medications and medication administration record (MAR) documentation.
- Nursing staff administered or delivered new medication orders within the required time frames and followed proper administrative protocols when preparing medications for inmate-patients.
- The institution's clinics had strong security controls over narcotic and non-narcotic medications.
- The institution's main pharmacy followed general security, organization, and cleanliness management protocols; properly stored and monitored non-narcotic medications that required refrigeration; and maintained adequate controls over narcotic medications.
- The institution followed key medication error reporting protocols.
- The institution provided timely monitoring for patients on anti-tuberculosis (INH) medications.
- The institution timely offered required preventive services, including influenza and pneumonia vaccinations and colorectal cancer screenings.
- For all patients sampled who were admitted to the CTC, nursing staff and providers conducted initial admission assessments, evaluations, and H&P examinations within required time frames.
- The institution's CTC had a working call button system and a procedure in place to ensure that during an emergency, medical staff could enter an inmate-patient's cell within a reasonable amount of time.
- High-priority and routine specialty services appointments occurred timely.
- When the institution denied specialty service requests, it processed those denials timely.

The following are strengths identified within the secondary (administrative) indicators:

- The institution promptly processed all inmate medical appeals in each of the most recent 12 months. In addition, the institution's second-level medical appeal responses addressed all inmate-patients' appealed issues.

- Monthly Quality Management Committee (QMC) meeting minutes were well documented and indicated the QMC took steps to evaluate both clinical performance and the accuracy of its Dashboard performance data.
- The institution completed medical emergency response drills for each watch in the most recent quarter the OIG tested.
- Providers, the pharmacist-in-charge, and the pharmacy had current licenses and registrations; nursing staff were current on required new employee training requirements, licenses, and certifications.
- Nurse supervisors completed periodic reviews of nursing staff, and providers received structured clinical performance appraisals.
- SOL nursing staff received annual clinical competency validations.

Program Weaknesses—Compliance Testing

The institution received ratings in the *inadequate* range for the following four primary indicators: *Diagnostic Services* (68.9 percent), *Health Information Management (Medical Records)* (58.1 percent); *Health Care Environment* (62.4 percent); and *Specialty Services* (65.8 percent). In the secondary indicator *Internal Monitoring, Quality Improvement, and Administrative Operations*, SOL also scored poorly (61.1 percent). The following are some of the weaknesses the OIG identified during its testing in the primary health care indicators:

- Patients under providers’ care for one or more chronic conditions did not always receive timely chronic care follow-up appointments; PCP follow-up visits subsequent to patients’ high-priority specialty appointments or upon their discharge from a community hospital were also untimely.
- When inmate-patients transferred into SOL from another institution and nursing staff referred the patient to a PCP, many did not receive their PCP appointments timely.
- When patients completed service requests and the nurse referred them to a provider, the patients did not always receive their initial provider appointments timely; patients seen by a provider did not always receive recommended follow-up appointments within the provider’s ordered time frame.
- Patients did not routinely receive timely laboratory services.
- Providers did not always review, initial, and communicate test results for radiology and pathology services within the required time frames; the institution did not receive final pathology reports within the required time frames.

- Institution staff did not always scan dictated provider notes and MARs into the eUHR within the required time frame; staff periodically mislabeled health care documents in patients' electronic unit health records.
- Clinicians' signatures on health care records were not always legible.
- Providers did not always timely review patients' hospital discharge reports.
- Most clinics inspected were not appropriately disinfected, cleaned, and sanitary; some clinics had bulk storage areas that were dirty and disorganized.
- Several inmate-patient restrooms lacked hygiene products.
- Several clinics lacked easily accessible personal protective equipment or sharps containers in exam rooms to control exposure to blood-borne pathogens.
- Clinics and exam rooms lacked essential core medical equipment and supplies; some exam rooms were not configured with sufficient space for comprehensive examinations; several clinics' exam rooms or common areas lacked auditory privacy when patients were triaged or had vital signs checked.
- Staff did not inventory some clinics' emergency response bags monthly or ensure that oxygen tanks were fully charged.
- Patients taking chronic care medications or returning from a community hospital did not always receive their medication within the required time frame; patients who transferred from one housing unit to another did not always receive their medication at their next dosing interval.
- All of SOL's medication line locations that offered outside walk-up service lacked an overhang or shaded area to protect inmate-patients from extreme heat or inclement weather.
- Pharmacy staff did not timely remove all expired medications from pharmacy stock; the pharmacist-in-charge did not timely report medication errors.
- Clinical staff did not always administer anti-tuberculosis medication to patients who tested positive for tuberculosis.
- For all patients sampled, nursing staff did not follow required procedures for timely administration and reading of annual tuberculosis skin tests.
- Providers often failed to review high-priority and routine specialty service reports within required time frames.

- The institution did not always provide timely specialty service appointments to patients who transferred into SOL from other institutions with previously approved or scheduled appointments.
- For most patients sampled who were denied a specialty service, the provider did not conduct a follow-up appointment to discuss the denial and an alternate treatment strategy.

The lowest scoring questions addressing secondary indicators resulted in the following administrative deficiencies:

- The institution did not adequately identify the status of performance objectives for all quality improvement initiatives identified in its 2014 Performance Improvement Work Plan.
- The Local Governing Body did not always conduct required quarterly meetings; when held, the meeting minutes lacked sufficient discussion of the general management and planning of patient health care.
- The warden did not sign any of the EMRRC minutes, and incident packages did not include all required documentation.
- Medical staff did not always submit initial inmate death reports to the CCHCS Death Review Unit within the required time frame.
- Not all custody managers maintained current medical emergency response certifications.

The *SOL 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.

SOL Executive Summary Table

<u>Primary Indicators (Clinical)</u>	<u>Case Review Rating</u>	<u>Compliance Score</u>	<u>Overall Indicator Rating</u>
<i>Access to Care</i>	Inadequate	75.1%	Inadequate
<i>Diagnostic Services</i>	Inadequate	68.9%	Inadequate
<i>Emergency Services</i>	Adequate	Not Applicable	Adequate
<i>Health Information Management (Medical Records)</i>	Inadequate	58.1%	Inadequate
<i>Health Care Environment</i>	Not Applicable	62.4%	Inadequate
<i>Inter- and Intra-System Transfers</i>	Inadequate	91.6%	Adequate
<i>Pharmacy and Medication Management</i>	Adequate	77.1%	Adequate
<i>Preventive Services</i>	Not Applicable	82.3%	Adequate
<i>Quality of Nursing Performance</i>	Adequate	Not Applicable	Adequate
<i>Quality of Provider Performance</i>	Adequate	Not Applicable	Adequate
<i>Specialized Medical Housing (OHU, CTC, SNF, Hospice)</i>	Inadequate	98.0%	Inadequate
<i>Specialty Services</i>	Inadequate	65.8%	Inadequate

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

<u>Secondary Indicators (Administrative)</u>		<u>Compliance Score</u>	<u>Overall Indicator Rating</u>
<i>Internal Monitoring, Quality Improvement, and Administrative Operations</i>	Not Applicable	61.1%	Inadequate
<i>Job Performance, Training, Licensing, and Certifications</i>	Not Applicable	94.6%	Proficient

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

Population-Based Metrics

California State Prison, Solano performed quite well for population-based metrics. For four of the five comprehensive diabetes care measures, SOL outperformed or closely matched other State and national organizations' highest scores, including Kaiser Permanente, typically one of the highest-scoring health organizations in California. These measures included monitoring diabetic patients, having a low percentage of diabetic patients under poor control, having a high percentage of patients under good control, and conducting eye exams of diabetic patients. However, for blood pressure control in diabetic patients, while SOL's results were better than or matched Medi-Cal, Medicaid, commercial health plans (based on data obtained from health maintenance organizations), Medicare, and the U.S. Department of Veterans Affairs (VA), SOL slightly trailed California's Kaiser Permanente for this measure.

With regard to influenza immunizations and colorectal cancer screenings, SOL outperformed all other comparable organizations in these measures. For pneumococcal immunizations, comparative data was only available for Medicare and the VA; although SOL outperformed Medicare, it did not perform as well as the VA for this measure. However, some of the sampled patients who did not receive the immunization had been offered the vaccine but refused it.

Overall, SOL's performance demonstrated by the population-based metrics comparison indicated that its chronic care program was adequately run and operating as intended.

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.

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

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

ABOUT THE INSTITUTION

The primary mission of SOL is to provide custody, care and treatment, and rehabilitative programs for sentenced offenders. SOL operates as a medium-security institution that houses general population inmates. Through educational and vocational training, industry assignments, and self-help programs, the institution provides inmates the opportunity to develop the life skills necessary for successful reintegration into society. The institution comprises four semi-autonomous facilities and a 125-bed administrative segregation unit. The institution operates seven clinics as well as a treatment and triage area (TTA) and a 16-bed correctional treatment center (CTC) for inmates who require inpatient care. In addition, on August 16, 2015, the institution received national accreditation from the Commission on Accreditation for Corrections. This accreditation program is a professional peer review process based on national standards set by the American Correctional Association.

According to information provided by the institution, SOL's vacancy rate among licensed medical managers, primary care providers, supervisors, and rank-and-file nurses was 33 percent in June 2015. The highest vacancy percentage was among nursing staff (38 percent). The majority of vacancies were LVN positions allocated for medication line operations that the institution had not been able to fill. Also included were three health care staff under disciplinary review, and six health care employees (one supervisor and five non-supervisory nursing staff) on long-term medical leave.

SOL Health Care Staffing Resources— June 2015

Description	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff		Totals	
	Number	%	Number	%	Number	%	Number	%	Number	%
Authorized Positions	5	3%	13	8%	10.5	6%	138.9	83%	167.4	100%
Filled Positions	5	100%	12	92%	9.5	90%	86	62%	112.5	67%
Vacancies	0	0%	1	8%	1	10%	52.9	38%	54.9	33%
Recent Hires (within 12 months)	0	0%	0	0%	3.5	37%	9	10%	12.5	11%
Staff Utilized from Registry	0	0%	0	0%	0	0%	9	10%	9	8%
Redirected Staff (to Non-Patient Care Areas)	0	0%	0	0%	0	0%	0	0%	0	0%
Staff under Disciplinary Review	0	0%	2	17%	0	0%	1	1%	3	3%
Staff on Long-term Medical Leave	0	0%	0	0%	1	11%	5	6%	6	5%

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

As of May 18, 2015, CCHCS showed that SOL had 3,855 inmate-patients. Within that total population, 8.7 percent were designated High-Risk, Priority 1 (High 1), and 17.2 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.

SOL Master Registry Data as of May 18, 2015

Medical Risk Level	# of Inmate-Patients	Percentage
High 1	335	8.7%
High 2	664	17.2%
Medium	1,703	44.2%
Low	1,153	29.9%
Total	3,855	100.0%

Commonly Used Abbreviations

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

OBJECTIVES, SCOPE, AND METHODOLOGY

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

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

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

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

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

CASE REVIEWS

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

PATIENT SELECTION FOR RETROSPECTIVE CASE REVIEWS

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

1. The goal of retrospective chart review is to evaluate all aspects of the health care system. Statewide, high-risk and high-utilization patients consume medical services at a disproportionate rate; 9 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 are 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-4, SOL Case Review Sample Summary*, the OIG clinicians evaluated medical charts for 62 unique inmate-patients. Both nurses and physicians reviewed charts for 13 of those patients, for 75 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 24 inmate-patients. These generated 1,325 clinical events for review (*Appendix B, Table B-3, SOL Event-Program*). The reporting format provides details on whether the encounter was adequate or had significant deficiencies, and identifies deficiencies by programs and processes to help the institution focus on improvement areas.

While the sample method specifically pulled only six chronic care patient records, i.e., three diabetes patients and three anticoagulation patients (*Appendix B, Table B-1, SOL Sample Sets*), the 62 unique inmate-patients sampled included patients with 259 chronic care diagnoses, including nine additional patients with diabetes (for total of 12), and four additional anticoagulation patients (for a total of seven) (*Appendix B, Table B-2, SOL 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 pilot inspections adequately reviewed 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 concluded that the case review sample size was more than adequate to assess the quality of services provided.

Based on the collective results of clinicians' case reviews, the OIG rated each quality indicator as either *proficient* (excellent), *adequate* (passing), *inadequate* (failing), or *not applicable*. A separate confidential *SOL Supplemental Medical Inspection Results: Individual Patient 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 June to July 2015, deputy inspectors general attained answers to 92 objective medical inspection test (MIT) questions designed to assess the institution's compliance with critical policies and procedures applicable to the delivery of medical care. To conduct most tests, inspectors randomly selected samples of inmate-patients for whom the testing objectives were applicable and reviewed their electronic unit health records. In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed health records for 485 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 June 1, 2015, field inspectors conducted a detailed onsite inspection of SOL's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,330 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 SOL's plant infrastructure, protocols for tracking medical appeals and local operating procedures, and staffing resources.

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

SCORING OF COMPLIANCE TESTING RESULTS

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

- Primary indicators: *Access to Care, Diagnostic Services, Health Information Management (Medical Records), Health Care Environment, Inter- and Intra-System Transfers, Pharmacy*

and Medication Management, Preventive Services, Specialized Medical Housing (OHU, CTC, SNF, Hospice), and Specialty Services.

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

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

DASHBOARD COMPARISONS

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

OVERALL QUALITY INDICATOR RATING FOR CASE REVIEWS AND COMPLIANCE TESTING

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

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

POPULATION-BASED METRICS

The OIG identified a subset of HEDIS measures applicable to the CDCR inmate-patient population. To identify outcomes for SOL, the OIG reviewed some of the compliance testing results, randomly sampled additional inmate-patients' records, and obtained SOL data from the CCHCS Master Registry. The OIG compared those results to metrics reported by other State and federal agencies.

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 SOL. Of those 12 indicators, seven were rated by both the case review and compliance components of the inspection, three were rated by the case review component alone, and two were rated by the compliance component alone.

Summary of Case Review Results: The clinical case review component assessed 10 of the 12 primary (clinical) indicators applicable to SOL. For these ten indicators, zero were *proficient*, four were *adequate*, and six were *inadequate*. The OIG physicians rated the adequacy of care for each of the 30 detailed case reviews they conducted. Of these 30 cases, six were *proficient*, 13 were *adequate*, and 11 were *inadequate*. For the 1,325 events reviewed, there were 484 deficiencies, of which 168 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.

Case review identified four adverse events. While not entirely reflective of the quality of care at SOL, they were illustrative of some of the more severe problems identified in this inspection.

- In case 3, the patient presented to the TTA with dizziness, several episodes of loss of consciousness, and severe hypertension. He had fallen several times in the past day. The nurse reported an initial blood pressure of 221/121 to the on-call physician. The on-call physician performed a cursory evaluation, did not examine the patient, and documented lower blood pressures than had been reported by the RN. The provider planned to send the patient back to housing even though the patient was still symptomatic. An inadequate history was obtained, and the PCP did not consider the patient's recent history of loss of consciousness. A diligent TTA nurse consulted a different physician, who subsequently sent the patient to a community hospital for further evaluation. This was considered a "near-miss" situation by the OIG clinicians, who have since learned that SOL and CCHCS have already dismissed the provider who delivered the poor care for various reasons, including quality of care.

- In case 46, the patient developed a large mass in his thyroid gland, so severe that it started causing difficulty swallowing both solids and liquids. He was eventually sent to an outside hospital, where the mass was removed. The hospitalist recommended labs and follow-up with both his primary care provider and ear, nose, and throat surgeon (otolaryngologist). However, none of these recommendations were followed, and the patient was not seen for over six weeks. This was a complete lapse in care, and this adverse event was classified as an unsafe condition.
- In case 49, the patient was hospitalized for a rapid heart rate and congestive heart failure. Multiple medications were changed at the hospital and were appropriately ordered by the RN and the physician upon return to the institution. However, a pharmacy staff member received the order and failed to implement the changes. The patient was not seen by his PCP after the hospitalization. The patient was hospitalized for recurrent congestive heart failure two weeks later. OIG clinicians also considered this a lapse in care and classified this adverse event as an unsafe condition. The OIG has also learned that SOL and CCHCS no longer employ the pharmacist who failed to implement the new orders.
- In case 36, upon the patient's transfer back to SOL from the hospital, the primary care provider reordered the same medications, which included alternating different doses (5 mg or 6 mg each day) of warfarin (blood-thinning medication) on different days. The licensed vocational nurse (LVN) did not properly block out the dates on the medication authorization record (MAR) when the medication was not intended to be administered, which resulted in the patient receiving both doses (11 mg total) simultaneously on four days, resulting in a markedly elevated INR level (blood coagulation test), and subsequent CTC admission. A full root cause analysis had already been performed by the institution for this error, and the institution had implemented corrective actions.

Compliance Results: The compliance component assessed 9 of the 12 primary (clinical) indicators applicable to SOL. For these nine indicators, OIG inspectors rated two *proficient*, three *adequate*, and four *inadequate*. The test questions used to assess compliance for each indicator are detailed in *Appendix A*.

ACCESS TO CARE

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

Case Review Rating:
Inadequate
Compliance Score:
75.1%
Overall Rating:
Inadequate

For this indicator, the OIG case review and compliance review processes yielded different results, with the case review giving an *inadequate* rating and the compliance review resulting in an *adequate* score. The OIG's internal review process considered the factors leading to both results and ultimately rated this indicator *inadequate*. For example, the OIG's case review identified multiple deficiencies related to access to medical care and the corresponding rating fell solidly into the *inadequate* range. Compliance testing revealed some of those same deficiencies; also, the compliance score barely fell into the *adequate* range. Therefore, the case review's *inadequate* rating was deemed a more accurate reflection of the appropriate overall rating.

Case Review Results

The Office of the Inspector General clinicians reviewed 327 provider, nursing, specialty, and outside hospital encounters where a follow-up needed to be scheduled and found 44 deficiencies related to *Access to Care*. While the majority of appointments occurred appropriately, many of the deficiencies were of such magnitude that poor health care access contributed significantly to the *inadequate* rating of six clinical cases.

Provider-to-Provider Follow-up Appointments

SOL performed well with provider-ordered follow-up appointments. These are among the most important aspects of the *Access to Care* indicator. Failure to accommodate provider-ordered appointments can often result in lapses in care, or can even result in patients being lost to follow-up. OIG clinicians reviewed 194 outpatient provider encounters and found only three deficiencies.

RN Sick Call Access

SOL performed adequately in nursing sick call access. The OIG clinicians reviewed 93 sick call encounters and found that registered nurses (RNs) only evaluated six of those calls timely.

RN-to-RN Follow-up Appointments

SOL performed well with RN-to-RN follow-up appointments. Clinical inspectors reviewed 118 RN case management encounters and identified only three deficiencies with RN follow-up.

RN-to-Provider Referrals

Sick call RN-to-provider referrals were sometimes problematic. There were 93 sick call nursing encounters reviewed, of which 20 resulted in new RN-to-provider referrals. Clinical inspectors identified four deficiencies where the provider appointment did not occur timely.

- In case 32, a patient, who was ultimately diagnosed with metastatic lung cancer, saw the nurse for shortness of breath, along with other symptoms, on four occasions. All four encounters had a nurse-to-provider referral. Only the fourth successfully resulted in a provider visit. This was two months after the first nurse referral.
- In case 40, after seeing the patient twice in the same week for complaints of a rash, the nurse referred the patient to the provider, but the provider appointment did not occur.

Provider Follow-up After Specialty Services

A provider generally saw patients to follow up on specialty services. Inspectors reviewed 157 diagnostic and consultative specialty services and identified only four deficiencies. While rare, these types of deficiencies had high potential for patient harm.

- In case 55, the patient required close monitoring by his primary care provider (PCP) as he was receiving active surveillance by multiple specialists after being treated for a rare cancer. On at least two separate occasions, his PCP did not see him for follow-up after the specialty consultation.

Intra-System Transfers

Patients who were transferred into SOL and were referred to the provider were generally seen timely. Inspectors reviewed eight transfer-in patients; the nurse referred four of the patients to the provider. A provider saw one of the four referred patients four days late (case 26).

Follow-up After Hospitalization

SOL had significant problems with post-hospitalization follow-up and was unable to ensure that providers saw their patients after return from an outside hospital or an emergency department. Inspectors reviewed 54 hospitalization or outside emergency events and identified 11 deficiencies with provider follow-up. This type of deficiency was found in cases 1, 3, 43, 49, 57, and the following notable cases:

- In case 32, the patient was discharged from the hospital with plans for hospice care after being diagnosed with terminal cancer. Neither his RN case manager nor his PCP saw him for more than a week. The day prior to his death, the staff found him in his cell confused, lethargic, and unable to care for himself.
- In case 42, the patient returned to SOL after a hospitalization for a painful sickle cell crisis. The nurse ordered a follow-up with his PCP, but it did not occur.
- In case 46, the patient returned to SOL after a hospitalization where he underwent a partial thyroid removal. The patient suffered a near complete lapse in care, in which neither his PCP nor the otolaryngology surgeon followed up with him after his discharge. Less than two weeks later, medical staff sent the patient to an outside emergency room for evaluation of neck pain. His regular PCP did not see him again for nearly a month.

Urgent/Emergent Care

SOL also had difficulty ensuring that patients evaluated in the triage and treatment area (TTA) were seen their by PCP or their RN case manager. The OIG reviewed 73 urgent/emergent encounters, 35 of which required a PCP or RN case manager follow-up. Deficiencies were identified where either the PCP or RN case manager follow-up from the TTA did not occur. The provider failed to follow up after hospitalization in cases 1, 3, 43, 49, 57, and the following four cases:

- In case 32, the patient with metastatic lung cancer was seen in the TTA for chest wall pain. A seven-day follow-up with the PCP was ordered, but it did not occur.
- In case 36, the patient was seen in the TTA for low blood sugar, confusion, and combativeness. He was treated for his low blood sugar, and his insulin dose was adjusted. TTA staff ordered same-day follow-up with his RN case manager, but this did not occur.
- In case 42, the patient was having a severe episode of sickle cell crisis but was not seen by the provider even after two TTA encounters.
- In case 46, the patient was seen in the TTA for an exacerbation of COPD with chest pain and shortness of breath. A follow-up with the RN in two days and the PCP in five days was ordered but did not occur.

Specialized Medical Housing

SOL performed well with provider access during and after admission to the correctional treatment center (CTC). A provider generally saw patients frequently and within the every-72-hour policy requirement. There were at least 11 CTC admissions with 63 CTC provider encounters reviewed. In addition, after CTC discharge, PCPs almost always saw the patients for follow-up. Inspectors found only one deficiency wherein the patient did not see his RN case manager after CTC discharge.

Diagnostic Results Follow-up

During the case review, a pattern emerged in which providers would review labs and request follow-up appointments, but those appointments were not generated timely. This deficiency occurred in cases 44, 48, and 56. Onsite discussion revealed that the forms used to generate these appointments, Notification of Diagnostic Results (CDCR Form 7393), were ambiguous and caused confusion among scheduling staff. Many times, the scheduler would not generate a duplicate appointment if the patient had a pending appointment already scheduled. From a case review perspective, those pending appointments may not have been clinically appropriate for the patient's condition. For example, in case 48, the provider reviewed anticoagulation labs and ordered a chronic care follow-up for three consecutive lab results. However, the patient had a chronic care appointment already scheduled for one month later; therefore, the schedulers did not generate duplicate appointments. From a clinical perspective, the patient's labs were not appropriately addressed and there was a delay in care.

Clinician Onsite Inspection

OIG clinicians interviewed SOL staff regarding the majority of access deficiencies identified in case review. There were various reasons for many of the scheduling deficiencies. Some of these included poor attendance by one provider, who had since been dismissed. There was another problem with all clinic appointments generated from the TTA, which SOL claimed to have already rectified. There was a variety of other explanations, including patients being scheduled but not seen for unknown reasons, scheduling errors, custody lockdowns, and unclear instructions on the CDCR Form 7393.

Clinician Summary

Access to Care was problematic at SOL. Inspectors found the most serious problems with PCP follow-ups after hospitalizations or TTA visits. There was also a less severe issue with RN-initiated PCP follow-ups from the sick call line. There was an uncommon but recurrent problem with provider-ordered follow-up appointments following abnormal labs, explained by a poorly formatted CDCR Form 7393. On the other hand, SOL did well with sick call RN access, RN-to-RN follow-up appointments, access for intra-system transfer patients, and CTC access. However, the problems identified played a significant role in the inadequacy rating of six case reviews, and resulted in an *inadequate* rating for this primary quality indicator.

Although there is discordance between the OIG case review's *inadequate* rating and the compliance review's minimally *adequate* score, both clinical and compliance inspectors found problems with follow-ups from RN referrals and hospitalizations. However, compared to compliance findings, the case reviews found that SOL performed better regarding PCP-to-PCP follow-up, post-specialty service follow-up, and intra-system transfers. This difference is most likely explained by the differences in the populations studied by the case review tool and those studied by the compliance

tool. A population that was sicker and had more medical needs may have been given higher priority for appointments than the rest of the population.

Compliance Testing Results

The institution received an *adequate* compliance score of 75.1 percent in the *Access to Care* indicator, scoring proficiently in the areas described below:

- Inmates had access to Health Care Services Request forms (CDCR Form 7362) at all five housing units inspected, receiving a score of 100 percent for this test (MIT 1.101).
- Inspectors sampled 30 Health Care Services Request forms (CDCR Form 7362) submitted by inmate-patients across all facility clinics. For 29 out of the 30 (97 percent), nursing staff reviewed the request form the same day it was received. The one exception related to a nurse neglecting to date one patient's service request form (MIT 1.003). Also, nursing staff timely completed a face-to-face patient triage encounter with all but one of the patients sampled (97 percent). In the one exception, the RN's face-to-face visit occurred one day late (MIT 1.004).

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

- For 13 health care service requests sampled where the nursing staff referred the inmate-patient for a PCP appointment, only seven of the patients (54 percent) received a timely appointment. Five patients received their routine appointments from one to 34 days late, and one other patient did not receive an appointment for the referred condition (MIT 1.005).
- Of the five patients whom nursing staff referred to a PCP and for whom the PCP subsequently ordered a follow-up appointment, only three (60 percent) received their follow-up appointments timely. One patient received his follow-up appointment two days late, and another patient received his follow-up appointment 16 days late (MIT 1.006).
- When inspectors sampled 29 inmate-patients who had been discharged from a community hospital, only 18 of the patients (62 percent) received or were offered a follow-up appointment with a PCP within five days of discharge. Ten of the inmate-patients were seen from one to 16 days late, and one patient was timely seen by a PCP but the hospitalization was not discussed (MIT 1.007).
- Inmate-patients who transferred into SOL from other institutions and who had either a pre-existing chronic care PCP follow-up visit need or a new PCP referral from the receiving institution's screening nurse did not always receive a timely PCP visit. Of the 28 patients sampled, only 19 (68 percent) received a timely appointment. Providers saw nine patients from 3 to 34 days late (MIT 1.002).

- Inspectors also sampled 29 inmate-patients who received a specialty service; only 20 of them (69 percent) received a timely PCP follow-up appointment. Eight exceptions related to high-priority specialty service follow-up appointments, for which five appointments ranged from one to 36 days late; three other patients did not receive a PCP follow-up appointment at all. In addition, one patient who received a routine specialty service did not receive a PCP follow-up appointment to discuss the results (MIT 1.008).
- The OIG reviewed recent appointments for 40 inmate-patients who suffered with one or more chronic care conditions; only 28 (70 percent) had received timely follow-up appointments. Six of the untimely follow-up appointments were held over one month late, including one appointment that was over four months late. An additional six appointments were between one and 20 days late (MIT 1.001).

CCHCS Dashboard Comparative Data

The Dashboard uses the average of nine medical access measure indicators to calculate the score for access to medical services. The OIG compared applicable SOL compliance scores with that Dashboard average.

The OIG score for *Access to Care* was 78 percent, 13 percentage points less than the Dashboard’s score of 91 percent. However, as indicated in the table below, the OIG based its compliance results on current documents as well as documents from the preceding one year; SOL’s June Dashboard data reflected only the institution’s May 2015 results.

Access to Care—SOL Dashboard and OIG Compliance Results

SOL DASHBOARD RESULTS	OIG COMPLIANCE RESULTS
Scheduling & Access to Care: Medical Services June 2015	<i>Access to Care</i> (1.001, 1.004, 1.005, 1.007) <i>Diagnostic Services</i> (2.001, 2.004) <i>Specialty Services</i> (14.001, 14.003) June 2014 – June 2015
91%	78%

Note: The CCHCS Dashboard data includes access to care for inmate-patients returning from CDCR inpatient housing units and from emergency departments, whereas OIG does not test follow-up appointments for these patients.

Recommendation

The OIG recommends that CCHCS revise the Notification of Diagnostic Results form (CDCR Form 7393) so the provider can document remarks about the diagnostic test results on one section of the form and document whether or not a follow-up is needed on another section. On the follow-up section of the form, include a time frame to remove ambiguity about when the provider intends to see the patient. This information will help the scheduler decide whether or not to bundle the appointment or create a new one according to the provider's instructions.

DIAGNOSTIC SERVICES

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

Case Review Rating:
Inadequate
Compliance Score:
68.9%
Overall Rating:
Inadequate

Case Review Results

The Office of the Inspector General clinicians reviewed 221 diagnostic-related events and found 62 deficiencies. Of those 62 deficiencies, 58 were related to health information management and only four related to the non-completion of ordered tests. Within health information management, the OIG considers test reports that were never retrieved or reviewed just as severe a problem as tests that were not completed as ordered.

Within the *Diagnostic Services* indicator, SOL displayed proficiency in the following:

- When diagnostic services were successfully completed, they were obtained timely.
- When providers notified patients of their test results, they did so quickly.
- Radiology provided excellent services without any deficiencies.
- SOL laboratory tests (predominately blood tests) were usually collected without problems. There were only four deficiencies relating to three patients (cases 38, 49, and 58) for whom diagnostic studies were ordered but were not processed; in one case, the staff performed the lab test with a short delay.

Within the *Diagnostic Services* indicator, SOL has room for improvement in the following areas:

- While providers reviewed most lab reports in a timely manner, the OIG identified various delays for provider review in cases 32, 33, 35, 36, 44, 47, and 48.
- Lab reports were misfiled in cases 36, 38, and 41.
- Scans of diagnostic reports were delayed in cases 32, 33, 34, 36, 41, 45, and 52. Most of these delays were minor and did not significantly affect the quality of care.

- In numerous instances, lab tests were collected and processed, but the associated lab reports were not in the medical record. Furthermore, there was no evidence of patient notification of the results. This severe deficiency greatly increased the risk of inadequate diagnosis and monitoring of several patients in the case review, and for some patients it delayed care. This deficiency existed in cases 33, 34, 36, 45, 47, 48, 51, 52, 53, and 54. It was repeated numerous times in cases 36 and 52.
- Providers failed to initial or date pathology reports in cases 33, 37, and 45. In addition, no pathology reports had evidence of the provider sending a notification of diagnostic results back to the patient.
- Routine EKGs also were performed without evidence of the provider sending notification of diagnostic results back to the patient. This occurred in all routine EKGs reviewed. Examples are identified in cases 38, 47, 50, and 54.

Clinician Onsite Inspection

SOL laboratory staff (phlebotomists who draw lab specimens and send specimens offsite for processing) explained that labs were drawn by non-laboratory staff in more acute clinical areas. As such, these non-laboratory staff may not have had their associated reports printed and processed through the usual means. In addition, when the providers reviewed early lab reports online, the reports were often not automatically printed in the SOL laboratory area. At SOL, automatic lab printing was the usual method employed for the processing of reports, where the report was then forwarded to the provider for review. Furthermore, many of the missing lab reports had been forwarded to a provider for review, but for unknown reasons the report processing was never completed. SOL medical records unit staff indicated that pathology reports and routine EKGs did not follow the same process of provider review and patient notification as did lab and radiology reports.

Clinician Summary

Adequate diagnostic lab testing is a critical element required for the diagnosis and monitoring of numerous medical conditions. The break in the chain of processing at SOL left numerous lab reports out of the eUHR, markedly increased the risk of inadequate review and future unavailability of those reports, and for some patients delayed medical care. Pathology reports were often retrieved later and separately from the actual diagnostic procedure. The scanning of pathology reports into the eUHR without ensuring that the provider was aware of the results also increased the risk of lapses in care. SOL's failure to notify patients of the results of pathology and EKG results was also notable. These failures were the major reasons for this indicator's *inadequate* rating.

Compliance Testing Results

The institution received an *inadequate* compliance score of 68.9 percent in the *Diagnostic Services* indicator. For clarity, each subcategory of diagnostic service is discussed separately below:

Radiology Services

- For all ten of the radiology services sampled, the service was timely performed (MIT 2.001). However, providers initialed and dated the radiology report, evidencing they reviewed the report within two business days of receipt, for only seven of those patients (70 percent). For two patients, the provider reviewed the report results one day late, and for one other patient, there was no evidence the provider reviewed the report (MIT 2.002). Providers only communicated the radiology results timely to seven of the patients (70 percent). For the other three patients, providers communicated the results one day late (MIT 2.003).

Laboratory Services

- Only six of the ten laboratory service orders sampled (60 percent) were timely performed. The institution provided four ordered lab services from three to five days after the time frame specified by the provider (MIT 2.004). However, for all ten samples, providers timely reviewed diagnostic reports within two business days of receipt and timely communicated those results to the patients (MIT 2.005, 2.006).

Pathology Services

- The institution received the final pathology report timely for only seven of ten inmate-patients sampled (70 percent). The three untimely reports were from 3 to 40 days late (MIT 2.007). In addition, providers did not properly evidence their review of pathology results for any of the sampled reports; none of the ten reports illustrated provider review as evidenced by a signature or initials and review date (MIT 2.008). Providers timely communicated the final pathology results to only five of the ten patients sampled (50 percent), communicating the results from one to 61 days late (MIT 2.009).

Recommendation

The OIG recommends that SOL develop a system to track ordered pathology services and follow up when final pathology reports are not received timely from outside entities.

EMERGENCY SERVICES

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

Case Review Rating:

Adequate

Compliance Score:

Not Applicable

Overall Rating:

Adequate

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 94 urgent/emergent events and found 35 deficiencies in a variety of areas. Most deficiencies were minor and did not significantly impact patient care. In general, SOL performed well with emergency response times, basic life support (BLS), and 9-1-1 call activation times. Patients requiring urgent/emergent services received timely and adequate care in the majority of cases reviewed.

Provider Care

The triage and treatment area (TTA) provider generally saw patients timely and made adequate assessments. The provider made sound triage decisions, sending patients to the appropriate levels of care. While the OIG identified a few minor deficiencies, the quality of provider care in *Emergency Services* was good.

- The TTA providers did not always document a progress note for the encounter. This occurred for both onsite and offsite TTA provider coverage, and inspectors identified the issue in cases 35, 44, and 46.
- The main TTA provider regularly used "cloned" notes. While this had a detrimental impact on the quality of care delivered in the CTC, it did not make any appreciable impact on the quality of triage decisions in the TTA.

Nursing Care

Emergency nursing care was also adequate, with documented evidence of commendable performances by experienced nurses in some of the emergency medical response cases reviewed.

- In case 44, a patient, poorly responsive after a seizure, was monitored in the TTA for approximately five hours, and various nurses closely monitored and documented assessment of the patient's vital signs and responsiveness status every 10 to 15 minutes as well as maintained ongoing contact with the physician on call.

In contrast, several case examples also demonstrated areas for improvement, primarily related to incomplete nursing assessment or documentation inaccuracies and discrepancies. The following cases are examples of these case review findings:

- In case 2, the technical skills of the nurse were questionable. The nurse obtained poor quality EKGs but did not then repeat them to obtain better quality. Additionally, the hypotensive manual blood pressure reading (88/72 mm/Hg) should have been rechecked or compared to the vital signs taken by the paramedics, who were also present in the TTA.
- In case 5, the nurse documented receiving orders from the provider for intravenous fluids and Tylenol for the patient with headache and dizziness. There were no verbal or telephone provider orders (CDCR Form 7221) found in the patient's health record.
- For case 36, the clinic nurse sent a patient to the TTA for high glucose testing results. The TTA nurse gave the patient insulin twice for continued high blood glucose readings, with a blood glucose check repeated two hours after each insulin injection. The TTA nurse failed to check the patient's vital signs and assess the patient for signs and symptoms of hyperglycemia at each encounter. This nurse documented three encounters for fingerstick glucose checks, and it was not clear whether the patient remained in the TTA for four hours or returned to the yard between fingerstick glucose encounters.
- There were numerous time or intervention discrepancies in documentation, entered by different medical staff or by one person on various documents, in cases 35, 42, 43, 44, and 46.

Patient Care Environment

- In case 4, the patient was sent from the clinic to the TTA to be sent out to an outside emergency room for higher-level evaluation of right neck, shoulder, and arm pain. There was a miscommunication between medical and custody staff regarding the initiation of the 9-1-1 emergency medical services (EMS) call to request a Code 3 ambulance, resulting in a 45-minute delay in EMS arrival at the TTA. The Emergency Medical Response Review Committee (EMRRC) minutes did not address the delay.

Onsite Clinician Inspection

Regarding the patient care environment in the TTA, the OIG clinicians found that the TTA was staffed appropriately and contained necessary supplies and equipment for providing safe patient care. There were two nurses (one medical responder) and one provider present in the TTA during the visit. One positive site-specific nursing staffing policy at SOL was that a third nurse was specifically assigned to assess the numerous patients returning from outside medical hospital admissions, emergency room evaluations, and medical appointments Monday through Friday, from noon to 8:00 p.m. Implementing a “medical returns” nurse had proven to be a very effective strategy during this typically very busy time of day at SOL. The TTA nurse and medical response nurse were able to focus on urgent/emergent patients, and the medical returns nurse was able to focus on the many patients returning from outside medical encounters. The nurse appropriately assessed patients upon return to the institution, discharge and specialty consult reports were reviewed by the nurse and contact was maintained with providers regarding recommendations and orders, and reports were forwarded to the nurse case managers for the next-day appointments for all returning hospital discharged patients.

The OIG noted during the onsite visit that some TTA nurses who received returning patients outside of the medical return nurse hours were unaware of the process and designated area for placing hospital and specialty reports for the nurse case managers. Specific examples of case review findings for patients returning from hospitalization outside of the medical returns nurse’s hours and on weekends are discussed in the *Intra- and Inter-System Transfers* indicator.

Clinician Summary

SOL staff provided adequate emergency services to their patients. TTA provider care was generally timely and appropriate. Nursing assessments and treatment and monitoring interventions were generally appropriate, timely, and legibly documented.

Recommendation

- SOL leadership can train TTA nurses who receive returning patients outside of the normal business hours to send their hospital and specialty reports to nurse case managers. The OIG recommends training for all TTA nursing staff regarding medical return patients, especially considering the high-risk patient population at SOL.

HEALTH INFORMATION MANAGEMENT (MEDICAL RECORDS)

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

Case Review Rating:

Inadequate

Compliance Score:

58.1%

Overall Rating:

Inadequate

Case Review Results

Hospital Records

- SOL performed extremely well with the retrieval of hospital and emergency department (ED) reports. The OIG inspectors reviewed 54 separate hospitalizations and outside emergency events and found no deficiencies with regard to retrieval or scanning.
- SOL performed extremely poorly with the initialing and dating of hospital and ED reports by primary care providers (PCPs). This step was necessary to show that the PCP reviewed the report and took responsibility for the patient's care. The PCP neither initialed nor dated any of the hospital or outside emergency room reports reviewed.
- SOL had a unique process wherein RN case managers were also responsible for reviewing outside hospital and ED reports. The RN case managers had implemented an informal workaround process in which most of these reports were forwarded to them, but this process was not always carried out thoroughly. RN case managers were not required to initial or date these reports.

Dictated PCP Progress Notes

- Inspectors found a strong pattern of delayed digital signatures on dictated PCP progress notes, a deficiency present in cases 5, 37, 38, 40, 43, 44, 47, 55, and 56. These reports are vital in communicating the assessment and plans among medical staff. While these deficiencies did not lead to harm, their frequency caused a high risk of harm when reports were not checked for accuracy in a timely manner.

- Problems with CCHCS centralized transcription services resulted in delays in transcription or delays in document delivery after transcription. The OIG identified these delays in cases 32, 37, 43, and 44.

Scanning Performance

- SOL performed very well with scanning times for ambulatory notes. Inspectors identified very few scanning delays for clinic documents (cases 34, 35, and 44). Scanning performance for specialty reports was generally acceptable. Delays in scanning diagnostic tests were more common and are discussed in the *Diagnostic Services* indicator.
- Mistakes were made in the document scanning process, i.e., mislabeled or misfiled documents. Erroneously scanned documents can greatly hinder providers' ability to find relevant clinical information. In addition, if a provider takes action for one patient based on another patient's report, there are potentially severe consequences. Documents were mislabeled in the eUHR in cases 2 and 55. Documents were filed in the wrong chart in cases 32, 38, 41, 42, 43, 51, and 55, and documents were incomplete or missing altogether in cases 38, 47, and 51.

Specialty Services Reports

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

Diagnostic Reports

- There were significant problems in the retrieval and review of diagnostic reports. These findings are discussed in detail in the *Diagnostic Services* indicator.

Legibility

- Illegible progress notes pose a significant medical risk to patients, especially when other staff must review past medical care or when a patient is transferred to a different care team. Inspectors found illegible progress notes, signatures, or initials from some of the physician providers sporadically throughout the review.

Clinician Summary

SOL had several areas that needed marked improvement. While all hospital and outside ED reports were retrieved, not one of them was initialed or dated by the PCP or the RN case manager to indicate that the required health care staff reviewed the critical report. Inspectors identified significant delays in various aspects of onsite dictated progress notes as well as serious problems with diagnostic and specialty reports, discussed further in their respective indicators. While scanning times were adequate, scanning accuracy, i.e., correct labeling and filing, was not. In

addition, providers did not consistently initial and date the reports they reviewed. Because of the multitude of problems with report-handling at SOL, the OIG rated this indicator *inadequate*.

Compliance Testing Results

The institution received a compliance score of 58.1 percent in the *Health Information Management (Medical Records)* indicator and has room for improvement in the following areas:

- The institution scored zero in its labeling and filing of documents scanned into inmate-patients' electronic unit health records. The most common errors included incorrectly labeled documents, inclusion of documents for another inmate, and missing transcribed versions of PCP progress notes. Inspectors also found instances of radiology test results and patient test result notifications being improperly scanned as one document (MIT 4.006).
- The OIG reviewed hospital discharge reports and treatment records for 30 sampled inmate-patients who were sent or admitted to the hospital. The community hospital discharge reports were complete and timely reviewed for only 12 of the sampled patients (40 percent). For 16 patients, the provider reviewed the hospital discharge reports between one and 32 days late. For two other patients, there was no evidence that a SOL provider had ever reviewed the hospital discharge report (MIT 4.008).
- Inspectors tested 18 PCP-dictated progress notes to determine if staff scanned the documents within five calendar days of the patient encounter date; only eight documents (44 percent) were scanned timely. Staff had scanned ten of the documents between one and eight days late (MIT 4.002).
- When the OIG reviewed various medical documents such as 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 16 of 32 samples (50 percent) showed compliance (MIT 4.007).
- Medical administrative staff did not always timely scan medication administration records (MAR) into patients' eUHR files, scanning only 10 of 20 sampled documents (50 percent) within the required time frames. Staff scanned the other 10 MARs between one and four days late (MIT 4.005).

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

- For each of the 20 hospital discharge reports sampled, SOL staff scanned the reports into the eUHR within three days of the patient's discharge, resulting in a score of 100 percent (MIT 4.004).

- SOL staff timely scanned 19 of 20 miscellaneous non-dictated documents sampled (95 percent) into the patient’s eUHR within three calendar days of the inmate-patient’s encounter. These documents included providers’ progress notes, inmate-patients’ initial health screening forms, and health care services request forms (MIT 4.001).
- For 17 of 20 specialty service consultant reports sampled (85 percent), SOL staff scanned the reports into the inmate-patient’s eUHR file within five calendar days. Three documents were scanned between one and 29 days late (MIT 4.003).

CCHCS Dashboard Comparative Data

As indicated below, for two of the four comparative measures, the OIG’s compliance results for SOL’s availability of health information were inconsistent with the SOL’s June 2015 Dashboard results. The OIG found a much higher level of compliance for non-dictated documents and a much lower level of compliance for dictated documents when compared to the Dashboard, even though both scores fell into the *inadequate* range. For specialty notes and community hospital records, the OIG compliance results and SOL’s Dashboard results were similar and showed a high level of compliance. As the table shows, the OIG based its test results on a review of current documents as well as documents from the preceding eight months. SOL’s June Dashboard data reflected only the institution’s May 2015 results.

***Health Information Management—
SOL Dashboard and OIG Compliance Results***

SOL DASHBOARD RESULTS	OIG COMPLIANCE RESULTS
Availability of Health Information: Non-Dictated Documents June 2015	<i>Health Information Management</i> (4.001) Non-Dictated Medical Documents October 2014 – May 2015
73%	95%

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

SOL DASHBOARD RESULTS	OIG COMPLIANCE RESULTS
Availability of Health Information: Dictated Documents June 2015	<i>Health Information Management</i> (4.002) Dictated Documents January 2015 – May 2015
62%	44%

Note: The Dashboard results were obtained from the Dictated Documents Drilldown data for “Medical Dictated Documents 5 Days.”

SOL DASHBOARD RESULTS	OIG COMPLIANCE RESULTS
Availability of Health Information: Specialty Notes June 2015	<i>Health Information Management (4.003)</i> Specialty Documents September 2014 – March 2015
91%	85%

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

SOL DASHBOARD RESULTS	OIG COMPLIANCE RESULTS
Availability of Health Information: Community Hospital Records June 2015	<i>Health Information Management (4.004)</i> Community Hospital Discharge Documents December 2014 – March 2015
91%	100%

Recommendation

The OIG recommends hospital and outside emergency department reports be distributed to the patient’s primary care team. At SOL, both the RN case manager and the PCP are required to review the report; they should both initial and date the report to indicate their review. In addition, providers should review community hospital discharge reports within three calendar days of a patient’s discharge.

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:

62.4%

Overall Rating:

Inadequate

Compliance Testing Results

The institution received a compliance score of 62.4 percent in the *Health Care Environment* indicator; 8 of the 11 test areas scored in the *inadequate* range, as described below:

- Only three of the nine clinics examined (33 percent) were appropriately disinfected, cleaned, and sanitary; the remaining six clinics had one or more problem areas. In four clinics, cleaning logs were not maintained; in one clinic, floors were only swept once a week; in another, dirt and dust were visible in the corners and under desks; and nursing staff indicated that in four of the clinics, modified programming negatively impacted staff's ability to clean (MIT 5.101).
- Only three of the nine clinical areas examined (33 percent) were supplied with adequate hygiene supplies; in six areas, the inmate-patient restrooms did not have either hand soap or disposable hand towels, or both (MIT 5.103).
- Only four of the nine clinic common areas and exam rooms (44 percent) had essential core medical equipment and supplies; the remaining five clinics had one or more problems. One clinic did not have its own emergency response bag and had to share one with another clinic, and four clinics had exam rooms missing core items, including a bio-hazard can or bags, hemocult cards (in the PCP room), tongue depressors, or a permanently affixed Snellen chart with an established distance line. The receiving and release (R&R) clinic did not have a Snellen chart, glucometer, peak flow meter, nebulization unit, oto-ophthalmoscope, or exam table (MIT 5.108).

- Only four of the nine clinics observed (44 percent) had appropriate space, configuration, supplies, and equipment to allow clinicians to perform a proper clinical exam. Five clinics had one or more deficiencies, including disorganized or unlabeled storage areas, an exam table that did not allow a patient to lie in a full, unhindered supine position, or unsecured medical records designated for destruction. Also, four clinics had exam areas that lacked audio and visual privacy during triage or examinations, and the R&R clinic’s exam area (Figure 1) was too small and contained unnecessary clutter (MIT 5.110).



Figure 1: Small R&R nursing triage area/exam space

- Five of nine clinics (56 percent) followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste. Three of the four remaining clinics had exam rooms that did not have a sharps container, and two of the four remaining clinics did not have unhindered access to needed personal protective equipment because custody staff maintained the storage location keys (MIT 5.105).

- Six of the nine clinics (67 percent) followed adequate medical supply storage and management protocols. However, three clinics were deemed inadequate due to one or more problems related to dirty and disorganized bulk storage rooms (Figure 2), unlabeled supply drawers, unorganized or cluttered equipment supply items, and food condiments commingled with medical supplies (MIT 5.107).

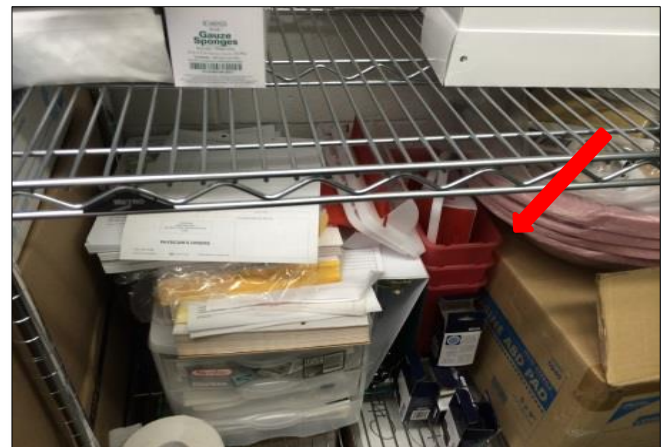


Figure 2: Unorganized storage, including unissued sharps containers

- Clinic common areas at six of nine clinics (67 percent) had an adequate environment conducive to providing medical services. Two clinics did not provide auditory privacy because the triage areas were in large rooms next to cubicles where clinicians also examined patients. In the TTA’s blood draw station, up to four patients were processed at the same time, which also compromised auditory privacy (MIT 5.109).
- Inspectors examined emergency response bags to determine if they were inspected daily and inventoried monthly and whether they contained all essential items. Emergency response

bags were compliant in four of the six clinical locations where bags were stored (67 percent). In one of the deficient clinics, an emergency response bag's contents had not been inventoried within the prior 30 days, and in the other deficient clinic, an emergency oxygen tank was not fully charged (MIT 5.111).

The institution performed well in the three areas below:

- SOL's non-clinic medical storage areas generally met the supply management process and support needs of the medical health care program. As a result, the institution scored 100 percent (MIT 5.106).
- Clinical health care staff at seven of eight applicable clinics (88 percent) ensured that reusable invasive and non-invasive medical equipment was properly sterilized or disinfected. The only exception was one clinic where staff did not replace the exam table paper between patient encounters (MIT 5.102).
- OIG inspectors observed clinicians' encounters with inmate-patients in eight of the institution's clinics. Clinicians followed good hand hygiene practices in seven (88 percent). A physician in one clinic did not properly sanitize his hands before and after patient contact (MIT 5.104).

Other Information Obtained from Non-Scored Results

The OIG gathered information to determine if the institution's physical infrastructure is maintained in a manner that supports health care management's ability to provide timely or adequate health care. The OIG does not score this question. When OIG inspectors interviewed health care management, they did not have any significant concerns. While management indicated that the current infrastructure does present some limitations and health care staff perform the best they can with the resources available, new construction projects underway will alleviate their concerns. SOL has three infrastructure projects underway, including a new 17,000-square-foot primary care and specialty clinic, four medication windows that will facilitate better medication administration operations, and a new medication central complex. Completion date ranges are mid-2016, early 2017, and late 2017, respectively (MIT 5.999).

Recommendations

- The OIG recommends that all clinics, including the R&R, have the following core items: glucometer, peak flow meter, exam table, and a Snellen chart (with a permanent distance line marker). Also, ensure clinical staff have unhindered access to personal protective equipment. In addition, ensure all exam rooms have a bio-hazard can or bags, a sharps container, and tongue depressors; and that provider rooms have hemocult cards.

- The OIG recommends that clinical staff properly label and organize supply areas, ensure that clinic common areas and exam areas maintain auditory and visual privacy for patients being examined or triaged in those areas, and shred or secure patients' confidential medical records so they are inaccessible to other inmates and staff.
-

INTER- AND INTRA-SYSTEM TRANSFERS

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 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 patients reviewed for *Inter- and Intra-System Transfers* include inmates received from other CDCR facilities and inmates transferring out of SOL to another CDCR facility. The OIG clinicians also evaluate the care provided to patients returning to the institution from an outside hospital and check to ensure appropriate implementation of the hospital assessment and treatment plans.

Case Review Rating:

Inadequate

Compliance Score:

91.6%

Overall Rating:

Adequate

For this indicator, the case review and compliance review processes yielded different results, with the case review giving an *inadequate* rating and the compliance review resulting in a *proficient* score. The OIG's internal review process considered the factors that led to both results and ultimately rated this indicator *adequate*. Because the case review and compliance review used different testing and scoring methodologies that resulted in vastly different conclusions, the inspection team determined the overall rating of *adequate* was appropriate.

Case Review Results

Clinician inspectors reviewed 22 encounters related to *Inter- and Intra-System Transfers*, including information from both the sending and receiving institutions. Eight encounters were reviewed for inmates transferring out of SOL to other institutions, and 14 for inmates transferring into SOL from other institutions. The OIG reviewed 52 events related to patients returning to SOL from a community hospitalization or outside emergency department.

Transfers In

Deficiencies the OIG found with inmates transferring into SOL from other CDCR institutions related primarily to the timeliness of new arrival provider appointments, discussed further in the *Access to Care* indicator.

Transfers Out

Deficiencies found with inmates transferring out of SOL 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 nurse did not document that the patient had a recent hospitalization for a closed head injury from an altercation, a head laceration wound with sutures, and shoulder burn wounds, or that daily wound care for ten days was still in progress at the time of transfer.
- In case 29, the transfer form did not include significant patient-specific information, such as the aortic and mitral valve (cardiovascular) surgical repair approximately three weeks previous and that the patient still had an intact peripheral intravenous cardiac catheter (PICC) line in place for antibiotic therapy for endocarditis (heart valve infection).

Hospitalizations

Patients returning from hospitalizations or from outside emergency departments (EDs) are some of the highest-risk encounters due to two factors. First, these patients' conditions are of higher acuity since they had just been hospitalized for a severe illness in most cases. Second, these patients are doubly at risk due to the potential lapses that can occur during any transfer of care. The medical returns TTA nurse processed hospital return patients, and that nurse appropriately reviewed the discharge medications and plan of care, obtained physician orders to implement the plan of care, and referred all returning patients to RN case managers for next-day follow-up assessment visits. Although the OIG identified very few medication errors at this transfer step, there was no evidence of a formal medication reconciliation process in place (also discussed in the *Pharmacy and Medication Management* indicator). Staff retrieved most discharge summaries from community hospitals and scanned them into the eUHR within acceptable time frames. However, none of the hospital or ED discharge summaries was signed or dated by a provider (further discussed in the *Health Information Management* indicator). There were significant problems with timely post-hospital or post-ED follow-up appointments (further discussed in the *Access to Care* indicator). The following cases illustrate some of the problems found regarding *Inter- and Intra-System Transfers*:

- In case 32, the patient returned from hospitalization, where a repeat CT scan showed a large upper-lobe lung cancer. The patient had been referred for hospice care, and upon return to SOL should have been evaluated for CTC placement. About ten days after return from hospitalization, custody staff reported the patient could not stand. The nurse went to the housing unit where the patient was found in a wheelchair, weak and unable to care for himself. The patient was admitted to the CTC and died the next day.

- In case 42, the patient returned from a community hospital (the return time was not documented) for sickle cell disease exacerbation. The TTA nurse noted “potential for pain due to sickle [cell] crisis” but did not assess or address the patient’s current pain level. There was no evidence found of post-hospital discharge medication reconciliation orders to ensure that continuing and new (if any) medications were properly reconciled upon transfer back into SOL.
- In case 44, the patient returned from a community hospital for evaluation for seizure activity, and the TTA nurse did not address the low phenytoin (anticonvulsant medication) level of 5.8 (lab blood test) or the hospital discharge prescriptions for amoxicillin (antibiotic) and recommended change in phenytoin dose with the on-call provider.
- In case 49, the patient was hospitalized for six days with atrial flutter (heart arrhythmia) and acute congestive heart failure. The patient returned to SOL from the hospital on Saturday evening, but the post-hospital medication orders were not carried out as ordered, even after clarification with the physician on the following day. These included: 1) glipizide (diabetes medication), which was dispensed at the prior dose instead of the newly ordered dose, 2) furosemide (diuretic), which was dispensed with instructions to take 60 mg in the morning and 40 mg in the evening, instead of the 40 mg twice daily as had previously been ordered, 3) potassium chloride (salt replacement medication), which was dispensed twice daily even though it had been discontinued upon return from the hospital, and 4) hydralazine (blood pressure medication), which was not discontinued as ordered. The RN dispensed warfarin (blood thinner) medication, but did not obtain orders for INR (blood coagulation lab work) monitoring, as had been specified on the discharge summary. The patient was again readmitted to the hospital one week later for congestive heart failure. Upon return to SOL, the TTA nurse did not transcribe the amiodarone (heart rhythm medication) order correctly. Although there was conflicting documentation in the hospital discharge paperwork, it was clear the patient was to start a lower dose of amiodarone after five days. Additionally, the provider reviewed the hospital discharge medications and signed the order for the incorrect, higher initial (loading) dose of amiodarone for 30 days. Fortunately, another provider corrected and lowered the dose on the seventh day of the 30-day period.

Systemwide Transfer Challenges

In reviewing *Inter- and Intra-System Transfers*, the OIG acknowledges systemwide challenges common to all institutions regarding pending specialty services referrals and reports and the potential for delay in needed follow-up and services. Nurses are responsible for accurately communicating pertinent information, identifying health care conditions that need treatment and monitoring, and facilitating continuity of care during the transfer process. While this is sufficient for most CDCR inmate-patients, it has not been adequate for patients with complex medical conditions or patients referred for complex specialty care. Often, nurses who are not familiar with the patient’s care or are not part of the primary care team initiate the CDCR Form 7371 transfer forms. In

addition, providers are often left out of the transfer process altogether, and patients are transferred without the provider's knowledge. Without a sending and receiving provider, the risk for lapses in care increase significantly. The OIG understands CCHCS is currently working to revise the transfer policy with its Patient Management Care Coordination Initiative and looks forward to reviewing that new policy once CCHCS finalizes it.

Clinician Summary

Although there were few issues with patient transfers to and from other CDCR institutions, there were several deficiencies with hospital return patients related to incomplete nursing assessments, inadequate review of hospital discharge reports, and incorrect medication orders, due to inconsistent medication reconciliation practices. In addition, there were problems with post-hospital review of records and follow-up with the responsible PCP. The various problems with post-hospital returns resulted in an *inadequate* clinician rating for this indicator.

Compliance Testing Results

The institution obtained a score of 91.6 percent in the *Inter- and Intra-System Transfers* indicator, scoring in the *proficient* range in three of the five tests, as described below:

- The OIG tested 30 patients who transferred into SOL from another CDCR institution; nursing staff completed an initial health screening assessment form on the same day of the patient's arrival for 29 of the patients (97 percent). In one instance, nursing staff neglected to answer all applicable questions on a patient's Initial Health Screening form (CDCR Form 7277) (MIT 6.001). Nursing staff timely completed the assessment and disposition sections of the screening form for all 30 patients (MIT 6.002).
- During the OIG's onsite inspection, four inmate-patients who were transferring out of the facility had their transfer packages inspected to determine whether they included required medications and support documentation. All four transfer packages were compliant, and the institution received a score of 100 percent for this test (MIT 6.101).

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

- Inspectors sampled 20 inmate-patients who transferred out of the institution to another CDCR institution to determine whether their scheduled specialty service appointments were listed on the Health Care Transfer Information form (CDCR Form 7371). Seventeen (85 percent) were correctly documented. For three inmate-patients, nursing staff did not document pending specialty services approved at SOL on the Form 7371 (MIT 6.004).
- For 17 sampled inmate-patients who transferred into the institution with an existing medication order, 13 patients (76 percent) received their medications without interruption

upon arrival to SOL. Four inmate-patients did not receive scheduled doses of one or more medications (MIT 6.003).

Recommendations

Recommendation for SOL

- The OIG recommends that the institution implement a formal medication reconciliation process for patients returning from hospital admissions. Create a special hospital return medication order that discontinues all prior outpatient medications and specifies the medication, dose, route, frequency, duration, and start time for each new prescription. When the prescriptions are given verbally, instruct nurses to verify each prescription in detail, including read-back with the ordering physician. Audit these orders to ensure completeness by both physicians and nurses. Additionally, remove pre-hospitalization medication administration records (MARs) from the medication binder, or clearly mark pre-hospital medications as discontinued.

Recommendations for CCHCS

With regard to systemwide transfers (not specific to California State Prison, Solano), the majority of patients who do not have complex medical conditions or who do not require complex specialty care would be well served by the existing nursing-only transfer process. However, the OIG recommends CCHCS create a process to identify patients who require special transfer handling that includes the following steps:

- Do not allow patients to transfer without physician involvement, as a nursing-only transfer process is insufficient.
- Include a clear disposition in the transfer process, identifying both the specific yard to which the patient is being transferred and the primary care physician who will be directly responsible for the patient's continued care.
- Require the transferring physician to dictate or type a transfer summary and communicate it to the accepting physician prior to transfer. Allow the transfer to occur only after the accepting physician has reviewed the summary, has had an opportunity to discuss the case with the sending physician, and has formally accepted the transfer.
- Ensure the transfer process comprehensively incorporates key utilization management information.

The OIG understands that these recommendations would place a significant logistical and staffing burden on both sending and receiving institutions, and that these measures are not practiced in the outpatient community generally. However, the transfer rate within CDCR is much higher than that in the outpatient community. 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.

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:

Adequate

Compliance Score:

77.1%

Overall Rating:

Adequate

Case Review Results

The OIG clinicians evaluated pharmacy and medication management as secondary processes as they relate to the quality of clinical care provided. Compliance testing was a more targeted approach and heavily relied on for the overall rating for this indicator.

Nursing Medication Errors

During the onsite visit, OIG clinicians met with medical, nursing, and pharmacy representatives regarding case review findings. Ongoing nursing instruction and monitoring of staff knowledge, skills, and practice regarding medication administration was evident by current records maintained in individual education and administrative nursing files. The nursing instructor and nursing administrators at SOL had implemented medication administration competency testing as part of the annual training for all nursing staff that included medication safety, dosage calculation, and medical waste management.

A total of 24 medication management nursing events were reviewed in the case reviews, of which the vast majority demonstrated that patients received medications timely and as prescribed. Medication errors found during case reviews were rare. The following deficiencies can be used for quality improvement purposes:

- In case 36, upon the patient's transfer back to SOL, the PCP reordered the same medications, which included alternating warfarin (blood-thinning medication) doses on different days. The licensed vocational nurse (LVN) did not properly block out the dates on the medication authorization record (MAR) when the medication was not intended to be administered, which resulted in the patient receiving both doses (11 mg total) simultaneously on four days, resulting in a markedly elevated INR level (blood coagulation test), and subsequent CTC admission. A full root cause analysis had already been performed

by the institution for this error. On the day of admission to the CTC, the patient had received his daily dose of atorvastatin 20 mg at the morning yard pill line. The CTC nurse erroneously administered the medication again at 6:00 p.m.

- In case 44, the patient had missed 10 of 12 twice-per-day doses of phenytoin (anticonvulsant) over a six-day period from Saturday through Thursday. There was no documentation of a PCP referral or SRN contact regarding the numerous missed doses of anticonvulsant medication. The patient missed four nighttime 300 mg doses of phenytoin in one month, according to the MAR. The LVN did not generate a medication management chrono (form) to report this or contact the provider or supervising nurse. The OIG clinicians reviewed this during the onsite visit and concluded that the LVN's failure to initiate provider and supervising nurse contact was due to the LVN's inadequate understanding of policy relating to missed medications.

Pharmacy Errors

Several pharmacy staff errors were discovered during the case review. During the onsite inspection, pharmacy staff acknowledged that performance issues with a pharmacist who was no longer working at SOL were largely responsible for the following errors:

- In case 49, the patient returned from a community hospitalization. However, multiple post-hospital medication orders were not carried out by the pharmacy, including changes to his glipizide (diabetes), furosemide (diuretic), potassium chloride (electrolyte replacement), and hydralazine (blood pressure) medications.
- In case 42, the patient was ordered Tylenol with codeine to be administered on an as-needed basis only. However, the pharmacist entered the order without the as-needed qualifier, resulting in significant erroneous non-compliance write-ups in the patient's file on days when he decided not to take the medication.

Medication Continuity

For the majority of cases reviewed, medication continuity was not a significant problem for patients transferring into the institution, returning from a community hospital, or receiving monthly chronic care medications. However, a few problems were identified:

- The patient in case 31 returned from a community hospital admission for shortness of breath. There was no clear documentation on the medication reconciliation form that the provider and the TTA nurse had completed a reconciliation for each continuing medication after the patient returned from the hospital.
- For patients admitted to the community hospital, there was no evidence that medications were discontinued. Furthermore, there was no clear evidence of performance of complete

medication reconciliations for patients returning from a higher level of care. Despite the lack of a formal reconciliation process, the vast majority of reviewed hospital transfers were accomplished without medication errors, indicating that SOL staff were performing informal medication reconciliations.

- In case 32, the provider discontinued simvastatin due to the patient's refusal to take the prescribed medication. The order was not communicated to the medication nurses for five days.
- In case 61, the patient was to receive a tapered prednisone regimen in which each tapered dose was to be administered for three days, starting with a 50 mg dose. The patient did not receive 50 mg of prednisone on the first day as ordered. He did receive the 50 mg dose on the second day, and refused the 50 mg dose on the third, according to the medication administration record. The tapered 40 mg dose was started even though the patient had not received the 50 mg dose for three consecutive days. There was no evidence of nursing staff contacting the provider for further directions.

Clinician Summary

Overall, *Pharmacy and Medication Administration* performance was rated *adequate*. However, there were specific concerns about initiating timely notification processes by medication LVNs when patients missed critical medications for immediate consecutive days rather than during periods based on days of the week, and documenting the reconciliation for each continuing and all new medication ordered for patients returning from hospital admissions. Pharmacy errors were uncommon during the case reviews and were typically explained by an underperforming pharmacy staff member who was no longer employed by SOL. Medication continuity was likewise maintained for the majority of patients reviewed by OIG clinicians.

Compliance Testing Results

The institution received an *adequate* compliance score of 77.1 percent for the *Pharmacy and Medication Management* indicator. For discussion purposes, this indicator is divided into three sub-indicators: Medication Administration, Observed Medication Practices and Storage Controls, and Pharmacy Protocols.

Medication Administration

This sub-indicator category consists of four applicable questions in which the institution received an average score of 74 percent, which falls in the *inadequate* range. The following are examples of lapses found in medication administration areas:

- Clinical staff timely provided new and previously prescribed medications to only 21 of 30 patients sampled who had been discharged from a community hospital (70 percent). Six patients received their medications from one to 28 days late and one patient never received their hospital discharge medications at all. For another patient, clinical staff did not date the MAR and inspectors could not determine when the patient received his medication. Also, one patient refused his medication but did not receive counseling; the patient also missed doses on the following two days (MIT 7.003).
- Inspectors evaluated 30 inmate-patients who transferred from one housing unit to another to verify they received their medications without interruption. Only 20 patients (67 percent) timely received their medication at the next dosing interval following a housing unit move. Nurses either failed to document why medications were not received or documented that the patient was a “no-show” or had “moved” but did not document follow-up efforts to deliver the medication to the patient or bring the patient to the medication line location (MIT 7.005).
- Chronic care medications were provided timely to only 27 of the 40 inmate-patients sampled (68 percent). Thirteen patients either received their medications late or did not receive required PCP counseling when they missed doses of their medication (MIT 7.001).

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

- Thirty-six of the 40 patients sampled (90 percent) received their new medication orders. Four inmate-patients received their medication one day late (MIT 7.002).

Observed Medication Practices and Storage Controls

This sub-indicator category consists of six applicable questions in which the institution received an average score of 77 percent. While this score falls into the *adequate* range, the institution received *proficient* scores in the following four areas:

- In each of the ten applicable clinics and medication line storage locations sampled, SOL had strong medication security controls over narcotic medications assigned to each area, scoring 100 percent for this test (MIT 7.101).
- Nursing staff at all eight of the medication and preparation administration locations followed appropriate administrative controls and protocols during medication preparation (MIT 7.105).

- The institution properly stored non-narcotic medications that require refrigeration at 15 of the 16 applicable clinics and medication line storage locations sampled (94 percent). The refrigerator in the administrative segregation unit (ASU) clinic room had a broken locking mechanism (MIT 7.103).
- The institution properly stored non-narcotic medications that do not require refrigeration at 14 of the 15 applicable clinics and medication line storage locations sampled (93 percent). In one clinic, external (topical) medications were improperly stored on the same cabinet shelf as internal medication, with no divider to separate them (Figure 3) (MIT 7.102).

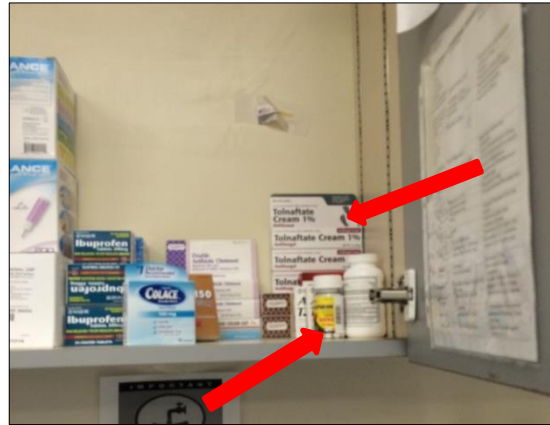


Figure 3: Internal and external medications stored together

The institution scored in the *adequate* range for one test and in the *inadequate* range for another, as follows:

- Inspectors observed the medication preparation and administration processes for eight medication line locations. Nursing staff were generally compliant with proper hand hygiene contamination control protocols at six of the medication lines (75 percent). For two of the medication lines, nurses failed to sanitize their hands prior to initially putting on gloves and between subsequent glove changes. One nurse did not change gloves after making contact with an inmate-patient, and also wore the same pair of gloves throughout the duration of the medication line (MIT 7.104).
- Inspectors toured eight medication areas and determined that none of them demonstrated appropriate administrative controls and protocols during medication distribution. More specifically, none of the seven outdoor medication lines had an overhang or shade covers to protect patients from extreme heat or inclement weather while they waited outdoors for their medication. In addition, inspectors observed that the ASU's indoor medication area staff distributed medications to patients without consistently requiring them to lift their tongues to demonstrate DOT medications were swallowed. As a result, SOL received a score of zero for this test (MIT 7.106).

Pharmacy Protocols

This sub-indicator category consists of five questions in which the institution received an average score of 80 percent, which falls in the *adequate* range. The institution scored 100 percent on the following four test areas:

- In its main pharmacy, the institution followed general security, organization, and cleanliness management protocols; properly stored and monitored non-narcotic medications that require refrigeration; and maintained adequate controls and properly accounted for narcotic medications (MIT 7.107, 7.109, 7.110).
- SOL followed key medication error reporting protocols in all 25 samples tested (MIT 7.111).

The institution could improve in the following pharmacy operational area:

- The pharmacy did not always properly stock non-refrigerated medications, scoring zero on this test. Specifically, medication that expired in July 2014 was still in the active pharmacy inventory stock (Figure 4). At the time of the OIG visit, the medication had been expired by nearly a year (MIT 7.108).



Figure 4: Expired Medication

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 without a score. At SOL, the OIG did not find any applicable medication errors (MIT 7.998).

The OIG interviewed inmate-patients in isolation units to determine if they had immediate access to their prescribed KOP rescue inhalers and nitroglycerin medications. All 11 of the sampled inmate-patients had access to their asthmatic inhalers or nitroglycerin medications (MIT 7.999).

CCHCS Dashboard Comparative Data

The Dashboard uses performance measures from the Medication Administration Process Improvement Program (MAPIP) audit tool to calculate the average score for its Medication Administration measure. The OIG compared similar SOL compliance scores with applicable June 2015 Dashboard results. As indicated in the following table, the Dashboard score of 97 percent is 22 percentage points higher than the OIG score of 75 percent. However, as noted in the table below, the OIG based its compliance results on a review of current documents as well as documents from the preceding one year; SOL’s June Dashboard data reflected only the institution’s May 2015 results.

***Pharmacy and Medication Management—
SOL Dashboard and OIG Compliance Results***

SOL DASHBOARD RESULTS	OIG COMPLIANCE RESULTS
Medication Management: Medication Administration June 2015	<i>Medication Administration</i> (7.001, 7.002) (Chronic Care & New Meds) <i>Preventive Services</i> (9.001) (Administering INH Medication) June 2014 – June 2015
97%	75%

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

Recommendations

- The OIG recommends that the institution’s clinics and medication lines have waiting areas that protect patients from extreme heat and inclement weather.
- The OIG recommends that, when admitting patients to a community hospital, the institution stop all prior medications automatically.
- The OIG recommends that, for patients returning from the hospital after hours, the TTA nurse review the hospital discharge orders and the patient’s most current medical reconciliation list with the provider. If the provider is not onsite, the TTA nurse can then obtain telephone orders and send the orders to the pharmacy and the medication nurse.

PREVENTIVE SERVICES

This indicator assesses whether the institution offers or provides various preventive medical services 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:

82.3%

Overall Rating:

Adequate

Compliance Testing Results

The institution performed in the *adequate* range in the *Preventive Services* indicator, with a compliance score of 82.3 percent. However, the institution scored at the *proficient* level in four of the six tests, as discussed below:

- The institution was compliant in offering annual influenza vaccinations to all 30 inmate-patients sampled (MIT 9.004).
- The OIG tested whether the institution offered vaccinations for influenza, pneumonia, and hepatitis to inmate-patients who suffered from a chronic care condition; 22 of the 23 sampled patients (96 percent) either received or were offered all recommended vaccinations at the required interval. The institution did not offer one patient a hepatitis A vaccine (MIT 9.008).
- The institution provided colorectal cancer screenings to 27 of 30 sampled inmate-patients subject to the annual screening requirement (90 percent). For three patients, there was no evidence that the patient either was offered a fecal occult blood test within the previous 12 months or received a normal colonoscopy within the previous ten years (MIT 9.005).
- Twenty-one of 24 inmate-patients sampled (88 percent) were properly monitored while taking INH tuberculosis medications. However, two patients did not receive all monthly monitoring during the three-month test period, and nursing staff did not properly complete the monitoring form for one additional patient (MIT 9.002).

The institution scored in the *inadequate* range in the following two areas:

- The institution scored 50 percent for conducting annual tuberculosis screenings. Although all 30 inmate-patients sampled were screened for tuberculosis within the prior year, zero of the 15 inmate-patients identified as Code 22 (requiring a tuberculosis skin test in addition to screening of signs and symptoms) were properly tested. For each of the 15 Code 22 patient screenings, inspectors identified one or more of the following exceptions: the 48-to-72-hour

window to read test results was not clear because nursing staff did not document either the administered (start) or read (end) date and time; test results were read outside of the required 72-hour time period; an LVN read the test results rather than an RN, public health nurse, or primary care provider; or nursing staff did not complete all required sections of the Tuberculin Testing/Evaluation Report (CDCR Form 7331) (MIT 9.003).

- The institution scored 70.8 percent for timely administration of anti-tuberculosis medications (INH). Of 24 patients sampled, 17 received all required doses of INH medication for the most recent three-month period. The seven remaining patients missed one or more medication doses, and did not receive counseling from a provider about the missed medication (MIT 9.001).

CCHCS Dashboard Comparative Data

Both the Dashboard and the OIG found a *proficient* level of compliance for colon cancer screening, with the OIG showing a slightly lower level of compliance than the Dashboard score.

Preventive Services—SOL Dashboard and OIG Compliance Results

SOL DASHBOARD RESULTS	OIG COMPLIANCE RESULTS
Colon Cancer Screening June 2015	Colon Cancer Screening (9.005) June 2015
95%	90%

Recommendations

No specific recommendations.

QUALITY OF NURSING PERFORMANCE

The *Quality of Nursing Performance* indicator is a qualitative evaluation of the institution's nursing services. The evaluation is completed 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), correctional treatment center (CTC), or other inpatient units are reported under the *Specialized Medical Housing* indicator. Nursing services provided in the triage and treatment area (TTA) or related to emergency medical responses are reported under *Emergency Services*.

Case Review Rating:
Adequate

Compliance Score:
Not Applicable

Overall Rating:
Adequate

Case Review Results

The OIG evaluated 486 nursing encounters for the SOL case review, of which 263 were outpatient nursing encounters. Of those 263, approximately 93 were sick call requests (CDCR Form 7362), 118 were for RN case management, and 52 were for other outpatient nursing services. In general, SOL nursing services performed well. Clinical inspectors found 99 deficiencies for outpatient nursing services, the majority of which were unlikely to contribute to patient harm. Nevertheless, they were clearly established in CCHCS policy as requirements for nursing care and practice, and therefore subject to appropriate quality improvement strategies. Moreover, several deficiencies were considered more serious due to the potential for adverse outcomes or unnecessary delays in needed health care services for patients in outpatient clinics. OIG nursing clinicians rated the overall *Quality of Nursing Performance* at SOL *adequate*.

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 3, the patient had abdominal pain that he said felt “like another hernia.” The nurse did not assess the patient and noted that the provider had not seen the patient. Inspectors found no evidence of a provider visit in the patient’s health record.
- In case 10, the patient had hip pain and a cough. The nurse assessed the patient for hip pain but not for the cough.
- The patient in case 11 had a painful penile lesion. The nurse contacted the provider, who ordered the pain medication administered in the clinic. The nurse did not document a physical assessment of the penile lesion or whether the pain medication was effective.
- In case 32, the patient complained of shortness of breath exacerbated by stressful situations and occasional chest pain. The nurse did not perform an adequate assessment of the nature of the shortness of breath or the chest pain. Although the nurse documented a routine referral was to be made to the provider, the nurse inadvertently closed out the encounter, resulting in the patient not being scheduled for a follow-up provider appointment. On another sick call visit for this patient, the nurse focused on the patient’s cold or flu symptoms, but did not follow up on the patient’s previous complaints of persistent cough, shortness of breath, and chest pain.

RN Case Management

The SOL leadership implemented an innovative RN case management program as an integral part of the primary care home model. Registered nurse case managers regularly saw the highest-acuity patients, including all patients returning from a hospitalization. Nurse case managers were responsible for reviewing hospital discharge and specialty reports, assessing the patient on the first business day after return from hospitalization, coordinating any necessary follow-up services, and maintaining ongoing communication with the provider and the patient. Nursing case managers coordinated and helped manage the care for patients with complex medical needs, such as anticoagulation (prevent or delay blood clotting) treatment based on the California Correctional Health Care Services (CCHCS) anticoagulation guidelines. They acted as a “second set of eyes” for this high-risk population and helped catch errors that may otherwise have been overlooked. SOL’s RN case management program was extremely impressive and should be considered a standard-setting practice for all (CCHCS) institutions.

Although the majority of patient encounters with nurse case managers contributed to timely coordination and continuity of necessary health services provided to high-risk patients, there were occasions when RN case managers failed to adequately meet the needs of these patients. The following are examples of deficiencies related to nursing case management:

- The patient in case 46 returned after hospitalization for thyroid surgery. The nurse case manager did not adequately review the discharge summary and did not arrange for recommended lab work and the follow-up post-surgery appointment at the ear, nose, and throat clinic.
- In case 48, the patient expressed concern about a cut on his finger that had taken 30 seconds to stop bleeding and his high INR lab (blood coagulation) results. He stated he refused his anticoagulation medication because of these bleeding problems. The nurse case manager did not contact the provider about the patient's concerns and decision to stop taking his medication. At another follow-up visit for anticoagulation therapy and subtherapeutic (low) INR results, the nurse case manager ordered the next follow-up appointment in 14 calendar days. That visit did not occur because the nurse case manager inadvertently canceled the appointment, which removed the follow-up appointment from the schedule. During a third visit approximately one month later, the nurse case manager did not assess the patient for current bruising or bleeding symptoms and did not address the most recent elevated INR lab results, but the nurse case manager did obtain an order from the provider for monthly INR lab checks. However, the monthly INR lab order was inappropriate since the patient was not in a stable range for anticoagulation.
- In case 55, the nurse case manager recognized that urgent diagnostic imaging studies were needed, but did not ensure the requested studies were completed in time for the scheduled specialty clinic appointment. The patient next saw the nurse case manager three months later for follow-up of his high-risk conditions. The nurse case manager did not recognize that the requested imaging studies had not yet been ordered. In this case, a three-month wait for the nurse case manager visit was too long to ensure this patient received appropriate care.

Other Outpatient Nursing Encounters

- In case 2, the nurse completed a wound assessment and dressing change, but did not assess vital signs for a patient with recent a head injury and a sutured head wound.
- In case 3, the provider ordered weekly blood pressure checks, which were not done for approximately three weeks.
- In case 43, the patient had an episode of shortness of breath and went to the clinic for a nebulizer breathing treatment. Although the nurse assessed respiratory peak flow levels before and after the treatment, the RN did not assess breath sounds, respiratory rate, or breathing effort before and after the treatment.

Medication Administration

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

Inter- and Intra-System Transfers

Although there were few major nursing issues found in the cases reviewed, various deficiencies existed in nursing services related to patients returning from hospital discharge. See the *Inter- and Intra-System Transfers* and *Diagnostic Services* indicators for specific findings.

OIG Onsite Clinicians' Visit

During the onsite visit, the OIG nurse and physician found nurses in outpatient clinic settings at SOL 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, and schedulers. 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.

During walking rounds, the RN and LVN staff generally verbalized having no major barriers with initiating communication with nursing supervisors, providers, and custody officers regarding patient care needs and provision of nursing services to patients. The public health nurse was very knowledgeable about inmate population surveillance, the current status of specific patients being monitored, and the well-organized filing system onsite for tracking current and past cases. The receiving and release nurse clearly demonstrated knowledge of processes established at SOL to assess the health care status and needs of incoming inmates. The OIG commends the nursing staff at SOL for their knowledge about assigned patients, specific processes and procedures for their individual assignments, and institution-wide nursing practice policies.

Recommendations

Although case review revealed the quality of outpatient nursing care was *adequate*, strategies for ongoing quality improvement emerged. SOL could easily improve its overall score by adhering to established policy and procedure and implementing the following specific recommendation(s):

- When completing face-to-face nursing assessments on each patient, ensure that the documentation is legible, including the signature and title.
- Nurse case managers have an important role in facilitating needed health services, coordinating crucial medical care, conducting timely consistent tracking of diagnostic test schedules and results, and monitoring the status of high-risk patients, including those

returning to the institution after hospital discharge. The OIG recommends SOL evaluate the processes currently in place for orienting, mentoring, and conducting periodic formal and informal evaluation of all nursing staff, including nurse case managers.

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 330 medical provider encounters and identified 114 deficiencies related to provider performance at SOL. As a whole, the OIG rated SOL provider performance *adequate*.

Assessment and Decision-Making

The SOL providers generally made sound assessments and decisions with available information. Of the 11 *inadequate* case reviews, only four were primarily due to problems with provider assessment or decision-making. Furthermore, the provider responsible for two of those inadequate cases had already been dismissed and no longer provided patient care at SOL at the time of the inspection.

Review of Records

The most common provider deficiency was regarding insufficient depth of review of medical records. This problem was provider specific, with some providers performing exceptionally well while others provided minimally adequate reviews of medical records. Providers generally reviewed records to a sufficient depth to care for their patients' immediate needs, but not enough to consistently provide comprehensive care for the most complex patients.

The following two cases demonstrated *proficient* care:

- In case 53, the patient was transferred from an out-of-state institution for treatment of testicular cancer. In this case, the provider performed exceptionally well, thoroughly reviewing the medical record, arranging appropriate diagnostics and referrals, and providing excellent care coordination along with the RN case manager to ensure that the patient received needed care.
- In case 57, the provider also performed very well. The provider evaluated the patient numerous times for symptoms of abdominal pain. The patient was hospitalized several times. Evaluations repeatedly returned unremarkable. However, the provider diligently

reviewed hospital records each time and made careful and thoughtful assessments and decisions, where other providers may have begun to minimize or dismiss the patient's symptoms. The patient ultimately improved with management of constipation, which included a surgical procedure to relieve an anal fissure.

The following cases demonstrated *inadequate* care:

- In case 46, the provider performed sufficient record review to manage the patient's primary problem, a large thyroid mass. However, the provider did not adequately review and address labs, which at different times showed undetectable levels and very high, potentially toxic levels of his seizure medications.
- In case 55, there were severe, systemic problems causing failure to retrieve critically important specialty reports needed for the coordination of treatment for the patient's cancer. Moreover, the provider was seemingly unaware of some of the available reports, did not review them adequately, and made little effort to coordinate the patient's specialty care.
- The TTA RN properly ordered the vast majority of medications for patients who returned from an outside hospital. However, in case 49, the provider signed an order for a potentially toxic initial (loading) dose of amiodarone (heart medication) to be continued over 30 days. The provider signed the new medication orders without careful review of the patient's record.
- The OIG also identified insufficient depth of record review in cases 2, 32, 37, 41, 45, 48, 50, and 54. While these errors were widespread, the primary care home model and the use of RN case managers mitigated many of the potential problems typically associated with them.

Emergency Care

The OIG clinicians reviewed 73 TTA encounters and found that SOL providers generally made appropriate triage decisions when patients presented emergently to the TTA.

Inspectors identified only sporadic problems in emergency provider care, which SOL can use for quality improvement purposes:

- In case 3, the patient presented to the TTA with critically high blood pressure. The on-call provider incorrectly documented blood pressures that were much lower than what the TTA nurse had documented. That provider failed to have this patient carefully assessed, instead having the patient sent back to housing. Fortunately, the TTA nurse obtained a second provider consultation, and the second provider treated the patient appropriately. The first provider was no longer employed at SOL at the time of the inspection.
- In case 36, the provider displayed an inability to access patient information in the eUHR, resulting in the provider missing a patient's history of renal insufficiency. This was likely

due to insufficient provider training, as all relevant information was present but located under the “inpatient” tab of the eUHR.

- In case 49, the on-call provider was not immediately available for consultation when advice was needed by the nurse. This resulted in an unnecessary emergency room send-out for this patient.

Chronic Care

Chronic care performance was generally acceptable; most providers demonstrated adequate to good care with diabetes, asthma, and hepatitis C. Appropriate monitoring, assessments, and interventions were the rule rather than the exception.

Anticoagulation management at SOL was variable in quality and presented opportunities for improvement. Registered nurse case managers primarily handled anticoagulation. Thus, anticoagulation performance was largely dependent on the performance of the individual case manager assigned to the case. In general, when RN case managers followed CCHCS guidelines for anticoagulation, the performance was good. However, in case 48, the RN case manager displayed poor assessment and decision-making. The anticoagulation guidelines were not followed, which were the primary reasons the case was rated *inadequate*.

Inspectors identified occasional inappropriate follow-up intervals in the case reviews. Onsite explanations revealed that providers were generally attempting to prevent duplication of appointments when ordering long follow-up intervals. This explanation revealed that only some providers were appropriately using the available scheduling system (MedSATS) to determine the appropriate follow-up interval. Inappropriate follow-up intervals were identified in cases 32, 40, 43, and 44. Registered nurse case managers helped to mitigate some of these problems by ensuring that patients’ care plans were still progressing despite the long follow-up intervals.

Inspectors also identified occasional questionable use of chronic opiate medication. These cases demonstrated an insufficient documentation of pain symptoms, objective evidence of disease, functional limitations, or efficacy of pain medications. The OIG questioned the chronic use of opiate medication without adequate documentation or proper pain assessment. Questionable utilization of chronic opiate medications were identified in cases 1, 46, and 48.

Specialty Services

Reviews of the specialty services referrals revealed that SOL providers referred appropriately and diligently the vast majority of the time. The Institutional Utilization Management Committee (IUMC), composed of medical providers, collaboratively ensured that only appropriate referrals were allowed.

Documentation Quality

The cases reviewed were mostly of highly complex patients who required lengthy and thorough documentation in order for providers to keep track of and address numerous medical problems. Multiple providers used template progress notes to keep track of patient issues. Unfortunately, template progress notes became cloned notes when the documented information became outdated or no longer applicable. Providers who depended on cloned notes sometimes overlooked issues that needed to be readdressed.

- In case 49, the CTC provider documented an excellent admission evaluation for the patient who just returned from the hospital. However, failure to reassess and update the cloned notes (which stated that the anticoagulation levels were being monitored and adjusted) led to the provider not adequately assessing or treating the patient's anticoagulation status for the first three weeks after hospitalization.
- In case 52, the patient had worsening kidney function. An onsite kidney specialist recommended restarting a certain class of medications to slow the progression of kidney disease. The provider's cloned progress notes failed to document the specialist's new recommendations, or the reason the provider had decided against following them. Though the provider claimed that the progress notes were reviewed and the decision not to implement the medication was intentional, it was not possible to ascertain the provider's decision-making through the cloned notes.
- Inspectors also found cloned notes in cases 36, 39, 45, 46, 49, and 52.

There were serious problems with providers' documentation quality in the CTC. These are further discussed in the *Specialized Medical Housing* indicator.

Provider Continuity

Provider continuity was excellent.

Health Information Management

Providers generally documented patient encounters on the same day. There was a problem with dictated progress notes that were not digitally signed timely by the provider. This is also discussed

in the *Health Information Management* indicator. In cases 32, 35, and 44, TTA providers (either onsite or on-call) failed to document progress notes for medical encounters.

Onsite Inspection

SOL providers were performing well as a whole. The institution was fully committed to a primary care home model. All providers were satisfied with their primary care teams and found working as a team both personally and professionally rewarding. SOL's innovative addition of RN case managers to the primary care home team helped advance patient care and mitigate many of the provider deficiencies identified, such as insufficient record review.

Onsite interviews with provider staff revealed adequate job satisfaction and good provider morale. Providers reported that the chief physician and surgeon (CP&S) and the chief medical executive (CME) were good leaders who had earned their respect. Medical managers were closely involved with clinical decisions, monitored their work closely, and were seen in the clinics regularly. They were also readily available for consultation and aid during the typical workday.

Interviews with the CP&S and the CME confirmed that provider's job performance was closely monitored. Performance was monitored in various ways, including annual clinical appraisals, CCHCS dashboard evaluations, IUMC meetings, careful review of specialty referrals, and informal death reviews. One provider had already been dismissed due to unsatisfactory performance by the time of the OIG inspection. The CP&S and CME seemed to be aware of the provider issues brought forward from the OIG case reviews, and had accurately assessed provider sentiment and morale. CCHCS had allotted SOL 12 line physician and one mid-level provider positions. At the time of the onsite interview, SOL had one vacant physician position open. The OIG did not identify any significant problems with provider recruitment or retention at SOL.

Clinician Summary

Providers at SOL demonstrated good assessment and decision-making capacity. However, there was occasional insufficient medical record review by some of the providers. Emergency services were good. Providers managed most chronic care conditions adequately. However, anticoagulation management needed improvement as some RN case managers did not follow the anticoagulation guidelines correctly. Providers occasionally ordered inappropriately long follow-ups, indicating that not all providers were utilizing MedSATS correctly when determining a patient's next follow-up interval. A pattern of questionable chronic opiate prescriptions, problems with cloned notes, and significant problems with CTC documentation emerged. Providers referred patients for specialty services appropriately. Provider continuity was excellent. Institutional medical managers supervised and managed providers well. An excellent adoption of the primary care home model helped mitigate many of the provider deficiencies identified and helped SOL achieve an *adequate* rating in this indicator.

Recommendations

- The OIG recommends that when RN case managers take on responsibilities normally associated with providers, i.e., anticoagulation management, the RN case managers' performance be audited to ensure compliance with published guidelines.
 - The OIG recommends that the use of cloned notes be identified and discouraged, as cloned notes increase the risk for errors or lapses in medical care.
-

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. SOL's only specialized medical housing unit is the correctional treatment center (CTC).

Case Review Rating:

Inadequate

Compliance Score:

98.0%

Overall Rating:

Inadequate

For this indicator, the OIG identified notably different findings between the case review and compliance review test results. While each area's results are discussed in detail below, the case review's *inadequate* rating and the compliance review's *proficient* score are readily explained by the different testing approaches. For example, specialized medical housing documents may have been present in the medical record as required by policy, and the finding was positively reflected in the compliance score. However, the clinical quality of those same documents may have been poor and negatively reflected in the case review rating. This indicator's overall rating is ultimately determined (as are all overall ratings) by the OIG inspection team's consideration of both case review and compliance review results and the totality and significance of the issues identified. For this indicator, because it was determined that the case review results significantly outweighed the compliance review results, the final rating was *inadequate*.

Case Review Results

SOL had a 15-bed CTC onsite with six beds designated for medical patients and nine beds for mental health patients. A total of 63 provider encounters and 71 nursing encounters were reviewed in 11 cases that included admissions to the CTC for higher level of supervised medical treatment and monitoring. The OIG clinicians identified deficient areas in both nursing and provider care.

Nursing Performance

Nursing performance in the CTC was generally good. The majority of nursing encounters reviewed demonstrated adequate nursing assessment and documentation. Although various practice improvement issues existed, the majority of these deficiencies involved inadequate assessment and incomplete documentation by nursing staff. Of the 19 deficiencies identified for nursing services, the majority were unlikely to contribute to patient harm. However, the following are some of the more important deficiencies:

Incomplete Nursing Documentation

- Nursing care plans were not individualized to the patient (case 32) or were not revised to reflect changes in treatment (case 39).
- The patient refused medications, and the nurse did not document a discussion of the related risks and benefits with the patient (case 59).

Inadequate Nursing Assessment and Intervention

- In case 39, the patient was on the wound vacuum machine and was prescribed daily wound assessment with dressing changes, but nursing missed the dressing change for one day.
- In case 58, the nurse documented that the patient complained of ear pain at severity level 6/10, but did not assess the ear or gather more information about the complaint.
- In cases 61 and 62, the nurse administered pain medication but did not reassess the effectiveness or the patient's response to the intervention.
- Also in case 61, the patient complained of a sudden onset of severe back and groin pain at severity level 10/10. Although the nurse contacted the provider and administered pain medication as ordered, the nurse did not assess vital signs, physical appearance of the rectal or scrotal area, bowel sounds, abdominal tenderness, or urinalysis.

Provider Performance

General provider performance in the CTC was inadequate due to poor documentation that contributed to questionable assessments and decision-making and insufficient continuity at the time of transfer into and out of the CTC. Of the 11 admissions and 63 CTC provider encounters the OIG reviewed, 25 deficiencies were identified.

One serious problem in the CTC was the use of cloned notes.

- In case 49, the patient returned from the hospital where he had a high anticoagulation level. The CTC provider's cloned note that stated the anticoagulation was being monitored and adjusted, but, in reality, the anticoagulation was not adjusted until three weeks after the patient had returned from the hospital. Cloned notes contributed to a lapse in care.
- The CTC provider also used cloned notes in cases 36 and 39.

Another pattern identified was that upon admission to the CTC, history and physical examinations (H&Ps) were often superficial and incomplete. Inadequate H&Ps erode the communication of care during the transfer of patients into the CTC.

- In cases 32 and 39, the CTC admitting provider substituted an outdated H&P from the most recent outside hospitalization in lieu of an independent H&P. Furthermore, the provider did not summarize the hospital course adequately and did not provide an updated assessment and plan that was appropriate for the current CTC admission. This practice was an extreme example of “form over substance,” where the H&P process was essentially bypassed during the course of the CTC admission process, and markedly increased the risk of errors in transfers.
- In cases 45 and 49, the CTC admitting providers performed independent H&Ps, but these were also superficial and incomplete and did not adequately transmit essential medical information to the CTC follow-up providers.

Discharge summaries in the CTC generally contained too little information and transmitted a minimally acceptable level of information back to the PCP for continuity of care.

- In case 45, the discharge summary did not adequately reflect the recommendations that accompanied the patient from the hospital and increased the risk of a lapse in care.

Provider assessment and decision-making in the CTC was occasionally questionable.

- In case 49, the patient developed recurrent and severe hypoglycemia, but the CTC provider was slow to respond and made insufficient adjustments to the once daily (basal) insulin when considering the degree of hypoglycemia the patient was regularly experiencing.
- Also in case 49, the patient had a history of recurrent hospitalizations for congestive heart failure. The provider’s monitoring of this condition was suspect, as the provider used cloned notes and did not use weight monitoring as a tool to assess the patient’s congestive heart failure.
- In case 36, the patient returned from a community hospital for renal failure and anasarca (fluid overload), and was not placed on any diuretic therapy. It would have been prudent for the provider to obtain some kind of objective evaluation of fluid status. The provider should have ordered fluid intake and output records with recurrent weight checks but did not.

Clinician Summary

While CTC nursing care was adequate, serious problems were identified with CTC provider performance. The use of cloned notes, inadequate H&Ps, and questionable assessment and decision-making resulted in an *inadequate* rating for this indicator.

Compliance Testing Results

The institution received a *proficient* score of 98 percent for the *Specialized Medical Housing* indicator, which focused on the institution's correctional treatment center (CTC). As indicated below, SOL scored 100 percent in all but one of the following compliance tests:

- For all ten inmate-patients sampled, nursing staff timely completed an initial health assessment on the day the patient was admitted to the CTC (MIT 13.001).
- Providers evaluated all ten sampled patients within 24 hours of admission and also completed a history and physical within 72 hours of admission (MIT 13.002, 13.003).
- Providers completed their subjective, objective, assessment, plan, and education (SOAPE) notes at required three-day intervals for nine of ten sampled patients (90 percent). A provider was two days late completing notes for one patient encounter (MIT 13.004).
- When the OIG observed the working order of call buttons in CTC patient rooms, they were all working properly. According to staff the OIG interviewed, custody officers and clinicians respond and access inmate-patients' rooms in less than one minute when an emergent event occurs. As a result, the institution received a score of 100 percent in this area (MIT 13.101).

Recommendations

No specific recommendations.

SPECIALTY SERVICES

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

Case Review Rating:

Inadequate

Compliance Score:

65.8%

Overall Rating:

Inadequate

Case Review Results

The OIG clinicians reviewed 207 events related to *Specialty Services*, including 157 specialty consultations or procedures, and 98 deficiencies were found in this area.

Primary Care Provider Performance

Providers generally referred patients for specialty services appropriately when needed. Only four deficiencies were identified, none of which significantly impacted patient care.

Specialty Access

Specialty services were generally provided within good time frames for both routine and urgent services. Out of 157 specialty consults and procedures, only seven times did the specialty service not occur within the time frame specified. Two of the lapses were related to a nephrology specialist who stopped providing specialty services onsite.

- Case 46 is provided for quality improvement purposes. In this case, the primary care provider ordered an urgent otolaryngology (ear, nose, and throat) specialist consult for a thyroid mass. This consultation did not occur, and no one followed up with the patient until he was hospitalized six weeks later for the same condition.

Health Information Management

Severe problems with the processing of specialty reports emerged. Of the 157 specialty consultations or procedures reviewed, there were 84 deficiencies with regard to health information management.

Specialty report retrieval was a widespread problem. Reports were retrieved late or not at all in cases 5, 32, 36, 38, 39, 40, 41, 44, 45, 47, 53, 54, 55, and 56. When specialty reports were not

retrieved or reviewed, patients were placed at higher risk for delays or even lapses in care. Lapses in care for some patients occurred. Notable examples are detailed below:

- In case 5, the patient underwent several diagnostic tests for severe vascular disease. Because the reports were not retrieved, the provider was not kept abreast of the patient's progress adequately enough to properly care for the patient.
- In case 53, the eUHR lacked numerous cancer specialty reports, which greatly increased the risk of lapses in care. Fortunately, diligent primary care teams ensured that patients received necessary interventions.
- In case 55, multiple specialists were seeing the patient for continued treatment of a rare nasal cancer. However, on many occasions, critically important reports from cancer specialists were not retrieved, reviewed, or scanned into the medical record by staff. This contributed to inadequate follow-up and delays in care.

Additionally, SOL did not employ a process that ensured that specialty reports were routed to and reviewed by the responsible provider.

- When specialty reports were retrieved, providers did not initial or date them. This was a widespread deficiency, identified in 100 percent of specialty reports reviewed.
- In most cases, the provider reviewed available reports with the patient during the face-to-face follow-up encounter. However, because specialty reports were not forwarded to the provider, there were some reports showing no evidence of provider review. This deficiency was identified in cases 47, 49, and 53.

Utilization Management

The OIG clinicians found evidence of a well-performing utilization management system. Providers generally reviewed referrals timely and with considerable depth. Some onsite providers complained of a high frequency of inappropriately denied specialty referrals, but the OIG case reviews did not identify this as a problem, with one exception:

- In case 40, SOL inappropriately denied a pulmonary consultation for the patient with an abnormal pulmonary function test. The medical leadership at SOL and the OIG held a lengthy medical discussion regarding this case, but the OIG ultimately maintained its original position that the pulmonary referral was inappropriately denied and contributed significantly to inadequate care. However, despite this case, the vast majority of referrals were reviewed and decided upon appropriately.

Nursing Performance

Patients returning from an outside specialty service usually encounter a registered nurse (RN) upon return to the facility. In general, SOL RNs appropriately reviewed specialty recommendations, initiated treatment changes, and ensured provider follow-up. However, there were two notable exceptions:

- In case 53, the patient returned from an urgent CT scan to look for metastatic cancer. The RN ordered a two-week PCP follow-up, which was an inappropriate follow-up for the urgent specialty service.
- In case 56, the patient returned from a specialist with recommendations to increase his medication frequency from twice daily to five times daily. The RN did not obtain a prescription for the increased dose. The patient subsequently ran out of medication early, and required hospitalization a few days after he ran out of medication.

Clinician Onsite Inspection

SOL did not have specialty staff available for discussion during the clinician onsite inspection. However, the OIG clinicians did discover that the offsite specialty services department employed no registered nurses. In addition, the offsite specialty services department was physically located far away from medical services and outside the fenced prison perimeter. Locating these important staff away from other health care staff, and their being LVNs instead of RNs, could impair their ability to perform adequately.

Clinician Summary

Some aspects of specialty services were well run at SOL. Providers did well in identifying and referring patients appropriately when needed. There was evidence of a well-functioning utilization review process. Specialty access was generally very good. However, there were severe problems with specialty report processing. Specialty reports were often not retrieved and not scanned into the medical record. When specialty reports were retrieved, often they were retrieved late. SOL also did not routinely forward specialty reports for provider review, as not one of the reports was initialed or dated by a provider. Occasionally this led to a provider not reviewing a specialty report, though most reports, if available, were reviewed during the face-to-face follow-up provider appointment. Because of the severe problems with specialty report processing, this indicator was rated *inadequate*.

Compliance Testing Results

The institution received an *inadequate* score of 65.8 percent in the *Specialty Services* indicator. While three of seven tested areas scored in the *proficient* range, four areas scored in the *inadequate* range. Opportunities for improvement were shown in the following areas:

- For 19 sampled patients who were denied a specialty service, only three (16 percent) received a timely notification of the denied service. California Correctional Health Care Services policy requires that when a specialty service is deferred or denied, the provider will communicate the decision to the patient and provide the patient with alternate treatment strategies during a follow-up visit within 30 days. For 12 patients, this requirement was not met at all; four other patients received a provider follow-up visit that was between 5 and 78 days late (MIT 14.007).
- When inmate-patients are approved or scheduled for specialty services appointments at one institution and then transfer to another institution, policy requires that the receiving institution ensure that the patient's appointment is timely rescheduled or scheduled, and held. Only 9 of the 20 patients sampled (45 percent) received their specialty services appointment timely. Ten patients received their specialty appointment between 2 and 92 days late, and one patient did not receive an appointment at all (MIT 14.005).
- When the institution ordered specialty services for patients, providers did not always review the specialists' reports within three business days after the service was performed. For high-priority specialty services, SOL providers timely reviewed specialists' reports for only 8 of the 15 patients sampled (53 percent). One patient's report was reviewed one day late, and another's, eight days late, while reports for the remaining five patients showed no evidence of review at all (MIT 14.002). Similarly, for routine specialty services, providers timely reviewed specialists' reports for only 10 of 15 patients sampled (67 percent). Three patients' reports were reviewed one to seven days late, while the remaining two patients' reports showed no evidence of review at all (MIT 14.004).

The institution performed within the *proficient* range in the following three areas:

- The institution received a score of 100 percent when the OIG tested the timeliness of SOL's denials of providers' specialty services requests for 20 inmate-patients (MIT 14.006).
- For 14 of the 15 inmate-patients sampled (93 percent), a routine specialty service appointment or service occurred within 90 calendar days of the provider's order; one inmate-patient received his specialty service seven days late (MIT 14.003).
- Thirteen of the 15 patients sampled (87 percent) received their high-priority specialty services appointments or services within 14 calendar days of the provider's order. Two patients received their specialty services three and ten days late (MIT 14.001).

Recommendations

- The OIG recommends that SOL staff its offsite specialty services department with an RN.
 - The OIG recommends that SOL consider relocating its specialty services department in closer proximity to other health care departments.
-

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 SOL.

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

INTERNAL MONITORING, QUALITY IMPROVEMENT, AND ADMINISTRATIVE OPERATIONS

This indicator focuses on the institution's administrative health care oversight functions. The OIG evaluates whether the institution promptly processes 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.

Case Review Rating:

Not Applicable

Compliance Score:

61.1%

Overall Rating:

Inadequate

Compliance Testing Results

Overall, SOL scored in the *inadequate* range for the *Internal Monitoring, Quality Improvement, and Administrative Operations* indicator, receiving a score of 61.1 percent. There is an opportunity for improvement in the following four areas:

- The OIG reviewed SOL's 2014 Performance Improvement Work Plan. The institution did not adequately document evidence of improvement in achieving targeted performance objectives for any of its 13 quality improvement initiatives, receiving a score of zero. The work plan included insufficient progress information to demonstrate that each of its performance objectives either improved or reached the targeted level (MIT 15.005).
- SOL's local governing body (LGB) only conducted two of four quarterly meetings during the 12-month period ending March 2015. For the two meetings convened, the minutes did not provide a detailed narrative of the LGB's general management and planning of patient health care. As a result, the institution scored zero for this test (MIT 15.006).
- The OIG inspected documentation for 12 emergency medical response incidents reviewed by the institution's EMRRC during the prior six-month period, and none of them complied with policy. The packages did not include the required Event Checklist form, and the warden did not approve the meeting minutes as required by policy; rather, the warden's designee approved them (MIT 15.007).
- Medical staff promptly submitted the Initial Inmate Death Report (CDCR Form 7229A) to CCHCS's Death Review Unit for only two of four deaths (50 percent) that occurred at SOL during the OIG review period. One death was reported one day late, and the other, only two hours late (MIT 15.103).

While SOL performed poorly in several areas, as noted above, it received *proficient* scores of 100 percent in the following areas:

- SOL timely processed all inmate medical appeals in each of the most recent 12 months. Based on data received from the institution, there was only one medical appeal categorized as overdue during the entire 12-month period ending April 2015 (MIT 15.001).
- Inspectors reviewed six recent months of QMC meeting minutes and confirmed that the QMC met monthly, evaluated program performance, and took action when improvement opportunities were identified (MIT 15.003). Also, SOL took adequate steps to ensure the accuracy of its Dashboard data reporting (MIT 15.004).
- Inspectors reviewed drill packages for three medical emergency response drills conducted in the prior quarter, and they all contained all required summary reports and related documentation. In addition, the drills included participation by both health care and custody staff (MIT 15.101).
- The institution's response addressed all of the patients' appealed issues for all ten second-level medical appeals reviewed (MIT 15.102).

Other Information Obtained from Non-Scored Areas

- The OIG gathered non-scored data regarding death review reports. The Death Review Committee at CCHCS headquarters did not timely complete its death review summary for the four deaths that occurred during the testing period. The CCHCS Death Review Committee is required to complete a death review summary within 30 business days of the death and submit it to the institution's chief executive officer (CEO). However, the committee completed its four summary reports between 23 and 95 days late, i.e., between 67 and 137 calendar days after the deaths. As a result, CCHCS did not timely submit any of its reports to the institution (MIT 15.996).
- Inspectors met with the institution's coordinator for health care appeals and the CEO to inquire about SOL's protocols for tracking appeals. The coordinator provides management with a weekly workload report that contains inmate-patient information, date and level of the appeal, staff response date, number of days overdue, category and issue of the appeal, and staff involved. According to the CEO, the report does not rank problem areas, but the CEO reviews the report and, if issues are identified that need addressing, they are presented and handled by the QMC. In the six months preceding the OIG onsite visit, management had not identified any serious issues regarding its medical appeals (MIT 15.997).

- Non-scored data gathered regarding the institution’s practices for implementing local operating procedures (LOPs) indicated that the institution has an effective process in place for developing LOPs. The Standards Compliance Coordinator (SCC) relies on the managers of the impacted areas to suggest new policy changes. The SCC makes any necessary changes to the LOP, routes the draft LOP to management for comment, incorporates comments and changes, and routes the draft LOP back to management for a second review. Next, the draft is routed to the QMC and then to the LGB for review and approval. Once approved, the LOP is forwarded to management and a copy is posted to the SharePoint drive. At the time of the inspection, the institution reported having LOPs that address 100 percent of the stakeholder-recommended core topical areas that warrant the creation of local procedures (MIT 15.998).
- The OIG discusses the institution’s health care staffing resources in the *About the Institution* section on page 1 of this report (MIT 15.999).

CCHCS Dashboard Comparative Data

Both the Dashboard and the OIG testing results show that SOL demonstrated a *proficient* level of compliance for timely processing its medical appeals, with both measures scoring 100 percent.

***Internal Monitoring, Quality Improvement, and Administrative Operations—
SOL Dashboard and OIG Compliance Results***

SOL DASHBOARD RESULTS	OIG COMPLIANCE RESULTS
<p style="text-align: center;">Timely Appeals June 2015</p>	<p style="text-align: center;">Medical Appeals-Timely Processing (15.001) 12 months ending June 2015</p>
100%	100%

Note: The CCHCS Dashboard data includes appeal data for American Disability Act (ADA), mental health, dental, and staff complaint areas; the OIG excluded these appeal areas.

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:

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.

SOL scored 100 percent for six of the indicator's eight tests and in the *proficient* range for another test, as follows:

- Nursing supervisors completed the required number of nursing reviews for all five of the nurses the OIG sampled (MIT 16.101).
- All providers received timely and complete performance appraisals, including applicable Unit Health Record Clinical Appraisals, PCP – 360 Degree Evaluations, and Core Competency-Based Evaluations (MIT 16.103).
- All providers, nursing staff, and the pharmacist-in-charge were current with their professional licenses and certification requirements (MIT 16.001, 16.105).
- The institution's pharmacy and providers who prescribe controlled substances were current with their Drug Enforcement Agency registrations (MIT 16.106).
- All nursing staff hired within the last year timely received new employee orientation training (MIT 16.107).
- Nine of the ten nurses sampled (90 percent) were current on their clinical competency validations. One nurse did not receive a clinical competency validation within the required time frame (MIT 16.102).

While the institution scored well in areas described above, the following area presented an opportunity for improvement:

- The OIG tested provider, nursing, and custody staff records to determine if the institution ensured that those staff members had current emergency response certifications. While the

institution's provider and nursing staff were all compliant, custody staff were not. Specifically, the institution did not require custody staff at the rank of captain or higher to maintain CPR certifications. While the California Penal Code exempts those custody managers who primarily perform managerial duties from medical emergency response certification training, CCHCS policy does not allow for such an exemption. Consequently, the institution received a score of 67 percent for this test (MIT 16.104).

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 California State Prison, Solano, nine HEDIS measures were selected and are listed in the following *SOL 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. SOL performed very well with its management of diabetes.

When compared statewide, SOL significantly outperformed the Medi-Cal scores in all five diabetic measures selected. When compared to Kaiser Permanente, SOL also outperformed or closely matched Kaiser in four of the five diabetic measures; SOL slightly underperformed Kaiser with respect to diabetic patient blood pressure control.

When compared nationally, SOL outperformed the averages for Medicaid, Medicare, and commercial health plans (based on data obtained from health maintenance organizations) in each of the five diabetic measures listed. When compared to the U.S. Department of Veterans Affairs (VA), SOL slightly outperformed the VA in monitoring diabetic patients and matched the VA in the three remaining comparative measures,

Immunizations

Comparative data for immunizations was only fully available for the VA, and partially available for Kaiser, commercial plans, and Medicare. With respect to administering influenza shots to both younger and older adult age groups, SOL outperformed scores for Kaiser Permanente, commercial plans, and the VA. Regarding pneumococcal vaccinations, SOL scored significantly higher than Medicare but scored 9 percentage points lower than the VA. However, an additional 5 percent of SOL's sampled patients had been timely offered the pneumococcal vaccination but refused it.

Cancer Screening

For colorectal cancer screening, SOL performed higher than Kaiser Permanente statewide. Nationally, SOL performed significantly higher than commercial plans and Medicare, and slightly higher than the VA.

Summary

The California State Prison, Solano, population-based performance exceeded or closely matched results of other State and national health care entities for seven of the nine comparative clinical measures. Statewide, SOL significantly outperformed Medi-Cal in all five diabetic measures and also outperformed or closely matched Kaiser Permanente in four of those five measures; blood pressure control for diabetic patients being the exception. Nationally, SOL outperformed or matched all entities, including the VA, for diabetic measures. Regarding immunizations and cancer

screening, SOL outperformed other entities that reported data, with one exception; the institution did not perform as well as the VA for pneumococcal vaccinations.

Overall, SOL's performance reflects an adequate chronic care program, corroborated by the institution's *adequate* scores in the *Quality of Provider Performance*, *Quality of Nursing Performance*, and *Preventive Services* indicators. With regard to SOL's performance in the pneumococcal immunization measure, the institution should make interventions to lower the rate of patient refusals.

SOL Results Compared to State and National HEDIS Scores

Clinical Measures	California				National			
	SOL 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}	19%	44%	18%	24%	44%	31%	25%	19%
HbA1c Control (<8.0%) ⁶	70%	47%	70%	62%	47%	58%	65%	-
Blood Pressure Control (<140/90)	80%	60%	84%	85%	62%	65%	65%	80%
Eye Exams	90%	51%	69%	81%	54%	56%	69%	90%
Immunizations								
Influenza Shots - Adults (18–64) ⁸	67%	-	54%	55%	-	50%	-	65%
Influenza Shots - Adults (65+)	90%	-	-	-	-	-	-	76%
Immunizations: Pneumococcal	84%	-	-	-	-	-	70%	93%
Cancer Screening								
Colorectal Cancer Screening	86%	-	80%	82%	-	64%	67%	82%

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

APPENDIX A—COMPLIANCE TEST RESULTS

California State Prison, Solano Range of Summary Scores: 58.06% - 98.00%	
Indicator	Score (Yes %)
Access to Care	75.12%
Diagnostic Services	68.89%
Emergency Services	Not Applicable
Health Information Management (Medical Records)	58.06%
Health Care Environment	62.37%
Inter- and Intra-System Transfers	91.63%
Pharmacy and Medication Management	77.08%
Prenatal and Post-delivery Services	Not Applicable
Preventive Services	82.33%
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	65.83%
Internal Monitoring, Quality Improvement, and Administrative Operations	61.11%
Job Performance, Training, Licensing, and Certifications	94.58%

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?	28	12	40	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?	19	9	28	67.86%	2
1.003	Clinical appointments: Did a registered nurse review the inmate-patient's request for service the same day it was received?	29	1	30	96.67%	0
1.004	Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed?	29	1	30	96.67%	0
1.005	Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the inmate-patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter?	7	6	13	53.85%	17
1.006	Sick call follow-up appointments: If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified?	3	2	5	60.00%	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?	18	11	29	62.07%	1
1.008	Specialty service follow-up appointments: Do specialty service primary care physician follow-up visits occur within required time frames?	20	9	29	68.97%	1
1.101	Clinical appointments: Do inmate-patients have a standardized process to obtain and submit health care services request forms?	5	0	5	100.00%	0
Overall Percentage:					75.12%	

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?	7	3	10	70.00%	0
2.003	Radiology: Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	7	3	10	70.00%	0
2.004	Laboratory: Was the laboratory service provided within the time frame specified in the provider's order?	6	4	10	60.00%	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?	7	3	10	70.00%	0
2.008	Pathology: Did the primary care provider review and initial the diagnostic report within specified time frames?	0	10	10	0.00%	0
2.009	Pathology: Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	5	5	10	50.00%	0
Overall Percentage:					68.89%	

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

Reference Number	Health Information Management (Medical Records)	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated progress notes, initial health screening forms, and health care service request forms scanned into the eUHR within three calendar days of the inmate-patient encounter date?	19	1	20	95.00%	0
4.002	Are dictated / transcribed documents scanned into the eUHR within five calendar days of the inmate-patient encounter date?	8	10	18	44.44%	22
4.003	Are specialty documents scanned into the eUHR within five calendar days of the inmate-patient encounter date?	17	3	20	85.00%	0
4.004	Are community hospital discharge documents scanned into the eUHR within three calendar days of the inmate-patient date of hospital discharge?	20	0	20	100.00%	0
4.005	Are medication administration records (MARs) scanned into the eUHR within the required time frames?	10	10	20	50.00%	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?	16	16	32	50.00%	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?	12	18	30	40.00%	0
Overall Percentage:					58.06%	

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?	3	6	9	33.33%	0
5.102	Infection control: Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	7	1	8	87.50%	1
5.103	Infection Control: Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	3	6	9	33.33%	0
5.104	Infection control: Does clinical health care staff adhere to universal hand hygiene precautions?	7	1	8	87.50%	1
5.105	Infection control: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	5	4	9	55.56%	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?	6	3	9	66.67%	0
5.108	Clinical areas: Do clinic common areas and exam rooms have essential core medical equipment and supplies?	4	5	9	44.44%	0
5.109	Clinical areas: Do clinic common areas have an adequate environment conducive to providing medical services?	6	3	9	66.67%	0
5.110	Clinical areas: Do clinic exam rooms have an adequate environment conducive to providing medical services?	4	5	9	44.44%	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?	4	2	6	66.67%	3
5.999	For Information Purposes Only: Does the institution's health care management believe that all clinical areas have physical plant infrastructures sufficient to provide adequate health care services?	Information Only				
Overall Percentage:					62.37%	

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?	13	4	17	76.47%	13
6.004	For inmate-patients transferred out of the facility: Were scheduled specialty service appointments identified on the Health Care Transfer Information Form 7371?	17	3	20	85.00%	0
6.101	For inmate-patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding Medical Administration Record (MAR) and Medication Reconciliation?	4	0	4	100.00%	4
Overall Percentage:					91.63%	

Reference Number	Pharmacy and Medication Management	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.001	Did the inmate-patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows?	27	13	40	67.50%	0
7.002	Did health care staff administer or deliver new order prescription medications to the inmate-patient within the required time frames?	36	4	40	90.00%	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?	21	9	30	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?	20	10	30	66.67%	0
7.006	For inmate-patients en route who lay over at the institution: If the temporarily housed inmate-patient had an existing medication order, were medications administered or delivered without interruption?	Not Applicable				
7.101	All clinical and medication line storage areas for narcotic medications: Does the institution employ strong medication security controls over narcotic medications assigned to its clinical areas?	10	0	10	100.00%	6
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?	14	1	15	93.33%	1
7.103	All clinical and medication line storage areas for non-narcotic medications: Does the institution properly store non-narcotic medications that require refrigeration in assigned clinical areas?	15	1	16	93.75%	0
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?	6	2	8	75.00%	8
7.105	Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for inmate-patients?	8	0	8	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?	0	8	8	0.00%	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
7.108	Pharmacy: Does the institution's pharmacy properly store	0	1	1	0.00%	0

Reference Number	Pharmacy and Medication Management	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
	non-refrigerated medications?					
7.109	Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications?	1	0	1	100.00%	0
7.110	Pharmacy: Does the institution's pharmacy properly account for narcotic medications?	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:					77.08%	

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?	17	7	24	70.83%	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?	21	3	24	87.50%	0
9.003	Annual TB Screening: Was the inmate-patient screened for TB within the last year?	15	15	30	50.00%	0
9.004	Were all inmate-patients offered an influenza vaccination for the most recent influenza season?	30	0	30	100.00%	0
9.005	All inmate-patients from the age 50 through the age of 75: Was the inmate-patient offered colorectal cancer screening?	27	3	30	90.00%	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?	22	1	23	95.65%	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:					82.33%	

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?	10	0	10	100.00%	0
13.004	For all higher level care facilities: Did the primary care provider complete the Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes on the inmate-patient at the minimum intervals required for the type of facility where the inmate-patient was treated?	9	1	10	90.00%	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?	13	2	15	86.67%	0
14.002	Did the PCP review the high priority specialty service consultant report within the required time frame?	8	7	15	53.33%	0
14.003	Did the inmate-patient receive the routine specialty service within 90 calendar days of the PCP order?	14	1	15	93.33%	0
14.004	Did the PCP review the routine specialty service consultant report within the required time frame?	10	5	15	66.67%	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?	9	11	20	45.00%	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?	3	16	19	15.79%	1
Overall Percentage:					65.83%	

Reference Number	Internal Monitoring, Quality Improvement, and Administrative Operations	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.001	Did the institution promptly process inmate medical appeals during the most recent 12 months?	12	0	12	100.00%	0
15.002	Does the institution follow adverse/sentinel event reporting requirements?	Not Applicable				
15.003	Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified?	6	0	6	100.00%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	1	0	1	100.00%	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	13	13	0.00%	1
15.006	For institutions with licensed care facilities: Does the local governing body (LGB), or its equivalent, meet quarterly and exercise its overall responsibilities for the quality management of patient health care?	0	4	4	0.00%	0
15.007	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	0	12	12	0.00%	0
15.101	Did the institution complete a medical emergency response drill for each watch and include participation of health care and custody staff during the most recent full quarter?	3	0	3	100.00%	0
15.102	Did the institution's second level medical appeal response address all of the inmate-patient's appealed issues?	10	0	10	100.00%	0
15.103	Did the institution's medical staff review and submit the initial inmate death report to the Death Review Unit in a timely manner?	2	2	4	50.00%	0
15.996	For Information Purposes Only: Did the CCHCS Death Review Committee submit its inmate death review summary to the institution timely?	Information Only				
15.997	For Information Purposes Only: Identify the institution's protocols for tracking medical appeals.	Information Only				
15.998	For Information Purposes Only: Identify the institution's protocols for implementing health care local operating procedures.	Information Only				
15.999	For Information Purposes Only: Identify the institution's healthcare staffing resources.	Information Only				
Overall Percentage:					61.11%	

Reference Number	Job Performance, Training, Licensing, and Certifications	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
16.001	Do all providers maintain a current medical license?	14	0	14	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?	9	1	10	90.00%	0
16.103	Are structured clinical performance appraisals completed timely?	13	0	13	100.00%	0
16.104	Are staff current with required medical emergency response certifications?	2	1	3	66.67%	0
16.105	Are nursing staff and the Pharmacist-in-Charge current with their professional licenses and certifications?	5	0	5	100.00%	1
16.106	Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	1	0	1	100.00%	0
16.107	Are nursing staff current with required new employee orientation?	1	0	1	100.00%	0
Overall Percentage:					94.58%	

APPENDIX B—CLINICAL DATA

Table B-1 SOL Sample Sets	
Sample Set	Total
Anticoagulation	3
CTC/OHU	5
Death Review/Sentinel Events	5
Diabetes	3
Emergency Services - Non-CPR	5
High Risk	5
Hospitalization	5
Intra-System Transfers-in	3
Intra-System Transfers-out	3
RN Sick Call	20
Specialty Services	5
	62

Table B-2 SOL Chronic Care Diagnoses

Diagnosis	Total
Anemia	4
Anticoagulation	7
Arthritis/Degenerative Joint Disease	11
Asthma	10
COPD	10
Cancer	10
Cardiovascular Disease	17
Chronic Kidney Disease	10
Chronic Pain	16
Cirrhosis/End Stage Liver Disease	8
Deep Venous Thrombosis/Pulmonary Embolism	2
Diabetes	12
Gastroesophageal Reflux Disease	30
Hepatitis C	17
Hyperlipidemia	29
Hypertension	39
Mental Health	16
Migraine Headaches	4
Seizure Disorder	3
Sickle Cell Anemia	1
Sleep Apnea	2
Thyroid Disease	1
	259

Table B-3 SOL Event - Program

Program	Total
Diagnostic Services	224
Emergency Care	94
Hospitalization	72
Intra-System Transfers-in	14
Intra-System Transfers-out	8
Outpatient Care	546
Specialized Medical Housing	160
Specialty Services	207
	1,325

Table B-4 SOL Case Review Sample Summary

	Total
MD Reviews Detailed	30
MD Reviews Focused	0
RN Reviews Detailed	21
RN Reviews Focused	24
Total Reviews	75
Total Unique Cases	62
Overlapping Reviews (MD & RN)	13

APPENDIX C—COMPLIANCE SAMPLING METHODOLOGY

California State Prison, Solano			
Quality Indicator	Sample Category (number of patients)	Data Source	Filters
<i>Access to Care</i>	Chronic Care (30—Basic Level) (40—Inter Level)	Master Registry	<ul style="list-style-type: none"> Chronic care conditions (at least one condition per inmate-patient—any risk level) Randomize
	Nursing Sick Call (5 per clinic) (minimum of 30)	MedSATS	<ul style="list-style-type: none"> Clinic (each clinic tested) Appt. date (2–9 months) Randomize
	Returns from <i>Community Hospital</i> (30)	Inpatient Claims Data	<ul style="list-style-type: none"> See <i>Health Information Management (Medical Records)</i> (returns from community hospital)
<i>Diagnostic Services</i>	Radiology (10)	Radiology Logs	<ul style="list-style-type: none"> Appt. Date (90 days–9 months) Randomize Abnormal
	Laboratory (10)	Quest	<ul style="list-style-type: none"> Appt. date (90 days–9 months) Order name (CBC or CMPs only) Randomize Abnormal
	Pathology (10)	InterQual	<ul style="list-style-type: none"> Appt. date (90 days–9 months) Service (pathology related) Randomize
<i>Health Information Management (Medical Records)</i>	Timely Scanning (20 each)	OIG Qs: 1.001, 1.002, 1.006, & 9.004	<ul style="list-style-type: none"> Non-dictated documents First 5 inmate-patients selected for each question
		OIG Q: 1.001	<ul style="list-style-type: none"> Dictated documents First 20 inmate-patients selected
		OIG Qs: 14.002 & 14.004	<ul style="list-style-type: none"> Specialty documents First 10 inmate-patients selected for each question
		OIG Q: 4.008	<ul style="list-style-type: none"> Community hospital discharge documents First 20 inmate-patients selected for the question
		OIG Q: 7.001	<ul style="list-style-type: none"> MARs First 20 inmate-patients selected
	Legible Signatures and Review (40)	OIG Qs: 4.008, 6.001/6.002, 7.001, 12.001/12.002, & 14.002	<ul style="list-style-type: none"> First 8 inmates sampled One source document per inmate-patient
	Complete and Accurate Scanning	Documents for any tested inmate	<ul style="list-style-type: none"> Any incorrectly scanned eUHR document identified during OIG eUHR file review, e.g., mislabeled, misfiled, illegibly scanned, or missing
Returns from Community Hospital (30)	Inpatient Claims Data	<ul style="list-style-type: none"> Date (2–8 months) Most recent 6 months provided (within date range) Rx count Discharge date Randomize (each month individually) First 5 inmate-patients from each of the 6 months (if not 5 in a month, supplement from another, as needed) 	

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
<i>Health Care Environment</i>	Clinical Areas (number varies by institution)	OIG Inspector Onsite Review	<ul style="list-style-type: none"> Identify and inspect all onsite clinical areas.
<i>Inter- and Intra-System Transfers</i>	Intra-System transfers (30)	SOMS	<ul style="list-style-type: none"> Arrival date (3–9 months) Arrived from (another CDCR facility) Rx count Randomize
	Specialty Service Send-outs (20)	MedSATS	<ul style="list-style-type: none"> Date of Transfer (3–9 months) Randomize
<i>Pharmacy and Medication Management</i>	Chronic Care Medication (30—Basic Level) (40—Inter Level)	OIG Q: 1.001	<i>See Access to Care</i> <ul style="list-style-type: none"> (At least one condition per inmate-patient—any risk level) Randomize
	New Medication Orders (30—Basic Level) (40—Inter Level)	Master Registry	<ul style="list-style-type: none"> Rx Count Randomize Ensure no duplication of inmate-patients tested in chronic care medications
	Intra-Facility moves (30)	MAPIP Transfer Data	<ul style="list-style-type: none"> 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)—<i>inmate-patient must have NA/DOT meds to qualify for testing</i> Randomize
	En Route (10)	SOMS	<ul style="list-style-type: none"> Date of transfer (2–8 months) Sending institution (another CDCR facility) Randomize Length of stay (minimum of 2 days) NA/DOT meds
	Returns from Community Hospital (30)	<i>Inpatient Claims Data</i>	<ul style="list-style-type: none"> <i>See Health Information Management (Medical Records) (returns from community hospital)</i>
	Medication Preparation and Administration Areas	OIG Inspector Onsite Review	<ul style="list-style-type: none"> Identify and inspect onsite clinical areas that prepare and administer medications
	Pharmacy	OIG Inspector Onsite Review	<ul style="list-style-type: none"> Identify and inspect onsite pharmacies
	Medication Error Reporting	OIG Inspector Review	<ul style="list-style-type: none"> Any medication error identified during OIG eUHR file review, e.g., case reviews and/or compliance testing
<i>Prenatal and Post-delivery Services</i>	Recent Deliveries (5) <i>N/A at this institution</i>	OB Roster	<ul style="list-style-type: none"> Delivery date (2–12 months) Most recent deliveries (within date range)
	Pregnant Arrivals (5) <i>N/A at this institution</i>	OB Roster	<ul style="list-style-type: none"> Arrival date (2–12 months) Earliest arrivals (within date range)

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
Preventive Services	Chronic Care Vaccinations (30—Basic Level) (40—Inter Level) <i>Not all conditions require vaccinations</i>	OIG Q: 1.001	<ul style="list-style-type: none"> Chronic care conditions (at least 1 condition per inmate-patient—any risk level) Randomize Condition must require vaccination(s)
	INH (all applicable up to 30)	Maxor	<ul style="list-style-type: none"> Dispense date (past 9 months) Time period on INH (at least a full 3 months) Randomize
	Colorectal Screening (30)	SOMS	<ul style="list-style-type: none"> Arrival date (at least 1 year prior to inspection) Date of birth (51 or older) Randomize
	Influenza Vaccinations (30)	SOMS	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Arrival date (at least 1 year prior to inspection) TB Code (22) Randomize
	TB Code 34, annual screening (15)	SOMS	<ul style="list-style-type: none"> Arrival date (at least 1 year prior to inspection) TB Code (34) Randomize
	Mammogram (30) <i>N/A at this institution</i>	SOMS	<ul style="list-style-type: none"> Arrival date (at least 2 years prior to inspection) Date of birth (age 52–74) Randomize
	Pap Smear (30) <i>N/A at this institution</i>	SOMS	<ul style="list-style-type: none"> Arrival date (at least three years prior to inspection) Date of birth (age 24–53) Randomize
	Valley Fever (number will vary) <i>N/A at this institution</i>	Cocci Transfer Status Report	<ul style="list-style-type: none"> Reports from past 2–8 months Institution Ineligibility date (60 days prior to inspection date) All
Reception Center Arrivals	RC (20) <i>N/A at this institution</i>	SOMS	<ul style="list-style-type: none"> Arrival date (2–8 months) Arrived from (county jail, return from parole, etc.) Randomize
Specialized Medical Housing	OHU, CTC, SNF, Hospice (10 per housing area)	CADDIS	<ul style="list-style-type: none"> Admit date (1–6 months) Type of stay (no MH beds) Length of stay (minimum of 5 days) Randomize

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
<i>Specialty Services Access</i>	High-Priority (10)	MedSATS	<ul style="list-style-type: none"> Appt. date (3–9 months) Randomize
	Routine (10)	MedSATS	<ul style="list-style-type: none"> Appt. date (3–9 months) Remove optometry, physical therapy or podiatry Randomize
	Specialty Service Arrivals (20)	MedSATS	<ul style="list-style-type: none"> Arrived from (other CDCR institution) Date of transfer (3–9 months) Randomize
	Denials (20)*	InterQual	<ul style="list-style-type: none"> Review date (3–9 months) Randomize
	<i>*Ten InterQual Ten MARs</i>	IUMC/MAR Meeting Minutes	<ul style="list-style-type: none"> Meeting date (9 months) Denial upheld Randomize
<i>Internal Monitoring, Quality Improvement, and Administrative Operations</i>	Medical Appeals (all)	Monthly Medical Appeals Reports	<ul style="list-style-type: none"> Medical appeals (12 months)
	Adverse/Sentinel Events (5)	Adverse/Sentinel Events Report	<ul style="list-style-type: none"> Adverse/sentinel events (2–8 months)
	QMC Meetings (12)	Quality Management Committee Meeting Minutes	<ul style="list-style-type: none"> Meeting minutes (12 months)
	Performance Improvement Plans (12)	Performance Improvement Work Plan	<ul style="list-style-type: none"> Performance Improvement Work Plan with updates (12 months)
	Local Governing Body (12)	Local Governing Body Meeting Minutes	<ul style="list-style-type: none"> Meeting minutes (12 months)
	EMRRC (6)	EMRRC Meeting Minutes	<ul style="list-style-type: none"> Meeting minutes (6 months)
	Medical Emergency Response Drills (3)	OIG Inspector Onsite Review	<ul style="list-style-type: none"> Most recent full quarter Each watch
	2 nd Level Medical Appeals (10)	OIG Inspector Onsite Review	<ul style="list-style-type: none"> Medical appeals denied (6 months)
	Death Reports (10)	OIG Inspector Onsite Review	<ul style="list-style-type: none"> Death reports (12 months)
	Local Operating Procedures (all)	OIG Inspector Onsite Review	<ul style="list-style-type: none"> Review all

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
<i>Job Performance and Training, Licensing, and Certifications</i>	RN Review Evaluations (5)	OIG Inspector Onsite Review	<ul style="list-style-type: none"> • Current Supervising RN reviews
	Nursing Staff Validations (10)	OIG Inspector Onsite Review	<ul style="list-style-type: none"> • Review annual competency validations • Randomize
	Provider Annual Evaluation Packets (all)	OIG Inspector Onsite Review	<ul style="list-style-type: none"> • All required performance evaluation documents
	Medical Emergency Response Certifications (all)	OIG Inspector Onsite Review	<ul style="list-style-type: none"> • All staff <ul style="list-style-type: none"> ○ Providers (ACLS) ○ Nursing (BLS/CPR) ○ Custody (CPR/BLS)
	Nursing staff and Pharmacist-in-charge Professional Licenses and Certifications (all)	OIG Inspector Onsite Review	<ul style="list-style-type: none"> • All licenses and certifications
	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations (all)	OIG Inspector Onsite Review	<ul style="list-style-type: none"> • All current DEA registrations
	Nursing Staff New Employee Orientations (all)	OIG Inspector Onsite Review	<ul style="list-style-type: none"> • New employees (within the last 12 months)

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

December 14, 2015


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

Dear Mr. Barton:

The purpose of this letter is to inform you that the Office of the Receiver has reviewed the draft report of the Office of the Inspector General (OIG) Medical Inspection Results for California State Prison, Solano conducted from June 2015 to July 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
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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