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(Acting)

Office of the Inspector General

California State Prison, Solano
Medical Inspection Results
Cycle 5

September 2017

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

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Medical Inspection Results
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EXECUTIVE SUMMARY

Pursuant to California Penal Code Section 6126 et seq., 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. In Cycle 5, for the first time, the OIG will be inspecting institutions that have been delegated back to CDCR from the Receivership. There will be no difference in the standards used for assessment of a delegated institution versus an institution not yet delegated.

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.

This fifth cycle of inspections will continue evaluating the areas addressed in Cycle 4, which included clinical case review, compliance testing, and a population-based metric comparison of selected Healthcare Effectiveness Data Information Set (HEDIS) measures. In agreement with stakeholders, the OIG made changes to both the case review and compliance components. The OIG found that in every inspection in Cycle 4, larger samples were taken than were needed to assess the adequacy of medical care provided. As a result, the OIG reduced the number of case reviews and sample sizes for compliance testing. Also, in Cycle 4, compliance testing included two secondary (administrative) indicators (*Internal Monitoring, Quality Improvement, and Administrative Operations*; and *Job Performance, Training, Licensing, and Certifications*). For Cycle 5, these have been combined into one secondary indicator, *Administrative Operations*.

Overall Rating: Inadequate

The OIG performed its Cycle 5 medical inspection at California State Prison, Solano (SOL), from February to April 2017. The inspection included in-depth reviews of 51 patient files conducted by clinicians, as well as reviews of documents from 398 patient files, covering 89 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 13 health care quality indicators applicable to the institution. 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 registered nurses trained in monitoring medical policy compliance. Of the indicators, seven were rated by both case review clinicians and compliance inspectors, three were rated by case review clinicians only, and three were rated by compliance inspectors only. The *SOL Executive Summary Table* on the following page identifies the applicable individual indicators and scores for this institution.

SOL Executive Summary Table

Inspection Indicators	Case Review Rating	Compliance Rating	Cycle 5 Overall Rating	Cycle 4 Overall Rating
1—Access to Care	*Inadequate*	*Inadequate*	***Inadequate***	*Inadequate*
2—Diagnostic Services	*Adequate*	*Inadequate*	***Inadequate***	*Inadequate*
3—Emergency Services	*Adequate*	Not Applicable	***Adequate***	*Adequate*
4—Health Information Management	*Adequate*	*Proficient*	***Adequate***	*Inadequate*
5—Health Care Environment	Not Applicable	*Inadequate*	***Inadequate***	*Inadequate*
6—Inter- and Intra-System Transfers	*Inadequate*	*Inadequate*	***Inadequate***	*Adequate*
7—Pharmacy and Medication Management	*Proficient*	*Inadequate*	***Inadequate***	*Adequate*
8—Prenatal and Post-Delivery Services	Not Applicable	Not Applicable	Not Applicable	Not Applicable
9—Preventive Services	Not Applicable	*Inadequate*	***Inadequate***	*Adequate*
10—Quality of Nursing Performance	*Adequate*	Not Applicable	***Adequate***	*Adequate*
11—Quality of Provider Performance	*Inadequate*	Not Applicable	***Inadequate***	*Adequate*
12—Reception Center Arrivals	Not Applicable	Not Applicable	Not Applicable	Not Applicable
13—Specialized Medical Housing	*Proficient*	*Proficient*	***Proficient***	*Inadequate*
14—Specialty Services	*Adequate*	*Inadequate*	***Adequate***	*Inadequate*
15—Administrative Operations (Secondary)	Not Applicable	*Inadequate*	***Inadequate***	*Adequate**

*In Cycle 4, there were two secondary (administrative) indicators. This score reflects the average of those two scores.

Clinical Case Review and OIG Clinician Inspection Results

The clinicians' case reviews sampled patients with high medical needs and included a review of 1,089 patient care events.[1] Of the 13 indicators applicable to SOL, 10 were evaluated by clinician case review; 2 were *proficient*, 5 were *adequate*, and 3 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.

SOL's recent transition to the Electronic Health Records System (EHRS) had the largest impact on the institution's performance, and had a negative effect on provider productivity and the scheduling process. The transition to the EHRS resulted in many delays in care and, in some cases, dropped care. It also created a new barrier for patients returning from a prolonged hospital stay because all of a patient's prior orders were automatically canceled when the patient was absent from the institution for more than 48 hours, and when the patient returned, SOL providers were unaware of the problem and unable to reorder the prior physician orders.

Program Strengths — Clinical

- SOL used the EHRS to track medication orders and document medication administration. SOL's medication management was good and problems were rare.

- Nurses provided proficient care and performed appropriate and timely assessments to patients in the correctional treatment center (CTC).

- The institution continued to perform diagnostic tests reliably and, with a few critical exceptions, the transition to the EHRS had markedly improved the transfer of onsite diagnostic results into the electronic medical record.

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

Program Weaknesses — Clinical

- After the EHRS implementation, SOL had a severe shortage of available provider appointments and attempted to cancel and reschedule numerous provider appointments that were almost or already past due. Providers had difficulty adjusting to the new EHRS and repeatedly failed to order follow-up appointments, resulting in numerous lapses in care and patients frequently being completely lost to follow-up appointments. Scheduling supervisors acknowledged that their process of systematically canceling and rescheduling provider appointments caused the automated California Correctional Health Care Services (CCHCS) performance data collection to be artificially enhanced.

- SOL had significant difficulty with ensuring continuity of medical care for recently hospitalized patients. If a patient was absent from the institution for more than 48 hours, all prior orders were automatically canceled, including provider appointments, specialty referrals, and diagnostic tests. SOL had no reliable method of renewing these canceled orders, which placed patients at great risk of lapsed care. Providers were not aware of this problem or of their responsibility to review and reorder the canceled orders when their patients returned to the institution.

- SOL nurses did not refer new patients with chronic conditions for initial nurse care management.

- Providers reported a significant increase in workload following the EHRS implementation. Providers did not adequately review patient medical records and rushed assessments.

Compliance Testing Results

Of the 13 health care indicators applicable to SOL, 10 were evaluated by compliance inspectors.[2] Of the ten indicators, two were rated *proficient,* , and eight were rated *inadequate*. There were 89 individual compliance questions within those ten indicators, generating 1,073 data points that tested SOL's compliance with CCHCS policies and procedures.[3] Those 89 questions are detailed in *Appendix A — Compliance Test Results*.

[2] The OIG's compliance inspectors are trained registered nurses with expertise in CDCR policies regarding medical staff and processes.
[3] The OIG used its own clinicians to provide clinical expert guidance for testing compliance in certain areas where CCHCS policies and procedures did not specifically address an issue.

Program Strengths — Compliance

The following are some of SOL's strengths based on its compliance scores on individual questions in all the health care indicators:

- Nursing staff at SOL reviewed patients' health care service requests the same day they were received, and completed face-to-face encounters within required time frames.
- SOL provided patients with timely radiology services; providers timely reviewed radiology reports and timely communicated the results to patients.
- Staff scanned non-dictated progress notes, dictated progress notes, and specialty service report documents into patient electronic health records within required time frames.
- Nursing staff at medication line locations followed proper administrative controls and appropriate protocols during medication preparation.
- SOL offered annual influenza vaccinations to patients during the most recent influenza season.
- Patients received their high-priority and routine specialty service appointments within required time frames.

Program Weaknesses — Compliance

The following are some of the weaknesses identified by SOL's compliance scores on individual questions in all the health care indicators:

- Patients did not always receive chronic care provider appointments as ordered. Several patients that received a registered nurse (RN) referral to a provider upon transferring into SOL did not receive their appointment or received their appointment late. In addition, patients that received a specialty service appointment did not always receive a provider follow-up appointment within the required time frame.
- The institution did not always provide patients with their pathology service within the required time frame, and providers did a poor job reviewing pathology reports and communicating the results to patients.
- Several clinic common area locations did not have all the necessary equipment on hand to allow clinicians to perform comprehensive services. Exam rooms at several clinic locations did not have an environment conducive for providers to examine patients.
- Patients that transferred into SOL from another CDCR institution did not always receive their prescribed medications within their next dosing interval. Staff did not include all of the

necessary medication documents in the patients transfer packages for patients that transferred out of SOL to another CDCR institution.

- SOL did not properly monitor all of its patients receiving tuberculosis (TB) medications.
- Patients that transferred into SOL from another CDCR institution, with a pending specialty service appointment, did not always receive their appointment within required time frames. Also, several patients who had a requested specialty service denied, never received notification from their provider of the denied service or received the notification late.
- Nursing staff did not properly perform nursing reviews of subordinate staff, and several providers did not receive an adequate annual review or received the review late.

Recommendations

- SOL should not cancel and reorder invalid appointment orders. Instead, SOL should use the override function that still allows the institution to reschedule invalid orders. By pursuing this strategy, compliance dates would not be lost, user error would be minimized, and the CCHCS Dashboard, the automatic medical care performance metrics, would better reflect SOL's true performance.
- The OIG recommends CCHCS audit a range of different laboratory report types to identify all data fields that are not transferring into the EHRS from the laboratory provider. Once identified, CCHCS should implement corrections to the EHRS to ensure that the critical information is available to health care staff. In the meantime, CCHCS should create an alternative workflow, for all institutions using the EHRS, to ensure missing information is retrieved timely and reviewed by providers.
- The OIG recommends CCHCS develop a set of electronic auditing tools that can identify diagnostic test results that providers have not reviewed and have not generated patient letters. SOL management should then use the auditing tools to ensure all test results are reviewed timely and that providers notify patients of test results.
- The OIG recommends SOL and CCHCS modify the process currently used to cancel orders after a patient is absent from the institution for more than 48 hours. Since the vast majority of these are outpatients, not all orders should be automatically canceled. SOL and CCHCS should consider subjecting only medication orders to the automatic cancellation process.
- If the existing automatic cancellation process is not modified as recommended, then SOL will need to implement a process where all canceled orders are systematically reviewed for renewal when patients return to the institution. At the time of the onsite inspection, SOL

providers were not aware of the automatic order cancellation process, their responsibility to review and renew those canceled orders, or a method of how to identify them.

Population-Based Metrics

In general, SOL performed well as measured by population-based metrics. In comprehensive diabetes care, SOL outperformed or performed similarly to most statewide and national health care plans.

With regard to immunization measures, SOL outperformed all statewide and national health care plans for influenza vaccinations for younger adults. However, SOL scored lower than all other health care plans for influenza and pneumococcal vaccinations to older adults. The high refusal rate of vaccinations by older adults negatively affected the institution's score. SOL outperformed or performed similarly to all other health care plans for colorectal cancer screenings.

Overall, SOL's performance as measured by population-based metrics indicated that the chronic care program was good in comparison to other health care plans reviewed. The institution may improve its scores for immunizations by reducing patient refusals through patient education.

INTRODUCTION

Pursuant to California Penal Code Section 6126 et seq., 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. The OIG conducts a clinical case review and a compliance inspection, ensuring a thorough, end-to-end assessment of medical care within CDCR.

California State Prison, Solano (SOL), was the fifth medical inspection of Cycle 5. During the inspection process, the OIG assessed the delivery of medical care to patients using the primary clinical health care indicators applicable to the institution. The Administrative Operations indicator is purely administrative and is not reflective of the actual clinical care provided.

ABOUT THE INSTITUTION

Located in Vacaville, SOL is a correctional facility that opened in August of 1984. At the time of the OIG inspection, SOL housed a population of over 4,000 male inmates. The primary mission of SOL is to provide custody, care and treatment, and to offer rehabilitative programs for sentenced offenders. CCHCS has designated SOL an "intermediate" institution; these institutions are located in predominately urban areas close to tertiary care centers and specialty care providers for the most cost-effective care. SOL operates as a medium-security institution that houses general population inmates. Through educational and vocational training, Prison Industry Authority (PIA) assignments, and self-help programs, the institution provides inmates with the opportunity to develop life skills necessary for successful reintegration into society.The institution has four semi-autonomous facilities and a 125-bed administrative segregation unit. The institution operates multiple clinics, a treatment and triage area (TTA), and a 16-bed correctional treatment center (CTC) for patients 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.

Based on staffing data the OIG obtained from the institution, SOL's vacancy rate among medical managers, primary care providers, supervisors, and rank-and-file nurses was 15 percent in February 2017. The highest vacancy percentage was among primary care providers, with a 25 percent vacancy rate, which equated to 3 vacant positions out of 12 authorized positions. The chief executive officer of health care services (CEO) reported that in February 2017, there were seven staff members under CDCR disciplinary review.

SOL Health Care Staffing Resources as of February 2017

	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff		Totals	
Description	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Authorized Positions	5	4%	12	9%	12	9%	109.2	79%	138.4	100%
Filled Positions	5	100%	9	75%	11	92%	92.2	84%	117.2	85%
Vacancies	0	0%	3	25%	1	8%	17.2	16%	21.2	15%
Recent Hires (within 12 months)	1	20%	4	44%	3	27%	17	18%	25	21%
Staff Utilized from Registry	0	0%	0	0%	0	0%	13	14%	13	11%
Redirected Staff (to Non-Patient Care Areas)	0	0%	0	0%	0	0%	0	0%	0	0%
Staff on Long-term Medical Leave	0	0%	0	0%	2	18%	2	2%	4	3%

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

As of February 6, 2017, the Master Registry for SOL showed that the institution had a total population of 4,195. Within that total population, 9.2 percent were designated as high medical risk, Priority 1 (High 1), and 14.1 percent were designated as high medical risk, Priority 2 (High 2). Patients' assigned risk levels are based on the complexity of their required medical care related to their specific diagnoses, frequency of higher levels of care, age, and abnormal laboratory results and procedures. High 1 has at least two high-risk conditions; High 2 has only one. Patients at high medical risk are more susceptible to poor health outcomes than those at medium or low medical risk. Patients at high medical risk also typically require more health care services than do patients with lower assigned risk levels. The chart below illustrates the breakdown of the institution's medical risk levels at the start of the OIG medical inspection.

SOL Master Registry Data as of February 6, 2017

Medical Risk Level	Number of Patients	Percentage
High 1	384	9.2%
High 2	591	14.1%
Medium	1,597	38.1%
Low	1,623	38.7%
Total	**4,195**	**100%**

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 15 indicators (14 primary (clinical) indicators and one secondary (administrative) indicator) 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 indicator addresses the administrative functions that support a health care delivery system. These 15 indicators are identified in the *SOL Executive Summary Table* on page *ii* in the *Executive Summary* of this report.

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 registered nurses. The ratings may be derived from the case review results alone, the compliance test results alone, or a combination of both these information sources. For example, the ratings for the primary quality indicators *Quality of Nursing Performance* and *Quality of Provider Performance* are derived entirely from the case review done by clinicians, while the ratings for the primary quality indicators *Health Care Environment* and *Preventive Services* are derived entirely from compliance testing done by registered nurse inspectors. As another example, primary quality indicators such as *Diagnostic Services* and *Specialty Services* receive ratings derived from both sources.

Consistent with the OIG's agreement with the Receiver, this report only addresses the conditions found related to medical care criteria. The OIG does not review for efficiency and economy of operations. Moreover, if the OIG learns of a patient needing immediate care, the OIG notifies the chief executive officer of health care services and requests a status report. Moreover, 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 added case reviews to the Cycle 4 medical inspections at the recommendation of its stakeholders, which continues in Cycle 5 medical inspections. The OIG's clinicians perform a retrospective chart review of selected patient files to evaluate the care given by an institution's primary care providers and nurses. Retrospective chart review is a well-established review process used by health care organizations that perform peer reviews and patient death reviews. Currently, CCHCS uses retrospective chart review as part of its death review process and in its pattern-of-practice reviews. CCHCS also uses a more limited form of retrospective chart review when performing appraisals of individual primary care providers.

Patient Selection for Retrospective Case Reviews

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

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

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

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

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

2. The health of less complex patients is more likely to be affected by processes such as timely appointment scheduling, medication management, routine health screening, and

immunizations. To review these processes, the OIG simultaneously performs a broad compliance review.

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

Benefits and Limitations of Targeted Subpopulation Review

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

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

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

Case Reviews Sampled

As indicated in *Appendix B, Table B–1: SOL Sample Sets*, the OIG clinicians evaluated medical charts for 51 unique patients. *Appendix B, Table B–4: SOL* Case Review Sample Summary clarifies that both nurses and physicians reviewed charts for 21 of those patients, for 72 reviews in total. Physicians performed detailed reviews of 25 charts, and nurses performed detailed reviews of 15

charts, totaling 40 detailed reviews. For detailed case reviews, physicians or nurses looked at all encounters occurring in approximately six months of medical care. Nurses also performed a limited or focused review of medical records for an additional 31 patients, and physicians performed one additional patient-focused case review. These generated 1,089 clinical events for review (*Appendix B, Table B–3: SOL Event-Program*). The inspection tool 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 6 chronic care patient records, i.e., 3 diabetes patients and 3 anticoagulation patients (*Appendix B, Table B–1: SOL Sample Sets*), the 51 unique patients sampled included patients with 223 chronic care diagnoses, including 16 additional patients with diabetes (for a total of 19) and 3 additional anticoagulation patients (for a total of 6) (*Appendix B, Table B–2: SOL Chronic Care Diagnoses*). The OIG's sample selection tool allowed evaluation of many chronic care programs because the complex and high-risk patients selected from the different categories often had multiple medical problems. While the OIG did not evaluate every chronic disease or health care staff member, the overall operation of the institution's system and staff were assessed for adequacy.

The OIG's case review methodology and sample size matched other qualitative research. The empirical findings, supported by expert statistical consultants, showed adequate conclusions after 10 to 15 charts had undergone full clinician review. In qualitative statistics, this phenomenon is known as "saturation." The OIG found the Cycle 4 medical inspection physician sample size of 30 detailed reviews far exceeded the saturation point necessary for an adequate qualitative review. At the end of Cycle 4 inspections, the case review results were analyzed again using 50 percent of the cases, resulting in no significant differences in the ratings. To improve inspection efficiency while preserving the quality of the inspection, the samples for Cycle 5 medical inspections were reduced in number. For Cycle 5 inspections, basic institutions, with few high-risk populations, case review will use 67 percent of the case review samples used in Cycle 4 inspection (20 detailed physician cases reviewed). For intermediate institutions or basic institutions housing many high-risk patients, the case review samples will use 83 percent (25 detailed physician cases reviewed). Finally, the most medically complex institution, CHCF, has retained the full 100 percent samples of Cycle 4 inspections.

With regard to reviewing charts from different providers, the case review is not intended to be a focused search for poorly performing providers; rather, it is focused on how the system cares for those patients who need care the most. Nonetheless, while not sampling cases by each provider at the institution, the OIG inspections adequately review most providers. Providers would only escape OIG case review if institutional management successfully mitigated patient risk by having the more poorly performing providers care for the less complicated, low-utilizing, and lower-risk patients. The OIG's clinicians concluded that the case review sample size was more than adequate to assess the quality of services provided.

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

COMPLIANCE TESTING

Sampling Methods for Conducting Compliance Testing

From February to April 2017, registered nurse inspectors attained answers to 89 objective medical inspection test (MIT) questions designed to assess the institution's compliance with critical policies and procedures applicable to the delivery of medical care. To conduct most tests, inspectors randomly selected samples of patients for whom the testing objectives were applicable and reviewed their electronic unit health records. In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed health records for 398 individual patients and analyzed specific transactions within their records for evidence that critical events occurred. Inspectors also reviewed management reports and meeting minutes to assess certain administrative operations. In addition, during the week of February 20, 2017, registered nurse 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 1,073 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 Cycle 5 medical inspection testing, the OIG reduced the number of compliance samples tested for 18 indicator tests from a sample of 30 patients to a sample of 25 patients. The OIG also removed some inspection tests upon stakeholder agreement that either were duplicated in the case reviews or had limited value. Lastly, for Cycle 4 medical inspections, the OIG tested two secondary (administrative) indicators; *Internal Monitoring, Quality Improvement, and Administrative Operations*; and *Job Performance, Training, Licensing, and Certifications,* and have combined these tests into one *Administrative Operations* indicator for Cycle 5 inspections.

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

After compiling the answers to the 89 questions in the 10 applicable indicators, the OIG derived a score for each quality indicator by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Based on those results, the OIG assigned a rating to each quality indicator of *proficient* (greater than 85 percent), *adequate* (between 75 percent and 85 percent), or *inadequate* (less than 75 percent).

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 registered nurse inspectors discussed the nature of individual exceptions found within that indicator category and considered the overall effect on the ability of patients to receive adequate medical care.

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

POPULATION-BASED METRICS

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

MEDICAL INSPECTION RESULTS

The quality indicators assess the clinical aspects of health care. As shown on the *SOL Executive Summary Table* on page *ii* of this report, 13 of the OIG's indicators were applicable to SOL. Seven indicators were evaluated by both the case review and compliance components of the inspection, three were rated by the case review component alone, and three were scored by the compliance component alone. The *Administrative Operations* indicator is a secondary indicator, and, therefore, was not relied upon for the overall score for the institution. Based on this analysis and the results of the case review and compliance testing, the OIG made a considered and measured opinion that the quality of health care at SOL was ***inadequate***.

Summary of Case Review Results: The clinical case review component assessed 10 of the 13 indicators applicable to SOL. OIG clinicians rated two *proficient*, five *adequate*, and three *inadequate*.

OIG physicians rated the overall adequacy of care for each of the 25 detailed case reviews they conducted. Of these 25 cases, one was *proficient*, 12 were *adequate*, and 12 were *inadequate*. In the 1,089 events reviewed, there were 343 deficiencies, of which 156 were considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

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

- In case 11, a patient with out-of-control diabetes received a strong recommendation from a specialist for a new type of medication. The provider repeatedly failed to review the records and ignored the specialist's recommendation even after a nurse notified the provider that the patient would no longer be able to see the specialist if the provider did not reorder the specialty service. The provider continued to ignore the recommendation and allowed the specialty care to lapse.

- In case 19, the nurse failed to adequately review emergency room documents for a patient who was sent to an emergency room for swollen legs. The nurse failed to communicate to the on-call provider the recommended medication changes for the patient and to ensure that the patient had a follow-up appointment. As a result, the patient did not receive a follow-up appointment after the outside emergency department (ED) visit.

- In case 22, the patient had colon cancer and a newly discovered lung nodule. The specialist was concerned that the nodule might represent spread of the colon cancer or might be a new lung cancer. The specialist recommended an emergency biopsy of the nodule, but the biopsy did not occur until nearly six months later. There were many reasons for the lapse in care, including delayed provider appointments, provider errors, and the lack of other specialty services.

- In case 33, the diabetic patient developed a foot infection. The provider ordered a follow-up appointment in five days, but it never occurred. When the patient finished the antibiotics, the infection returned. The nurse did not contact the provider or ensure the provider saw the patient. Extremely poor access to care allowed the infection to worsen, until the patient required hospitalization. The patient had a partial amputation of his foot.

Summary of Compliance Results: The compliance component assessed 10 of the 13 indicators applicable to SOL. Of these ten indicators, OIG inspectors rated two *proficient*, and eight *inadequate*. The results of those assessments are summarized within this section of the report. The test questions used to assess compliance for each indicator are detailed in *Appendix A*.

1 — *ACCESS TO CARE*

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

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(74.5%)

Overall Rating:
Inadequate

Case Review Results

OIG clinicians reviewed 453 provider, nurse, specialty, and hospital events that required a follow-up appointment and identified 103 deficiencies, 68 of which were significant (placing the patient at risk for harm). Problems with access to care were widespread. Significant deficiencies were identified once each in cases 2, 5, 11, 14, 15, 20, 23, 25, 27, 36, 39, 41, 42, 46, and 47; twice in cases 1, 3, 13, 21, 24, 33, and 45; three times in cases 8, 16, and 25; four times in case 44; five times in cases 17 and 18; and six times in case 19.

Provider-to-Provider Follow-up Appointments

The institution performed poorly with scheduling timely provider-ordered follow-up appointments. During the OIG's inspection period, 141 outpatient provider appointments were reviewed. The OIG identified deficiencies in provider-ordered follow-up appointments in cases 4, 13, 15, 19, and 23. They occurred twice in cases 3, 8, 16, and 18, in addition to the following cases:

- In case 17, the provider ordered a chronic care follow-up within three months, but the follow-up appointment did not occur until five months later.
- In case 10, the provider ordered a follow-up in seven days to re-evaluate the patient's out-of-control diabetes. The patient was not seen until more than five months later.
- In case 18, the provider ordered a chronic care follow-up to occur in three months. A nurse repeatedly rescheduled the appointment until it was past the requested time frame. The order was eventually discontinued when the patient was hospitalized and was not renewed when the patient returned.
- In case 33, the provider ordered a follow-up in five days to re-evaluate the patient's diabetic foot infection. Nurses rescheduled the appointment several times and eventually canceled it. The patient was hospitalized when the infection spread to the bone and had to have partial amputation of his foot.

RN Sick Call Access

The institution performed well with RN sick call access. At the onsite inspection, SOL reported there were no backlogs in nursing appointments. The OIG reviewed 82 sick call events and identified 7 sick call appointments had not timely occurred (cases 17, 39, 40, 45, 46, and 47).

- In case 44, the RN appointment did not occur on two occasions, prompting the patient to submit multiple sick call requests.

RN-to-Provider Referrals

SOL did not ensure that providers saw patients after a nurse referral. In 15 of the 40 RN-to-provider referrals the OIG reviewed, an appointment did not occur timely or at all. These deficiencies were identified in cases 3, 10, 14, 35, 45, and 47. They occurred twice in cases 19 and 23, and also in the following cases:

- In case 17, the patient saw the nurse for uncontrollable coughing and vomiting. The nurse referred the patient to the provider within seven days, but the patient was not seen until over a month later.

- In case 36, the patient saw the nurse for back pain. The nurse referred the patient to the provider within two weeks, but the patient was not seen until two and a half months later.

- In case 44, the patient saw the nurse repeatedly for back pain. On three occasions, the nurse referred the patient to the provider, but the appointments did not occur.

RN Follow-up Appointments

The institution did not ensure that their nurses saw patients who were referred for RN follow-up appointments. Most of the follow-up appointments were for chronic care management. Of the 44 RN follow-up referrals reviewed, there were 11 deficiencies where the RN appointment was delayed or did not occur. These deficiencies were identified in cases 1, 5, 11, 15, 16, 17, 18, 21, and 33. They occurred twice in case 44.

Provider Follow-up After Specialty Services

The OIG reviewed 172 specialty appointments and procedures that required the provider to follow up. There were 23 deficiencies identified in which provider follow-up appointments were late or did not occur. Deficiencies of this type were identified in cases 1, 3, 11, and 13; twice in cases 15, 19, 22, 23, 24, and 25; and in the following case:

- In case 18, the patient saw an endocrinologist for nodules in the adrenal glands. The specialist recommended a diagnostic test and some medication changes. The patient was scheduled to go back to his regular provider, but the appointment was repeatedly rescheduled to a later date by a nurse. Eventually the appointment was canceled when the

patient was hospitalized with pneumonia. Fortunately, an astute provider finally reviewed the recommendations after the patient returned from the hospital.

Intra-System Transfers and Reception Center

Patients who transferred in from another CDCR facility were not given timely provider appointments. Of the13 intra-system transfer events reviewed, 11 resulted in referrals for provider follow-up appointments. Appointments were delayed or dropped in cases 2, 21, 27, and 42.

Follow-up After Hospitalization

SOL ensured that providers saw patients after a hospitalization or an outside emergency room visit. After hospitalizations, nurse care managers usually saw patients the next business day and providers saw patients within five days. In the 24 events the OIG reviewed, there was just one case where the provider did not see the patient after hospitalization, and this occurred because the receiving nurse failed to order the required appointments (case 19).

The OIG discovered that there was a serious risk of lapse in care with respect to hospitalizations and the EHRS. When a patient has been removed from the institution for more than 48 hours, all orders were automatically canceled. These orders included provider and nurse appointments, specialty appointments, and all pending diagnostic tests. While SOL did a good job of ensuring a provider appointment after hospitalization, the providers were unaware that all other prior orders had been canceled. Likewise, the providers were unaware that they were responsible for the reorder. This worrisome situation is discussed further in the *Intra- and Inter-System Transfers* indicator.

Follow-up After Emergent Care

SOL ensured that providers saw patients after a TTA visit. The OIG reviewed 23 cases in which the patient went to the TTA, returned to housing, and required provider follow-up. In nine of these cases the patient also required a nurse to follow up. There were only four deficiencies in this area. They occurred in cases 13 and 41, and also in the following cases:

- In case 5, the provider ordered a nurse to follow up within 24 hours after the patient went to the TTA for difficulty breathing. The appointment did not occur.

- In case 21, the provider ordered a nurse to follow up within 24 hours to ensure the patient was stable after a TTA visit for chronic obstructive pulmonary disease (COPD) exacerbation (sudden worsening of chronic lung disease symptoms that may include shortness of breath or difficulty breathing). The nurse saw the patient six days later.

Specialized Medical Housing

Providers admitted patients quickly to the CTC where they were checked on regularly. OIG clinicians reviewed 8 CTC admissions and 39 CTC provider encounters. There were only a few times where the CTC providers did not check on patients frequently enough to meet the state-mandated 72-hour requirement (case 3). This did not affect the quality of care.

Specialty Access and Follow-up

SOL performed well in specialty access and follow-up with few exceptions. Performance in this area is discussed further in the *Specialty Services* indicator.

Diagnostic Results Follow-up

Because SOL providers reviewed their laboratory tests within the EHRS, they no longer completed a Notification of Diagnostic Test Results (CDCR Form 7393). Instead, providers generated patient letters and ordered appointments directly within the EHRS.

Clinician Onsite Inspection

OIG clinicians interviewed SOL staff regarding poor performance in critical areas of the *Access to Care* indicator, such as provider-to-provider follow-ups, RN-to-provider referrals, and intra-system transfers. The lead scheduling manager was not present during the onsite inspection. SOL attributed the majority of the problems to a shortage of provider appointments because of the implementation of the EHRS. According to SOL staff, provider productivity had decreased for several months before and after the implementation of the EHRS.

OIG clinicians also investigated why nurses had modified numerous provider appointments. Nurses would repeatedly cancel, reorder, and push back compliance dates for appointments that were about to be or were already past due. SOL managers explained that many appointment orders had become "glitched," or were no longer valid in the EHRS and could not be acted upon. When SOL was unable to keep up with the demand for patient appointments, SOL nurses began to move the start date backward. When the start date became later than the end date, the order became invalid and could no longer be scheduled. Likewise, when an appointment became overdue, the computer error would not allow the appointment to be scheduled. To rectify the situation, SOL began to cancel all the orders that were invalid or were about to become invalid and would order them again with later compliance dates.

According to a scheduling supervisor, there was another solution; staff could schedule appointments, even when orders were no longer valid, by using an override function in the EHRS. Despite the availability of this override function, nurses went ahead with a mass cancellation of appointments so they could then reorder them.

This caused several problems. Canceling the appointments erased the compliance dates and there was no way of prioritizing patient appointments. The institution had to depend on the clinical

judgment of nurses unfamiliar with the needs of the patients. Furthermore, every appointment that was cancelled so it could be ordered again added to the risk of user error. These problems led to patients being seen late and sometimes not at all. This contaminated the internal process that CCHCS had developed to monitor institutional performance, called the Dashboard. By canceling overdue appointments in order to reschedule them with later compliance dates, SOL turned out-of-compliance appointments into compliant ones. This process artificially enhanced SOL's Dashboard performance. Scheduling staff acknowledged that the Dashboard performance was not representative of their true performance in this area, but claimed that attempts to schedule the few available appointments was an acceptable trade-off to maintain patient care. According to SOL leadership, access to care would improve now that staff was more familiar with the EHRS and provider productivity was close to what it was before the EHRS implementation.

Case Review Conclusion

In *Access to Care*, SOL performed well in most areas, but had serious problems with some critical aspects that lowered the overall rating for this indicator. There were significant problems with provider-to-provider follow-ups, RN-to-provider referrals, and intra-system transfers. SOL's attempt to work around the "glitch" of the EHRS transition resulted in lost compliance information and inaccurate Dashboard information. The *Access to Care* indicator rating was *inadequate*.

Compliance Testing Results

The institution performed in the *inadequate* range in the *Access to Care* indicator, with a compliance score of 74.5 percent, with low test scores in the following areas:

- Among 25 patients sampled who transferred into SOL from other institutions and were referred to a provider based on nursing staff's initial health care screening, only 8 (32 percent) were seen timely. Fifteen patients received their provider appointment from one to 179 days late, and for two other patients, there was no medical record evidence found to indicate they were ever seen (MIT 1.002).

- Only 12 of 24 (50 percent) sampled patients who received a high-priority or routine specialty service appointment also received a timely follow-up appointment with a provider. Of the 12 patients who did not receive a timely follow-up appointment, 5 patients' high-priority specialty service follow-up appointments were two to six days late, and 2 did not receive an appointment at all. Four patients' routine specialty service follow-up appointments were 4 to 46 days late, and one did not receive an appointment at all (MIT 1.008).

- Inspectors sampled 24 patients who suffered from one or more chronic care conditions; only 16 patients timely received their provider-ordered follow-up appointments (67 percent). Among the other eight patients, the following exceptions occurred: three patients had follow-up appointments occur between 2 and 28 days late; one patient's appointment was

143 days late; and two appointments for one patient with multiple chronic care conditions were 136 and 226 days late. For three patients, there was no evidence the appointment occurred at all (MIT 1.001).

The institution scored within the *adequate* range on the following tests:

- Of 15 sampled health care service requests on which nursing staff referred the patient for a provider appointment, 12 of the patients (80 percent) received a timely appointment. For three patients, the follow-up appointment occurred between 18 and 69 days late (MIT 1.005).

- Inspectors tested 25 patients discharged from a community hospital to determine if they received a provider follow-up appointment at SOL within five calendar days of their return to the institution, or earlier if a TTA provider ordered the appointment to occur sooner. Inspectors found 20 of the patients (80 percent) received a timely provider follow-up appointment. Five other patients received appointments from 3 to 22 days late (MIT 1.007).

- Of the eight sampled patients whom nursing staff referred to a provider and for whom the provider subsequently ordered a follow-up appointment, six (75 percent) received their follow-up appointments timely. For one patient, the appointment occurred three days late. For one other patient, there was no evidence the visit occurred at all (MIT 1.006).

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

- Inspectors sampled 30 services request forms submitted by patients across all facility clinics. Nursing staff reviewed all forms on the same day they were received (MIT 1.003).

- Patients had access to services request forms at all six housing units the OIG inspected (MIT 1.101).

- For 26 of the 30 patients sampled (87 percent) who submitted services request forms, nursing staff completed a face-to-face encounter with the patient within one business day of reviewing the form. For three patients, the nurse conducted the visit between one and six days late. For one other patient, there was no evidence the visit occurred at all (MIT 1.004).

2 — *DIAGNOSTIC SERVICES*

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(69.3%)

Overall Rating:
Inadequate

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

For this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance testing resulting in an *inadequate* score. The primary reason for the compliance testing's score of *inadequate* was that many laboratory and pathology reports had not received timely provider review and were not communicated timely to patients. Delays in the communication of health information can negatively impact the delivery of quality healthcare. The OIG inspection team considered both case review and compliance testing results and concluded that the final rating for the *Diagnostic Services* indicator was *inadequate*.

Case Review Results

OIG clinicians reviewed 168 diagnostic events and identified 41 deficiencies. Of the 41 deficiencies, 38 were related to health information management, and 3 were specifically for ordered tests that were not complete. Twelve of the deficiencies were significant and occurred in cases 4, 7, 12, 13, 17, 21, 22, 23, 25, and three times in case 15.

Test Completion

SOL performed diagnostic tests proficiently. By using the EHRS, the institution tracked and completed diagnostic orders reliably within the ordered time frames. Out of 168 events, there were only 3 occasions where a test was not complete. In general, these rare deficiencies were due to user error when a faulty order was entered into the EHRS.

Health Information Management

The institution did well in performing diagnostic tests, but had problems relaying the test results to the provider and ensuring the provider had reviewed, signed-off, and communicated the results to the patient.

Not all test results were transferred into patients' electronic medical records. When test results were not transferred to the EHRS, the missing results were overlooked, increasing the risk of patient harm. These deficiencies were identified twice in cases 1 and 23, and also in the following cases:

- In case 15, the results of two different abnormal urine cultures were not transferred into the EHRS. Because the results were not in the electronic medical record, the provider did not timely assess if the abnormal tests represented a urinary tract infection and if the patient needed treatment.

- In case 17, the pathology report from a gastrointestinal biopsy to rule out cancer had not been retrieved, reviewed, or scanned into the EHRS for almost a month after the test had been completed.

- In case 22, the patient had an entire set of laboratory test results that were not transferred into the EHRS. Because the results were not in the medical record, the provider did not review them.

- In case 25, the results of an abnormal urine toxicology test were not transferred into the EHRS.

Providers reviewed test results late or not at all in cases 3, 4, 7, 12, 13, 20, 22, and twice in case 15. Though uncommon, this finding was present in enough cases to establish a pattern of deficiencies. Providers did not sign off on the pathology reports during case review in cases 15, 17, and 22. Providers often failed to notify their patients of test results. This finding was widespread throughout the case reviews and was identified in cases 2, 9, 10, 11, 13, 16, 17, and 19; twice in cases 15 and 21; three times in case 23; and four times in case 24.

Clinician Onsite Inspection

SOL diagnostic staff explained that some problems had developed since the transition to the EHRS. They were aware that some test results, such as urine cultures were not transferring from the laboratory provider to the EHRS. Providers were aware of the problem, but SOL had not developed a process yet to retrieve missing results and forward them to the provider for timely review. The institution did not know until the OIG onsite inspection, that additional test results were not transferring to the EHRS, such as urine toxicology or blood count differential results. SOL explained that these problems were not unique to their institution and would likely affect other institutions transitioning to the EHRS. Some of the identified problems had been reported to CCHCS and SOL was waiting for CCHCS to implement a fix.

Through the EHRS, providers were notified via electronic message when new laboratory or other reports were available for review. While most providers diligently reviewed their messages and test results, some providers did not. Some results were reviewed late or not at all.

Providers were responsible for generating patient letters for all results they reviewed in the EHRS. SOL providers had great difficulty performing this task consistently, resulting in the widespread errors.

Case Review Conclusion

When compared to Cycle 4, SOL continued to perform well performing diagnostic tests. Most laboratory results were transferred into the EHRS. This was a significant improvement from Cycle 4. There still was a significant risk from test results, including urine cultures and toxicology and white blood cell differential counts, consistently failing to transfer from the laboratory provider to the EHRS. Providers continued to have difficulty consistently reviewing the test reports. Compared to Cycle 4, SOL did significantly worse and providers had great difficulty notifying patients of test results. The institution still had some difficulty retrieving pathology reports and ensuring provider review. Despite the problems identified, the vast majority of diagnostic tests were performed and reviewed appropriately, so the *Diagnostic Services* indicator was rated *adequate*.

Compliance Testing Results

The institution received an *inadequate* compliance score of 69.3 percent in the *Diagnostic Services* indicator, which encompasses radiology, laboratory, and pathology services. For clarity, each type of diagnostic service is discussed separately below:

Radiology Services

- Radiology services were timely performed for nine of ten sampled patients (90 percent). One patient received his service two days late (MIT 2.001). SOL providers timely reviewed the corresponding diagnostic services reports for nine of ten patients (90 percent). For one other patient, there was no evidence the report was reviewed at all (MIT 2.002). Providers timely communicated the test results to nine of ten patients (90 percent). For one patient, there was no evidence that test results were communicated to the patient (MIT 2.003).

Laboratory Services

- Nine of ten sampled patients (90 percent) timely received provider ordered laboratory services. For one patient, the service was provided two days late (MIT 2.004). SOL providers reviewed seven of ten resulting laboratory services reports within the required time frame (70 percent). Two reports were reviewed 6 and 14 days late, and for one report, there was no evidence it was ever reviewed by the primary care physician (MIT 2.005). Providers timely communicated the results to six of ten patients (60 percent). Two patients received results seven and eight days late. Two other patients never received results (MIT 2.006).

Pathology Services

- The institution timely received five of the ten (50 percent) sampled pathology reports. Five reports were not received at all (MIT 2.007). With regard to providers' review and communication of the pathology results, SOL scored poorly. Providers evidenced review by initialing and dating or electronic signature for two out of six (33 percent) sampled final pathology reports (MIT 2.008). Furthermore, providers communicated pathology results timely to only three of the six patients who received services (50 percent). For two patients, the provider communicated the results 5 and 15 days late. For one additional patient, inspectors did not find evidence in the medical record that the patient received notification of the test results (MIT 2.009).

3 — *EMERGENCY SERVICES*

Case Review Rating:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

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

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

Case Review Results

OIG clinicians reviewed 43 urgent or emergent events and identified 24 deficiencies, 4 of which were significant. The OIG clinicians rated this indicator *adequate*.

CPR Response

During the review period, there was only one case that required CPR response:

- In case 5, the CPR response was appropriate. First medical responders arrived on the scene quickly and instructed custody staff to begin CPR. While the CPR response time was good, the response time could have been further improved if custody staff had not waited for the first medical responder before initiating CPR.

Provider Performance

Provider performance was adequate. In the vast majority of TTA encounters, providers performed appropriate assessment and decision-making in urgent or emergent situations. On-call providers often returned to SOL to perform evaluations when needed. On-call providers usually documented a progress note, even for their telephone encounters. The few exceptions are as follows:

- In case 1, the patient had advanced heart disease and complained of chest pain and shortness of breath. The patient's EKG showed evidence of myocardial ischemia (reduced blood flow to the heart), but the provider overlooked the finding. The patient also had previously had an abnormal lung examination, but the provider did not obtain an immediate chest x-ray. The patient should have been sent directly to a higher level of care, but was instead released to housing. The following day, the patient was sent to the hospital emergency room.

- In case 17, the patient had advanced lung disease and complained of severe cough and chest pain. The patient had an abnormal lung examination, but the provider did not order a chest x-ray or a follow-up appointment for the patient soon enough. This oversight increased the risk of a missed diagnosis of pneumonia or other lung conditions.

- In case 21, the patient developed an exacerbation of chronic lung disease. The provider treated the patient for this condition, but did not document a progress note or order a provider follow-up appointment. By failing to order a provider follow-up appointment for the acutely ill patient, the TTA provider increased the risk of a lapse in care if the patient did not respond as expected to the initial treatment. At the onsite inspection, the provider explained that SOL had a severe shortage of provider appointments and that avoiding following up was an attempt at conserving those appointments.

Nursing Performance

The institution's TTA nurses provided prompt emergency medical response and appropriate intervention. There was only one significant deficiency involving nursing performance:

- In case 22, the first medical responder assessed a patient who had blood in his stool in the housing unit. The patient had advanced colon cancer. The nurse did not bring the patient to the TTA for further assessment and did not notify the provider. Instead, the nurse instructed the patient to fill out a sick call request.

Nursing Assessment and Documentation

OIG clinicians identified a pattern of incomplete nursing assessment and documentation. At the onsite inspection, the nurses claimed most of these deficiencies resulted from their unfamiliarity with the EHRS. Nursing leadership also attributed some documentation deficiencies to issues with the EHRS. Although the nursing deficiencies did not affect patient care, they demonstrated SOL nurses' failure to depict clinical situations or the care that they provided accurately or clearly. The OIG clinicians noted that as SOL nurses became more familiar with the EHRS, nursing documentation improved and some of these issues resolved.

Nurses failed to assess and monitor the condition of patients in the TTA and did not document pertinent information, such as the time an on-call physician or an EMS ambulance were contacted in cases 3, 15, 17, 18, 20, 21, and 41.

Emergency Medical Response Review Committee (EMRRC)

The EMRRC adequately discussed, identified deficiencies, and documented actions to take to correct problems in the three emergency medical response cases reviewed by OIG clinicians.

Clinician Onsite Inspection

The TTA had ample space for health care staff to perform patient care, sufficient nursing staff assigned at all times, and a nursing supervisor always available. One provider was assigned during business hours, one on-call physician was available after hours and on weekends, and one nurse was designated as a first medical responder. Medical supplies were sufficient and the nearby automated medication dispensing cabinet was adequately stocked.

Case Review Conclusion

The institution performed well in CPR response and in urgent or emergent nursing and provider performance. The OIG clinicians rated the *Emergency Services* indicator *adequate*.

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4 — *HEALTH INFORMATION MANAGEMENT*

Case Review Rating:
Adequate
Compliance Score:
Proficient
(86.3%)

Overall Rating:
Adequate

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

For this indicator, the case review and compliance scores yielded different results, with case review providing an *adequate* rating and compliance testing resulting in a *proficient* score. The OIG internal review process considered the factors that lead to both results. Although the compliance testing found strong performance in most areas, the case review found 29 significant deficiencies in the form of important documents that were mislabeled, misfiled, or not timely reviewed by a clinician. These deficiencies in health record management could have contributed to patient harm. As a result, the medical inspection team determined the overall score for this indicator was *adequate*.

At the time of the OIG's testing period (February to April 2017), SOL had recently converted to the new Electronic Health Record System (EHRS) (August 2016); therefore, most testing occurred in the EHRS, with a minor portion of the review occurring in the electronic Unit Health Record (eUHR).

Case Review Results

The OIG clinicians reviewed 1,085 events and identified 81 deficiencies, 29 of which were significant. Significant deficiencies were identified in cases 6, 8, 12, 13, 20, 21, 23, 24, and 25; two times in cases 4, 11, 17, 19, and 22; three times in case 3; and seven times in case 15.

Inter-Departmental Transmission

SOL transitioned to the EHRS during the review period. One of the main benefits of electronic health records is real time availability of most health information. Orders are far less likely to be lost in transmission. Furthermore, the EHRS has a built-in messaging system that allows health care staff to communicate most types of health information quickly and conveniently. The OIG did not find any problems in this area; however, the transition to the new electronic system did negatively impact SOL's provider productivity and scheduling process. This is discussed in detail in the *Quality of Provider Performance* and *Access to Care* indicators.

Hospital Records

The institution did well with retrieving emergency department (ED) physician reports and hospital discharge summaries. OIG clinicians reviewed 8 outside ED events and 16 community hospital events. ED reports and hospital discharge summaries were retrieved and scanned in a timely manner in all cases, with the exception of case 8. Providers consistently reviewed and signed off on ED physician reports and hospital discharge summaries. However, they did not sign off the summaries in cases 1 and 6.

Specialty Services

The institution performed poorly in retrieving and scanning specialty reports. Providers often failed to sign off on the specialty reports. This is discussed further in the *Specialty Services* indicator.

Diagnostic Reports

SOL performed well in most aspects of diagnostic reports, but providers failed to review all reports and often did not notify patients of the test results. This is discussed in detail in the *Diagnostic Services* indicator.

Urgent/Emergent Records

SOL's performance in this area was good. A vast majority of nurses and providers documented their emergent encounters into the EHRS. This is also discussed in the *Emergency Services* indicator.

Scanning Performance

SOL's internal documents were created and stored in the EHRS and did not require scanning. Outside medical reports did require scanning and there were delays in the retrieval of some of those reports, as discussed in the *Diagnostic Services* and *Specialty Services* indicators. Once the reports were retrieved, they were scanned quickly and accurately and rarely mislabeled or misfiled.

Legibility

Legibility was not an issue since most documents in the EHRS were either typewritten or dictated.

Clinician Onsite Inspection

The OIG observed clinical information transmission during the daily morning huddles. According to SOL's staff, a standard huddle script was followed to ensure that patients seen outside of normal clinic hours had an appropriate follow-up appointment. In several huddles, providers were either absent or were only covering for the regular provider. In all but one team huddle, discussion on individual patients was superficial and revealed an unfamiliarity with patients.

Case Review Conclusion

The institution performed well with inter-departmental transmission; retrieval of outside ED reports and hospital discharge summaries; urgent and emergent documentation; scanning performance; and legibility. SOL handled diagnostic reports well, but handled specialty reports in specialty services poorly. The OIG clinicians rated SOL *adequate* in the *Health Information Management* indicator.

Compliance Testing Results

The institution received an *adequate* compliance score of 86.3 percent in the *Health Information Management* indicator, with scores in the *proficient* range in four tests, as follows:

- The institution timely scanned all sampled non-dictated progress notes, patients' initial health screening forms, and requests for health care services into the electronic health record (MIT 4.001).

- The institution had one applicable sample of dictated or transcribed provider progress notes, which was timely scanned into the patient's electronic medical record (MIT 4.002).

- Staff at SOL timely scanned into the patient's electronic health record 18 of the 20 discharge records sampled (90 percent). Two records were scanned one and ten days late (MIT 4.004).

- The institution scored 88 percent in its labeling and filing of documents scanned into patients' electronic health records. For this test, once the OIG identifies 24 mislabeled or misfiled documents, the maximum points are lost and the resulting score is zero. For SOL's medical inspection, inspectors identified two documents that were mislabeled and one documents that was missing (MIT 4.006).

The following test scored in the *adequate* range:

- SOL's staff scanned reports into the patient's health record file within five calendar days in 16 of the 20 specialty service consultant reports sampled (80 percent). The other four sampled reports were scanned two to five days late (MIT 4.003).

The institution showed room for improvement with an *inadequate* score in one test, as follows:

- Among 25 patients admitted to the hospital and then returned to SOL, providers timely reviewed hospital discharge reports within three days of the patient's discharge for only 15 (60 percent). For ten of the sampled patients, providers did not timely review the discharge reports; six of the patients' reports were reviewed one to two days late, and one patient's report was reviewed 24 days late. For one patient there is no evidence of the report ever being received or reviewed. Two patients' reports were not reviewed at all (MIT 4.007).

5 — *HEALTH CARE ENVIRONMENT*

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

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(66.1%)

Overall Rating:
Inadequate

This indicator is evaluated entirely by compliance testing.

Compliance Testing Results

The institution received an *inadequate* compliance score of 66.1 percent in the *Health Care Environment* indicator and showed room for improvement in the following test areas:

- The non-clinic bulk medical supply storage areas did not follow the supply management process or meet the support needs of the medical health care program. Medical supplies were stored in the warehouse for longer than the manufacturer's guidelines. As a result, the institution scored zero on this test (MIT 5.106).

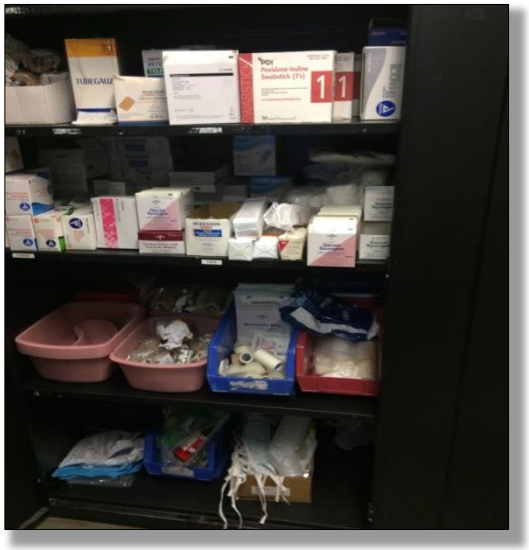

Figure 1: Unlabeled exam room supplies

- Only two of nine clinic exam rooms observed (22 percent) had appropriate space, configuration, supplies, and equipment to allow clinicians to perform a proper clinical examination. Seven clinic locations had one or more of the following deficiencies: access to the exam tables was impeded, torn vinyl covers on exam tables, lack of privacy due to multiple patients examined in one room shared by multiple clinicians, and exam room supplies were not clearly labeled for identification (*Figure 1*). One clinic location also had an examination room with inadequate space for examining patients (*Figure 2)* (MIT 5.110).

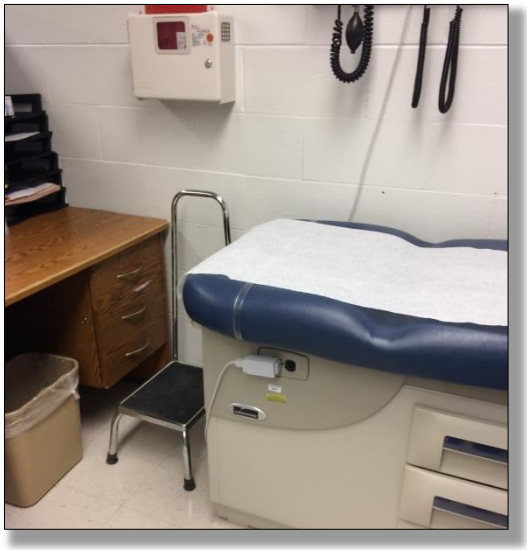

Figure 2: Inadequate space for examining patients

- Inspectors examined emergency medical response bags (EMRBs) to determine if they were inspected daily and inventoried monthly and whether they contained all essential items. EMRBs were compliant in only three of the seven applicable clinics (43 percent). Crash carts were missing some medical supplies at three clinics; one clinic's EMRB had an empty oxygen tank; one clinic was missing a stethoscope; and at one clinic, there was no documentation that an inventory had been completed in the previous month (MIT 5.111).

- Only five of nine clinic locations (56 percent) met requirements for core equipment and supplies. The remaining four clinics were missing one or more functional pieces of properly calibrated core equipment or other medical supplies necessary to conduct a comprehensive exam. The missing items included a demarcation line for the Snellen eye exam chart, an exam table, and bio-hazard waste receptacles, or labeled plastic bags (MIT 5.108).

- In five of eight clinics, clinicians followed good hand hygiene practices (63 percent). At three clinic locations, clinicians failed to wash their hands before or after patient contact or before applying gloves (MIT 5.104).

- When inspectors examined SOL's nine clinics to verify that adequate hygiene supplies were available and sinks were operable, only six of nine clinics (67 percent) were in compliance. In three clinics, the patient restrooms did not have sufficient quantities of hygiene supplies, such as disposable hand towels (MIT 5.103).

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

- All nine applicable clinics properly sterilized or disinfected reusable invasive and non-invasive medical equipment (MIT 5.102).

- All nine clinics followed adequate medical supply storage and management protocols (MIT 5.107).

- All nine clinics had an environment adequately conducive to providing medical services (MIT 5.109).

- Eight of the nine clinics observed (89 percent) were appropriately disinfected, cleaned, and sanitary. In one clinic, the cleaning log was missing an entry and there was no evidence the clinic was cleaned that day (MIT 5.101).

- Eight of the nine clinics (89 percent) followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste. In one clinic, the sharps container was filled past the safety line (MIT 5.105).

6 — *INTER- AND INTRA-SYSTEM TRANSFERS*

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(67.3%)

Overall Rating:
Inadequate

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

Case Review Results

OIG clinicians reviewed 42 inter- and intra-system transfer events, including information from both the sending and receiving institutions. The transfer events included 24 hospitalization and outside emergency room events, which usually resulted in a transfer back to the institution. There were 26 deficiencies identified, 11 of which were significant (once each in cases 8, 18, 19, 20, 21, 27, and 42, and twice each in cases 2 and 3).

Transfers In

The institution performed poorly with patients transferring into the institution. OIG clinicians reviewed 13 patients who transferred into SOL from another CDCR institution. The receiving and release (R&R) nurse generally reviewed the health care transfer information and performed adequate initial health screening. Four of these patients were directly admitted to the CTC and were assessed by the CTC nurse.

As discussed in the *Access to Care* indicator, the problems SOL had with access to providers happened after patients arrived at the institution. Nurses usually did not refer newly arrived patients with chronic conditions for an initial nurse care management appointment, as required by CCHCS policy. These failures resulted in severe loss of continuity of care, as illustrated in the following cases:

- In case 2, the patient's provider appointment occurred four months late. SOL staff explained that the appointment did not transfer over to the EHRS correctly and the only reason the appointment happened at all was the patient was sent out to the hospital and was seen by the provider as a hospital return. The patient was lost to chronic care follow-up, and his blood pressure medications lapsed.

- In cases 21 and 27, nurses did not always document significant information such as pending specialty appointments and mental health referrals. In case 21, the patient arrived at SOL and was supposed to be seen within a week, but the provider appointment and nurse care management appointment were both dropped and never occurred. In case 27, the patient arrived at SOL and was supposed to be seen within two weeks, but was not seen for nearly two months.

- In case 42, the patient arrived at SOL with a hepatitis C infection and was scheduled for a provider history and physical examination. The patient was supposed to be seen within a month, but the appointment never occurred because it was rescheduled twice and eventually canceled.

Transfers Out

OIG clinicians reviewed five patients who transferred out of SOL to other CDCR institutions. Nurses performed adequate face-to-face evaluations prior to patient transfers. Nursing staff sent health care transfer information, medications, and health care equipment with the patient to the receiving institution in all cases, and generally performed adequately in the transfer out process. There were no deficiency patterns identified.

Hospitalizations

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

The institution performed poorly with patients returning from the hospital. The OIG clinicians reviewed 24 events where patients returned to SOL from an offsite hospital or ED and identified 13 deficiencies, of which 6 were significant. Nurses performed adequate assessment, reviewed hospital reports, and ensured that the correct medications were ordered for most patients who returned from the hospital. However, SOL had problems reconciling previously ordered medical appointments and also with ensuring that follow-up appointments were ordered. Many prior appointments were dropped after patients had been admitted to the hospital.

- In case 2, the patient was sent to an outside ED for facial numbness. When the patient returned, the nurse did not recognize that the patient had not seen the RN care manager for chronic care management since the patient arrived at SOL over four months earlier. The

nurse should have referred the patient to the RN care manager, but the patient never saw the RN care manager.

- In case 3, the patient was hospitalized for syncope (loss of consciousness) where it was determined the patient had an irregular heart rhythm. When the patient returned to SOL, the nurse erroneously entered proposed orders for extra medications that were not recommended at the time of discharge. The provider erroneously signed those orders and the patient was administered three extra blood pressure medications. These errors increased the patient's risk for adverse side effects. Over the next few weeks, the patient had repeated episodes of low blood pressure.

- In case 18, the patient was hospitalized for pneumonia and exacerbation of chronic lung disease. When the patient returned, staff administered the patient's medications late. More importantly, staff did not reconcile the patient's appointment orders, resulting in lost chronic care and post-specialty appointments.

- In case 19, the nurse failed to adequately review the ED report and discuss the ED physician's recommendations with the on-call provider. The recommended medication changes were not ordered and the nurse did not ensure the provider and nurse care manager appointments were ordered. The patient was lost to follow-up after returning from the ED and had no pending chronic care appointments.

- In case 20, the patient was hospitalized for chest pain. When the provider saw the patient for hospital follow-up, the provider did not reorder the prior appointments and failed to order a new follow-up. These errors resulted in dropped appointments and a high risk of a lapse in care.

Clinician Onsite Inspection

The R&R area had adequate space to conduct the initial health screenings. There was one nurse assigned each watch during business days. Transfer notifications were generally received weekly and the R&R nurse prepared the health care transfer information packet. When interviewed by the OIG, the R&R nurses demonstrated sufficient knowledge of the transfer process. Patients returning from an outside hospital or ED were assessed in the TTA area. The TTA area is also discussed in the *Emergency Services* indicator.

Most providers were not aware that all prior orders, including provider, nurse, and specialty appointment orders, were automatically canceled if a patient was absent from the institution for more than 48 hours. They were also unaware that they were responsible for reordering all orders that were canceled due to the patient's hospitalization. Furthermore, SOL providers were not aware that patients could be lost to follow-up if the orders were not reordered. The providers were not familiar with any process to identify the orders that had been automatically canceled. The chief

medical executive (CME) had recently been made aware of the potential for dropped care due to the automatic discontinuation of orders and was working on a solution for the problem.

Case Review Conclusion

The institution had challenges ensuring patients saw a provider after they arrived from another institution. SOL had great difficulty with the loss of appointments that were automatically canceled when a patient was admitted to an outside hospital. This problem placed patients at high-risk for lapses in care. In most cases, nurses did well with reviewing outside hospital reports and ensuring that returning patients received the correct medications. The institution also did well with ensuring continuity of care for patients transferring out to a different institution. Given the high-risk posed by the poor performance with transfers in and hospital-return processes, SOL was rated *inadequate* in the *Inter- and Intra-System Transfers* indicator.

Compliance Testing Results

The institution obtained an *inadequate* score of 67.3 percent in the *Inter- and Intra-System Transfers* indicator, with room for improvement on the following tests:

- The OIG tested four patients who transferred out of SOL during the onsite inspection to determine whether the patients' transfer packages included required medications and related documentation. All transfer packages were missing the required medication administration record. SOL received a score of zero (MIT 6.101).

- Of 25 sampled patients who transferred into SOL, 14 had an existing medication order upon arrival. Only 10 of the 14 patients (71 percent) received their medications without interruption. Four patients incurred medication interruptions of one or more dosing periods, upon arrival (MIT 6.003).

The institution scored in the *adequate* range on the tests below:

- Among 20 sampled patients who transferred out of SOL to other CDCR institutions, 17 had their scheduled specialty service appointments properly included on the health care transfer form (85 percent) (MIT 6.004).

- The OIG tested 25 patients who transferred into SOL from other CDCR institutions to determine whether they received a complete initial health screening from nursing staff on the day they arrived. SOL received a score of 80 percent on this test because nursing staff timely completed the assessment for only 20 of the sampled patients. For five patients, nurses neglected to answer one or more of the screening form questions (MIT 6.001).

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

- For all 24 patients tested, nursing staff timely completed the assessment and disposition sections of the screening form on the same day staff completed the health screening (MIT 6.002).

7 — *PHARMACY AND MEDICATION MANAGEMENT*

Case Review Rating:
Proficient
Compliance Score:
Inadequate
(64.2%)

Overall Rating:
Inadequate

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

In this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *adequate* rating, and the compliance review resulting in an *inadequate* score. The OIG's internal review process considered those factors that led to both scores and ultimately rated this indicator *inadequate*. While case review focused on medication administration, the compliance testing was a more robust assessment of medication administration and pharmacy protocols combined with onsite observations of medication and pharmacy operations. As a result, the compliance score of *inadequate* was deemed appropriate for the indicator rating.

Case Review Results

The OIG clinicians evaluate pharmacy and medication management as secondary processes as they relate to the quality of clinical care provided. Compliance testing is a more targeted approach and is heavily relied on for the rating of this indicator. The OIG clinicians evaluated 33 events related to medications and identified 5 deficiencies, of which only one was significant.

Medication Continuity

The institution performed well ensuring medication continuity with no deficiency patterns in this area.

Medication Administration

SOL nurses administered medications timely and accurately. There were no deficiency patterns in this area.

Pharmacy Errors

The OIG clinicians did not detect any deficiency patterns in this area, but there was one significant deficiency:

- In case 23, the pharmacy failed to provide high-dose steroids to treat the patient's kidney disease, despite several orders by the provider.

Clinician Onsite Inspection

Because SOL transitioned to the EHRS, all medication orders and administration were tracked electronically. This involved very little manual input and decreased the risk of user error.

Case Review Conclusion

SOL performed well in the *Pharmacy and Medication Management* indicator and was rated *proficient*.

Compliance Testing Results

The institution received an *inadequate* compliance score of 64.2 percent in 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

In this sub-indicator, the institution received an *inadequate* score of 52.0 percent. The institution scored poorly in the following areas:

- Among 20 sampled patients, only 6 (30 percent) timely received chronic care medications. Current policy requires keep on person (KOP) medication be made available at least one business day prior to exhaustion. Out of 20 sampled patients, 11 did not receive their KOP monthly replenishment medications timely. The nurse documented on the medication administration record (MAR) summary that two patients were chronic no shows, one for 11 days and one for 40 days, but did not document any efforts to contact custody or have the patients sent to the medication line. These patients did not receive timely provider counseling if they received counseling at all. One of these patients had the statement, "Not Done: Task Duplication" on their MAR, yet there was no documentation that the medication was administered (MIT 7.001).

- Nursing staff administered medications without interruption to two of four patients who were en route from one institution to another and who had a temporary layover at SOL (50 percent). For two other patients, there was no medical record evidence that medications were administered as ordered (MIT 7.006).

- Of the 25 sampled patients, 13 timely received their newly ordered medications (52 percent). Of the 12 patients who did not timely receive their medication, 11 had a delay from one to four days, and one other patient received his medication 23 days late (MIT 7.002).

- SOL timely ordered, made available, and administered hospital discharge medications to 15 of 25 patients sampled (60 percent). Five patients were provided discharge medications one to two days late, and for one other patient, no evidence was found that the ordered medication was provided. In addition, four patients did not have their medications ordered within eight hours of their return (MIT 7.003).

Observed Medication Practices and Storage Controls

In this sub-indicator, the institution received an *inadequate* score of 61.0 percent. SOL performed in the *inadequate* range in the following three areas:

- The institution employed adequate security controls over narcotic medications in only two of the seven applicable clinic and medication line locations where narcotics were stored (29 percent). At four clinics, the narcotics log book lacked evidence on multiple dates that a controlled substance inventory was performed by two licensed nursing staff and one of the four clinic locations had narcotic medication stored in the refrigerator without double lock security. At one other clinic, the OIG inspector observed the medication nurse removing narcotic medications in a manner that did not allow spontaneous count (MIT 7.101).

- SOL properly stored non-narcotic medications not requiring refrigeration in only three of the nine applicable clinic and medication line storage locations (33 percent). In six locations, one or more of the following deficiencies were observed: the medication area lacked a designated area for return-to-pharmacy medications; external and internal medications were not properly separated when stored; multiuse medication was not labeled with the date it was opened: a crash cart was not secured with a red tamper-resistant number seal; and the crash cart log was missing an entry for daily seal security check (MIT 7.102).

- Non-narcotic refrigerated medications were properly stored in four of nine applicable clinics and medication line storage locations (44 percent). The medication area lacked a designated area for return to pharmacy refrigerated medications at five other locations (MIT 7.103).

The institution performed in the *adequate* range in the following two areas:

- Nursing staff at four of the five sampled medication preparation and administration locations (80 percent) followed proper hand hygiene and contamination control protocols during the medication preparation and administrative processes. At one location, not all medication nurses washed or sanitized their hands prior to putting on gloves and administering medication (MIT 7.104).

- Nursing staff followed appropriate administrative controls and protocols when distributing medications to patients at four of the five applicable medication preparation and administrative locations (80 percent). At one location, patients did not have protection from inclement weather at the outdoor medication line (MIT 7.106).

The institution performed in the *proficient* range in the following area:

- At all five of the inspected medication line locations, nursing staff employed appropriate administrative controls and followed appropriate protocols during medication preparation (MIT 7.105).

Pharmacy Protocols

In this sub-indicator, the institution received an *adequate* score of 80.0 percent. The institution scored 100 percent in the following test areas:

- In its main pharmacy, the institution followed general security, organization, and cleanliness management protocols; properly stored and monitored non-narcotic medications that required refrigeration; and maintained adequate controls over and properly accounted for narcotic medications (MIT 7.107, 7.109, 7.110).

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

The institution showed room for improvement in the following area:

- In its main pharmacy, SOL did not properly store non-refrigerated medication. The OIG inspectors encountered medication boxes stored on the floor of the pharmacy, and the institution received a score of zero (MIT 7.108).

Non-Scored Tests

- In addition to testing reported medication errors, the OIG investigates any significant medication errors identified during the compliance testing to determine whether the errors were properly identified and reported. The OIG provides those results for information purposes only; however, at SOL, none of the medication errors identified by compliance or case review staff during testing was applicable for this test (MIT 7.998).

- The OIG tested patients housed in isolation units to determine if they had immediate access to their prescribed KOP rescue inhalers and nitroglycerin medications. Inspectors interviewed all ten of SOL's applicable patients and determined all had their rescue medication (MIT 7.999).

8 — *PRENATAL AND POST-DELIVERY SERVICES*

This indicator evaluates the institution's capacity to provide timely and appropriate prenatal, delivery, and postnatal services. This includes the ordering and monitoring of indicated screening tests, follow-up visits, referrals to higher levels of care, e.g., the high-risk obstetrics clinic, when necessary, and postnatal follow-up.

Because SOL was a male-only institution, this indicator did not apply.

Case Review Rating:
Not Applicable
Compliance Score:
Not Applicable

Overall Rating:
Not Applicable

9 — *PREVENTIVE SERVICES*

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

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(69.5%)

Overall Rating:
Inadequate

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

Compliance Testing Results

The institution performed in the *inadequate* range in the *Preventive Services* indicator, with a compliance score of 69.5 percent, with room for improvement in the following areas:

- The institution scored poorly for monitoring of patients on TB medications. For seven of ten patients sampled, the institution either failed to complete monitoring at all required intervals or failed to scan the monitoring forms into the patient's medical record in a timely manner (30 percent) (MIT 9.002).

- OIG inspectors sampled 30 patients to determine whether they received a TB screening within the last year. Fifteen of the sampled patients were classified as Code 22 (requiring a TB skin test in addition to a signs and symptoms check), and 15 sampled patients were classified as Code 34 (subject only to an annual signs and symptoms check). Of the 30 sampled patients, nursing staff timely and appropriately conducted those screenings for only 18 (60 percent). More specifically, nurses properly screened 11 of the Code 22 patients and 7 of the Code 34 patients. Inspectors identified the following deficiencies (MIT 9.003):

    - Four of the Code 22 patients had test results read by a licensed vocational nurse (LVN) or psychiatric technician rather than an RN, public health nurse, or primary care provider as required by CCHCS policy in place at the time of the OIG's review.

    - For eight of the Code 34 patients, nursing staff did not complete the required history portion of the Tuberculin Testing/Evaluation Report (CDCR Form 7331). For one additional patient, the signs and symptoms portion of the form was not completed.

- Of 24 sampled patients, 17 (71 percent) either had a normal colonoscopy within the last ten years or were offered a colorectal cancer screening in the last year. The medical records of seven other patients did not contain evidence of a normal colonoscopy within the last ten

years or show that they were offered a colorectal cancer screening within the previous year (MIT 9.005).

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

- SOL scored 80 percent for administering timely TB medications to patients. Eight of ten patients received their medication timely. However, one patient missed a required "now" TB medication dose and an additional dose six days later, and did not receive the required provider counseling for the missed doses. Another patient missed two scheduled days of medication and received doses on two other unscheduled days (MIT 9.001).

- Among the 15 sampled patients who suffered from chronic care conditions, 12 (80 percent) were offered vaccinations for influenza, pneumonia, and hepatitis at required intervals. For two patients, there was no evidence of receipt or refusal of a pneumococcal immunization within the last five years, and for one patient, there was no evidence of documented immunity or of receipt or refusal of hepatitis A and B immunizations (MIT 9.008).

The institution performed in the *proficient* range in the following area:

- SOL offered annual influenza vaccinations to 24 of 25 sampled patients subject to the annual screening requirement (96 percent). For one other patient, there was evidence of a refusal although there was no documentation of the nurses certification of the refusal (MIT 9.004).

10 — *QUALITY OF NURSING PERFORMANCE*

Case Review Rating:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

The *Quality of Nursing Performance* indicator is a qualitative evaluation of the institution's nursing services. The evaluation is completed entirely by OIG nursing clinicians within the case review process, and does not have a score under the OIG compliance testing component. Case reviews include face-to-face encounters and indirect activities performed by nursing staff on behalf of the patient. Review of nursing performance includes all nursing services performed on site, such as outpatient, inpatient, urgent/emergent, patient transfers, care coordination, and medication management. The key focus areas for evaluation of 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, and accurate, thorough, and legible documentation. Although nursing services provided in the CTC are reported in the *Specialized Medical Housing* indicator and nursing services provided in the TTA or related to emergency medical responses are reported in the *Emergency Services* indicator, all areas of nursing services are summarized in this *Quality of Nursing Performance* indicator.

Case Review Results

This indicator was rated *adequate*. OIG clinicians reviewed 361 nursing encounters, of which 183 were in the outpatient setting. Most outpatient nursing encounters were for sick call requests and nurse care management visits. There were 89 deficiencies identified related to nursing performance, 18 of which were significant. Although most of the deficiencies were not likely to cause patient harm, they demonstrated the difficulty nurses at SOL had in meeting some basic nursing care and practice requirements, which should be subject to appropriate quality improvement strategies.

Nursing Assessment

Most nurses performed adequate assessments, but there was a pattern of deficiencies in the TTA and outpatient clinics. These deficiencies are discussed further in the *Emergency Services* and *Specialized Medical Housing* indicators.

Nursing Intervention

SOL nurses did not always recognize the need for appropriate or timely intervention. Deficiencies in this phase of the nursing process included: failure to address the patient's health care needs, failure to refer the patient to the provider or RN care manager, and failure to provide education or instructions.

Nursing Documentation

Nursing documentation was good at SOL. Nurses documented well in the CTC and showed evidence of good nursing care and timely communication of the patient's condition to the providers. However, there were some documentation deficiencies, primarily in the TTA and outpatient clinics.

Nursing Sick Call

The OIG clinicians reviewed 82 nursing sick call visits and found appropriate nursing performance. Nurses reviewed most sick call requests timely, saw patients the next business day, and made proper assessments, interventions, and dispositions. There were only a few documentation deficiencies. While most nurses performed appropriately for the majority of reviewed cases, there were occasions when nurses failed to see patients with non-urgent conditions within one business day. These cases were identified in the *Access to Care* indicator. Nurses did not recognize potentially urgent conditions, failed to assess the patient, or did not intervene appropriately in cases 1, 13, 36, 39, 42, 44, 46, and in the following cases:

- In case 9, the patient saw the nurse for thumb pain. The nurse noted that the thumb appeared swollen and disjointed, but did not immediately refer the patient to the provider. Instead the patient was scheduled for a routine (14-day) follow-up.

- In case 14, the nurse saw the patient for groin pain, but did not assess the groin area for redness, swelling, or tenderness. Three weeks later, the nurse saw the patient for a toe infection and did not assess for signs of infection or refer the patient to the provider. Two months later, the patient told the nurse that the ophthalmologist recommended a change in medications. The nurse did not review the report and did not inform the provider of the recommendation.

- In case 17, the patient submitted a sick call request for a provider to discuss being placed back on a breathing machine and requested an asthma medication to help with the patient's breathing and choking. The nurse responded that the patient had a provider appointment on the same day, but the provider did not see the patient that day. The nurse did not assess the patient or ensure that the patient saw the provider.

- In case 22, the patient with colon cancer was evaluated by emergency medical responders for blood in his stool. A first responder nurse saw the patient, but did not perform an adequate assessment and instead instructed the patient to submit a sick call request. The clinic nurse received the sick call request the next day, but did not see the patient on the same day. Three weeks later, the patient submitted a sick call request for severe stomach pain and again was not seen on the same day.

- In case 33, the nurse did not see a diabetic patient with a continued non-healing wound on the same day the sick call request was reviewed. The nurse saw the patient four days later

and referred the patient to the provider. The patient was sent to the hospital and had a partial foot amputation.

Care Management

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

SOL continued to provide an efficient nurse care management program. One RN care manager was assigned in each of the main clinics. Patients with the highest acuity due to their chronic conditions or recent hospitalizations saw the RN care manager to ensure that necessary or immediate health care needs were met. The RN care managers also assisted and coordinated the management of patients on anticoagulation treatment.

Most RN care managers provided appropriate chronic care follow-up and post-hospital-return evaluations. Of the 79 nursing care management encounters reviewed, 16 deficiencies were identified related to nursing, 2 of which were significant. The OIG clinicians determined that significant deficiencies occurred in the following two cases:

- In case 11, the patient saw the endocrinology specialist who recommended new medications and changes in the current insulin medications to treat his poorly controlled diabetes. The RN care manager saw the patient for follow-up, but did not review the endocrinology report and did not inquire with the provider why the recommendations were not followed. Two months later, the RN care manager saw the patient for follow-up and again failed to review the endocrinology recommendations and failed to ask the provider why those recommendations had not been considered.

- In case 12, the patient saw the RN care manager for diabetes follow-up to adjust his insulin medication dosage. The RN care manager failed to review the laboratory results and blood sugar logs. The RN care manager failed to discuss the elevated blood sugar readings with the provider and failed to inquire if any additional interventions were necessary.

In addition, the following case was an example of an RN care manager who failed to timely address patient healthcare needs:

- In case 7, the patient asked for assistance in obtaining his bi-level positive airway pressure (BiPAP) machine (device for sleep apnea). The provider ordered the machine to be delivered in two weeks. The RN care manager failed to order a follow-up visit to check if the patient received the machine. Three months later, the RN care manager saw the patient

again but did not inquire why the BiPAP machine was not yet delivered. The patient received the machine five months after it was ordered.

OIG clinicians identified another pattern of deficiencies in which RN care managers failed to document pertinent information. The RN care managers did not always document plans of care, follow-up appointments, and patient education. Although these documentation deficiencies were determined as not likely to result in patient harm, documentation requirements are established in existing CCHCS nursing policy and protocols. Examples of these deficiencies were identified in cases 3, 18, 19, and 21. The institution also had problems with nurse follow-up appointments for care management. These problems are further discussed in the *Access to Care* indicator.

Urgent/Emergent Care

OIG clinicians reviewed 44 urgent/emergent events and identified 15 deficiencies related to nursing performance. The TTA nurses showed patterns of inadequate assessments and documentation deficiencies. Most deficiencies did not affect the outcome of the emergency medical care provided. These findings are discussed in the *Emergency Services* indicator.

Specialized Medical Housing

The nursing care provided in the CTC was excellent. OIG clinicians reviewed 53 nursing encounters and did not find a single clinically significant deficiency. These findings are discussed in the *Specialized Medical Housing* indicator.

Transfers and Reception Centers

The institution performed poorly when new patients arrived in the institution. The R&R nurses did not consistently refer the newly arrived patients with chronic conditions for initial RN care management appointments, contributing to the lapse in care in some of the cases reviewed. However, nurses ensured that health care information, medications, and medical equipment transferred along with the patients leaving the institution. The institution also had problems reconciling previous medical appointments and ensuring provider follow-up after patients returned from the hospital or emergency room. These findings are also discussed in the *Inter- and Intra- System Transfers* indicator.

Out to Medical Return and Specialty Service

OIG clinicians reviewed 84 nursing encounters with patients returning from their specialty appointments and found that most nurses performed well. More detail on these findings are discussed in the *Specialty Services* indicator.

Medication Administration

SOL demonstrated good performance related to the accuracy and timeliness of medications administration.

Clinician Onsite Inspection

OIG clinicians attended the morning huddles on two days in the outpatient clinics. In one clinic, the provider was not present during the huddle. All other staff members participated in the team discussion, including the chief nurse executive (CNE) and the supervising registered nurse. Due to the absence of a provider, the huddle lacked a meaningful discussion of a plan of care to address patient health care needs. Only one outpatient clinic huddle was thorough and meaningful information shared.

OIG clinicians visited the various clinic areas and interviewed staff about the nursing sick call and care management processes. One primary care nurse and one RN care manager were each assigned to the four main outpatient clinics. On an average day, each clinic received about 40 sick call requests, 10 of which included symptom complaints. The primary care nurse saw approximately ten patients a day. The primary care nurse reported that there were no walk-in patients received in the clinic. If a patient needed to see a nurse or provider that day, the patient had to state he was experiencing a medical emergency and be transported to the TTA for evaluation. Nursing staff identified no communication barriers with providers, supervisors, and custody staff when meeting patient care needs. Nurses were knowledgeable about their duties, responsibilities, and assigned patient population. Nurses reported overall job satisfaction and believed they provided quality nursing care to patients.

The nurses and providers at SOL said the CNE and CME did not verbally communicate with clinical staff. Most nurses did not believe that this affected nursing performance or the nurses ability to work well with provider staff.

Case Review Conclusion

The *Quality of Nursing Performance* indicator was rated *adequate*. The institution's patients generally received good nursing care. The nursing deficiencies identified in this indicator can be addressed as areas of quality improvement.

11 — *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, triage and treatment area (TTA), specialized medical housing, and specialty services. The assessment of provider care is performed entirely by OIG physicians. There is no compliance testing component associated with this quality indicator.

Case Review Rating:
Inadequate
Compliance Score:
Not Applicable

Overall Rating:
Inadequate

Case Review Results

The OIG clinicians rated this indicator *inadequate*. There were 183 medical provider encounters and the OIG inspectors identified 60 deficiencies related to provider performance, of which 38 were significant.

Assessment and Decision-Making

Other than errors in ordering follow-up appointments and chronic care performance, providers generally made adequate assessments and decisions in most of the provider events reviewed. However, SOL providers performed poorly in assessments and decision-making because they consistently failed to order follow-up appointments. This placed patients at risk for lapses in care. These deficiencies were widespread and were identified in cases 3, 8, 9, 10, 11, 13, 20, 23, and the following cases:

- In case 12, the provider failed to order appointments for chronic care follow-up and abnormal laboratory result follow-up, resulting in the patient being lost to follow-up for nearly five months.

- In case 16, the patient had liver cancer and had recently refused to see the cancer specialist. The provider advised the patient to reconsider his decision and educated the patient on his cancer condition. The provider neglected to order a follow-up appointment, increasing the risk of a lapse in care.

- In case 25, the patient had an uncommon eye condition that required specialty care. The provider neglected to order follow-up appointments on multiple occasions. This contributed to a lapse in care. Fortunately, the provider recognized the error and resumed specialty care.

Review of Records

SOL providers often performed poorly with reviewing records. Failure to review records led to medical errors that increased the risk of harm. These deficiencies were identified in cases 2, 3, 22, 25, and the following cases:

- In case 11, the patient had out-of-control diabetes. The endocrinologist recommended a new class of diabetic medication because the patient was already on a high-dose of insulin. For more than six months, the provider failed to review the specialty reports and to prescribe the recommended medication.

- In case 12, the patient had laboratory results that showed anemia with small red blood cells. The provider did not effectively review the laboratory results or investigate the cause for the anemia. This increased the patient's risk of harm because one potential cause was cancer. The OIG notified SOL leadership of this case; SOL promised to expedite the investigation into this case.

- In case 23, the kidney specialist was given incorrect information. The specialist was told that the patient could not tolerate and did not receive a recommended treatment for his kidney disease. The specialist then recommended an alternative, more powerful medication regimen with more potential complications. The provider failed to carefully review the specialist notes and ordered the second regimen even though the patient had actually completed the first regimen. Fortunately, the patient did not suffer any harm from the second regimen.

Emergency Care

SOL providers demonstrated adequate emergency and on-call care. Performance in this area is further discussed in the *Emergency Services* indicator.

Chronic Care

Providers were not effective in chronic care performance. In many cases, the institution's patients were lost to follow-up and OIG case reviewers could not completely assess provider chronic care performance. Despite this limitation, OIG case reviewers identified potential problems with both diabetic and anticoagulation management.

Providers often failed to order appropriate follow-up appointments and follow-up intervals for diabetic care. This contributed to prolonged periods without appropriate diabetes assessment or intervention. Poor diabetic care was identified in the following cases:

- In case 2, the patient had diabetes that was not well controlled. The provider made insulin adjustments, but did not make any plans to review the patient's blood sugars for another three months. This did not follow current guidelines to review blood sugars every week to determine if further insulin adjustment is needed.

- In case 11, the patient's diabetes was out of control. The provider ignored the case manager's request for laboratory tests, failed to review blood sugar results, failed to act on markedly abnormal laboratory results, ordered follow-up intervals too far apart, and allowed the endocrinology specialty consultations to lapse.

- In case 12, the provider made insulin adjustments for the patient's poorly controlled diabetes. The provider failed to order a follow-up appointment, resulting in a lapse in care. When laboratory results showed that the diabetes remained poorly controlled, the provider failed to intervene and did not order a follow-up appointment. A different provider made an insulin adjustment, but also failed to order a follow-up appointment.

For anticoagulation management, SOL utilized RN care managers to regularly track, monitor, and assess their patients. There were significant problems identified in this area, which are further discussed in the *Specialty Services* indicator.

Specialized Medical Housing

SOL providers performed well with care in the CTC. This is discussed in more detail in the *Specialized Medical Housing* indicator.

Specialty Services

SOL providers performed well in making specialty referrals and reviewing specialty reports. This is discussed in more detail in the *Specialty Services* indicator.

Clinician Onsite Inspection

For most SOL providers, the single largest factor in their daily work had been adjusting to the new EHRS. Most providers recounted a large learning curve for relearning all aspects of health care delivery. For example, if the provider did not correctly enter specific times and dates in a medication or laboratory order, the order would not be performed. Providers explained they often neglected to order follow-up appointments because the EHRS did not prompt them to do so during a patient visit. Providers reported spending many more hours performing desktop medicine since the transition to the EHRS. Providers explained that initially their productivity had drastically declined following the EHRS transition, but productivity had begun to improve around the time of the onsite inspection.

Providers reported poor morale and that the institution was understaffed, as evidenced by the lack of coverage for their patients whenever they took time off. Providers commented that SOL's understaffing could be attributed to persistent problems with physician recruitment due to both a difficult working environment and noncompetitive compensation and benefits. Some providers remarked that working conditions were worse compared to the Cycle 4 inspection. The institution had lost several good providers, including the prior chief physician and surgeon. Some providers noted that the CME was highly intelligent, fair, and effective, but lacked good interpersonal skills.

A minority claimed the CME was a micromanager and did not allow them enough freedom to practice medicine. Several providers revealed that SOL's performance was hampered from extreme separation between the CME and CNE. Several health care staff confirmed that they had never witnessed verbal communication between CME and CNE.

Managers said that providers had transitioned well to the EHRS, but were spending an extra 60 to 90 minutes per day using the EHRS and had not yet returned to full productivity. Managers confirmed that SOL had problems with physician recruitment. At the time of the onsite inspection, SOL had two physician vacancies, but there had been continuous vacancies for over a year. The CME believed that SOL's problems with physician recruitment were part of a statewide systemic problem. Since passage of the federal Patient Protection and Affordable Care Act, community physician compensation had risen to become on par or even better than state prison physician compensation. Managers were pleased with the quality of the majority of their providers and also noted the recent departure of one provider who was not providing adequate care.

Case Review Conclusion

Providers frequently failed to order follow-up appointments and often did not review prior medical records appropriately. Providers also did not demonstrate good chronic care performance. Of the 25 cases reviewed, one was *proficient*, 12 were *adequate*, and 12 were *inadequate*. The OIG rated the *Quality of Provider Performance* indicator *inadequate*.

12 — *RECEPTION CENTER ARRIVALS*

Case Review Rating:
Not Applicable
Compliance Score:
Not Applicable

Overall Rating:
Not Applicable

This indicator focuses on the management of medical needs and continuity of care for patients arriving from outside the CDCR system. The OIG review includes evaluation of the ability of the institution to provide and document initial health screenings, initial health assessments, continuity of medications, and completion of required screening tests; address and provide significant accommodations for disabilities and health care appliance needs; and identify health care conditions needing treatment and monitoring. The patients reviewed for reception center cases are those received from non-CDCR facilities, such as county jails.

Because SOL did not have a reception center, this indicator did not apply.

13 — *SPECIALIZED MEDICAL HOUSING*

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

Case Review Rating:
Proficient
Compliance Score:
Proficient
(92.5%)

Overall Rating:
Proficient

Case Review Results

The institution's CTC had six medical beds and nine mental health beds. There was one designated negative pressure room, a space designed to minimize the spread of airborne infection. OIG clinicians reviewed eight CTC admissions, including 39 provider and 54 nursing encounters. They identified eight minor deficiencies, mostly consisting of incomplete nursing assessment and documentation.

Provider Performance

Providers performed well in the CTC, making good quality assessments and decisions. Providers reviewed documents with appropriate depth and performed admission history and physical examinations regularly. Providers did not always visit their CTC patients every three days as required by policy, but this did not noticeably affect the quality of care provided. Some providers extensively copied and pasted computer text from previous encounters, resulting in "cloned" progress notes. However, these were only minor deficiencies and no significant provider deficiencies were identified.

Nursing Performance

Nurses provided effective care and performed appropriate and timely assessments for CTC patients. The nurses assessed patients at least once each watch. When there was a change in clinical condition, CTC nurses performed a thorough evaluation and appropriately communicated the patient's status to the CTC provider. CTC nurses reported to the receiving nurse and gave discharge instructions and education to patients when they were discharged from the CTC. There were five nursing deficiencies, but no pattern that could likely contribute to patient harm.

Clinician Onsite Inspection

During the inspection, all of the CTC medical beds were filled. Three nurses, including a shift lead nurse and one licensed psychiatric technician, were assigned on each watch. Nursing staff had immediate access to patients and custody staff was present to assist and provide access to mental health patients. Policies and procedures manuals were readily available to staff. Interviews with

nurses revealed demonstrated knowledge of CTC procedures and expressed a high level of job satisfaction.

Case Review Conclusion

Providers and nurses performed well with respect to care in the CTC. OIG clinicians rated the *Specialized Medical Housing* indicator *proficient*.

Compliance Testing Results

SOL received a *proficient* compliance score of 92.5 percent in the *Specialized Medical Housing* indicator, which focused on the institution's CTC. SOL scored in the *proficient* range in the following areas:

- Providers evaluated all ten sampled patients within 24 hours of admission and completed the required history and physical examination (MIT 13.002).

- Inspectors observed the working order of call buttons in CTC patient rooms and found all worked properly. According to SOL staff, custody officers and clinicians were able to quickly access patients' rooms during emergent events (MIT 13.101).

- For nine of ten sampled patients (90 percent), nursing staff timely completed an initial health assessment on the day the patient was admitted to the CTC. For one patient, the nurse completed the initial assessment one day late (MIT 13.001).

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

- The OIG tested whether providers completed their Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes at required intervals. Providers completed timely SOAPE notes for eight of the ten sampled patients (80 percent). For two other patients, provider notes were late; one note was one day late, the other note was four days late (MIT 13.003).

14 — *SPECIALTY SERVICES*

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

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(70.0%)

Overall Rating:
Adequate

In this indicator, the OIG case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance testing an *inadequate* score. The OIG's internal review process considered the factors leading to both scores and ultimately rated this indicator *adequate* based on two factors. Compliance testing determined SOL performed poorly with providing pre-approved specialty services for patients that had arrived from another institution. When SOL denied a specialty service, it did not inform the patient of the denial within the required time frame. Because the first deficiency is also a problem with patient transfers, the *Intra- and Inter-system Transfer* indicator rating is more representative of SOL's poor performance in this area. The process of informing the patient of the denied specialty service had less of a clinical impact on medical care as the other conducted tests in which SOL performed well. For these reasons, SOL's performance for *Specialty Services* was *adequate*.

Case Review Results

OIG clinicians reviewed 252 events related to specialty services, which included 165 specialty consultations and procedures, 84 nursing encounters, and 3 warfarin clinic encounters. Out of the 252 events, there were 69 deficiencies identified, 37 of which were significant.

Access to Specialty Services

SOL performed adequately with providing access to specialty services, but during the review period, SOL had problems obtaining gastroenterology and cardiothoracic surgery consultations. Of 165 specialty consultations and procedures, there were 13 deficiencies in scheduling these services. Significant deficiencies were identified in case 14 and the following cases:

- In case 8, the provider ordered endoscopy tests of the upper and lower gastrointestinal tract to evaluate the cause of iron deficiency. The tests occurred five weeks later than requested.

- In case 17, the patient had vomiting and difficulty swallowing. The CME expedited the upper gastrointestinal endoscopy request to occur within two to three weeks. The test did not occur until a month later than requested.

- In case 22, the cardiothoracic surgeon scheduled to perform a biopsy of a potentially cancerous lung nodule became unavailable. The institution had to restart the workup at a different medical center, contributing to a delay in care.

Nursing Performance

SOL nurses performed adequately for patients returning from an offsite specialty appointment. Generally, nurses assessed the patient, reviewed the specialty recommendations, and obtained pertinent orders to further patient care. They also scheduled provider follow-ups to review the specialty reports and discussed recommendations with the patient. Occasionally, nurses failed to perform a thorough assessment, document adequately, provide adequate instructions to patients following a procedure, or ensure a provider follow-up. There were 12 deficiencies identified related to nursing, 4 of which were significant.

- In cases 3 and 24, the nurse failed to schedule a provider follow-up after the specialty appointments, increasing the risk of a lapse in care.

- In case 25, the patient went to an offsite specialty appointment twice. On both occasions, the nurse failed to schedule provider follow-up appointments and to assess the patient and complete progress notes.

The telemedicine nurse assisted patients utilizing telemedicine specialty services. SOL nurses performed well in this area.

Provider Performance

SOL providers performed well with specialist referrals. Most providers recognized the need for referral and ordered the correct referrals with appropriate priority, but some made errors making specialty referrals (cases 11, 17, 21 and 22).

Providers performed well when reviewing specialty reports. Most providers reviewed the reports and made appropriate decisions based on the specialty recommendations. Some providers occasionally neglected to review the specialty reports with sufficient depth or failed to review specialty reports at all. These deficiencies occurred in cases 22, 25, and in the cases below:

- In case 11, the specialist recommended a medication for the patient with out-of-control diabetes. The provider repeatedly neglected to review the specialty report for more than six months and allowed the specialty care to drop.

- In case 23, the patient had a kidney condition that needed attention from a specialist. The provider did not adequately review the patient's reports and incorrectly reported to the

specialist that the patient could not take a medication to block the inflammation causing the kidney disease. Because of this inaccurate information, the specialist recommended another medication, a steroid, which had more side effects. Fortunately, no lasting harm resulted from the provider's error.

For anticoagulation management, SOL utilized RN care managers to regularly track, monitor, and assess their patients. RN care managers could follow the anticoagulation protocol, notify the provider, and obtain appropriate orders as needed. At least one RN care manager was not performing this task adequately.

- In case 8, the RN care manager failed to review the INR result (laboratory test to measure blood thinning level), assess the patient, or order follow-up warfarin monitoring.

- In case 9, there were eight deficiencies attributed to the RN care manager, seven of which were significant. The RN care manager repeatedly failed to review the anticoagulation laboratory tests, evaluate the patient, discuss medication compliance, and order follow-up anticoagulation monitoring. The provider also did not adequately address the patient's anticoagulation.

Health Information Management

The institution performed poorly with the retrieval and scanning of specialty reports. SOL demonstrated a pattern of retrieving specialty reports late or not at all. These deficiencies occurred in cases 4, 17, 20, 21, 22, and 24; three times each in cases 3 and 6; and four times in case 15.

- In case 3, the patient had throat cancer. On two occasions, there was a severe delay in the retrieval and scanning of the ear, nose, and throat specialty report and on another occasion, the report was not retrieved at all. Fortunately, the patient still received the needed care.

- In case 6, the patient had a critically narrowed aortic valve. The patient underwent an ultrasound and activity monitor test for the heart. There was a severe delay in the retrieval of these tests results. Fortunately, the cardiologist continued with the work-up even without the results of the tests.

- In case 15, the patient underwent bladder tumor surgery for cancer. The operative report was not retrieved until the OIG notified SOL the document was missing.

The OIG identified widespread deficiencies consisting of providers neglecting to sign off specialty reports. In the EHRS, providers are sent notification messages for each new report. Providers can sign off the reports in the EHRS, but repeatedly did not.

Clinician Onsite Inspection

SOL providers commented they had difficulty obtaining gastrointestinal specialty services during the review period and complained of insufficient time to review their messages. While providers said they always reviewed the specialty reports, they may not have consistently signed off on the reports.

Case Review Conclusion

The institution performed well with specialty access and nursing and provider performance in specialty services. Nurses aided with telemedicine services and properly reviewed specialty recommendations. Providers referred patients to specialists when needed and reviewed and acted upon specialty recommendations. However, anticoagulation management was inconsistent and providers often failed to sign off on the specialty reports they had reviewed. SOL also performed poorly with the timely retrieval of specialty reports. SOL was rated *adequate* in the *Specialty Services* indicator.

Compliance Testing Results

The institution received an *inadequate* compliance score of 70.0 percent in the *Specialty Services* indicator, receiving low scores in the following test areas:

- For 20 patients sampled who had a specialty service denied by SOL's health care management, 5 patients (25 percent) received timely notification of the denied service. For ten sampled patients, this requirement was not met at all and five other patients received a follow-up visit 7 to 88 days late (MIT 14.007).

- When an institution approves or schedules a patient for specialty services appointments and the patient then transfers to another institution, policy requires the receiving institution ensure a patient's appointment occurs on time. Only 7 of the 20 patients sampled who transferred into SOL with an approved specialty service (35 percent) received it within the required time frame. Eight patients received their pending specialty service appointment from four days to three months late and five other patients never received their specialty service appointment (MIT 14.005).

- The institution timely denied providers' specialty service requests for 13 of 20 patients sampled (65 percent). For six other patients, specialty services requests were denied between one to 47 days late. For one other patient, there was no sign-off authorizing the denial of service (MIT 14.006).

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

- Providers timely reviewed reports following routine specialty service appointments for 11 of 14 cases reviewed (79 percent). For three patients, providers reviewed the reports from 4 to 36 days late (MIT 14.004).

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

- For all 15 patients sampled, high-priority specialty service appointments occurred within 14 calendar days of the provider's order (MIT 14.001).

- Providers timely received and reviewed the specialists' reports for 14 of the 15 sampled patients (93 percent) who received a high-priority service. For one patient, SOL received the specialist's report 2 days late and the provider reviewed the report 12 days late (MIT 14.002).

- For 14 of 15 patients sampled (93 percent), routine specialty service appointments occurred within the required time frame. One patient reportedly refused to accept a request to receive the specialty service, but the proper refusal form was not documented (MIT 14.003).

15 — *ADMINISTRATIVE OPERATIONS (SECONDARY)*

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(70.4%)

Overall Rating:
Inadequate

This indicator focuses on the institution's administrative health care oversight functions. The OIG evaluates whether the institution promptly processes patient medical appeals and addresses all appealed issues. Inspectors also verify the institution follows reporting requirements for adverse/sentinel events and patient deaths. The OIG verifies the Emergency Medical Response Review Committee (EMRRC) performs required reviews and 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. In addition, 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. The *Administrative Operations* indicator is a secondary indicator, and, therefore, was not relied on for the overall score for the institution.

Compliance Testing Results

The institution received an *inadequate* compliance score of 70.4 percent in the *Administrative Operations* indicator. The institution showed room for improvement in the following test areas:

- The institution did not take adequate steps to ensure the accuracy of its Dashboard data. SOL did not provide substantial evidence of discussion of the methodologies used to conduct periodic data validation or the results of that data validation testing. The Quality Management Committee (QMC) meetings did not include discussion of methodologies used to train staff who collected Dashboard data. Therefore, SOL received a score of zero (MIT 15.004).

- The OIG inspected records from December 2016 for five nurses to determine if their nursing supervisors properly completed monthly performance reviews. Inspectors identified the following deficiencies for five nurses' monthly nursing reviews resulting in a zero score on this test (MIT 15.104):

    - The supervisor did not complete the required number of reviews for one nurse.

    - The supervisor's review did not summarize aspects that were well done or needing improvement for five nurses.

- The documentation did not confirm the supervising nurse discussed the findings with four nurses.

- Only one of SOL's ten providers had a proper clinical performance appraisal completed by their supervisor (10 percent). Nine of the providers did not have either timely or properly completed appraisals, including the following (MIT 15.106):

  - One provider's annual evaluation was overdue by three months.

  - Evaluations for six providers did not include the required 360 degree evaluations.

  - An Evaluation for one provider was not available, and the CME did not discuss an evaluation with another provider.

- Inspectors reviewed drill packages for three medical emergency response drills conducted in the prior quarter. Only one of the three drill packages were properly completed (33 percent). For two other drill packages, staff did not complete the Medical Report of Injury or Unusual Occurrence (CDCR Form 7219) and First Responder — Data Collection Tool (CDCR Form 7463) (MIT 15.101).

- The institution's local governing body (LGB) met quarterly during the four-quarter period ending March 2016. However, for two of the LGB meetings, the CEO signed the meeting minutes the day of the meeting, but the CEO should have signed the meeting minutes at the next scheduled meeting. As a result, the institution scored 50 percent for this test (MIT 15.006).

- Of the 12 sampled incident packages for emergency medical responses reviewed by SOL's Emergency Medical Response Review Committee (EMRRC) during the prior 12-month period, 8 (67 percent) complied with policy. Three of the incident review packages included EMRRC review forms without the clinical review portion completed. One package did not include the required EMRRC checklist (MIT 15.005).

- Medical staff properly reviewed, signed, and promptly submitted the Initial Inmate Death Report (CDCR Form 7229A) to CCHCS's Death Review Unit for two of the three applicable deaths (67 percent) that occurred at SOL in the prior 12-month period. One report was missing an initial by the CEO or the CME (MIT 15.103).

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

- The institution promptly processed all patient medical appeals in each of the most recent 12 months (MIT 15.001).

- All of the institution's QMC monthly meetings evaluated program performance and took action when management identified areas for improvement opportunities (MIT 15.003).

- Based on a sample of ten second level medical appeals, the institution's responses addressed all of the patients' appealed issues (MIT 15.102).

- All ten nurses sampled were current with their clinical competency validations (MIT 15.105).

- All providers, nursing staff, and the pharmacist in charge were current with their professional licenses or certification requirements (MIT 15.107, MIT 15.109).

- All active duty providers, nurses, and custody staff were current with their emergency response certifications (MIT 15.108).

- All pharmacy staff and providers who prescribed controlled substances had current Drug Enforcement Agency registrations (MIT 15.110).

- All nursing staff hired within the last year timely received new employee orientation training (MIT 15.111).

Non-Scored Results

- The OIG gathered non-scored data regarding the completion of death review reports by CCHCS's Death Review Committee (DRC). Three deaths occurred during the OIG's review period, two unexpected (Level 1) deaths and one expected (Level 2) death. The DRC was required to complete its death review summary report within 60 days from the date of death for the Level 1 deaths and within 30 days from the date of death for the Level 2 death; the report should then be submitted to the institution's CEO within seven calendar days thereafter. However, for one of the Level 1 deaths, the DRC completed its report 51 days late (111 days after death) and submitted them to SOL's CEO 64 days late. For the other Level 1 death, the final death review report had not yet been completed at the time of the OIG's inspection. For the one Level 2 death, the DRC completed its report 36 days late (66 days after death) and submitted it to the CEO 46 days late (MIT 15.998).

- SOL's health care staffing resources are discussed in the *About the Institution* section on page *1* of this report (MIT 15.999).

RECOMMENDATIONS

- The OIG recommends SOL not cancel and reorder invalid appointment orders, and instead use the override function that still allows the institution to reschedule invalid orders. By pursuing this strategy, compliance dates would not be lost, user error would be minimized, and the CCHCS Dashboard, the automatic medical care performance metrics, would better reflect SOL's true performance.

- The OIG recommends CCHCS audit a range of different laboratory report types to identify all data fields that are not transferring into the EHRS from the laboratory provider. Once identified, CCHCS should implement corrections to the EHRS to ensure that the critical information is available to health care staff. In the meantime, CCHCS should create an alternative workflow, for all institutions using the EHRS, to ensure missing information is retrieved timely and reviewed by providers.

- The OIG recommends CCHCS develop a set of electronic auditing tools that can identify diagnostic test results that providers have not reviewed and have not generated patient letters. SOL management should then use the auditing tools to ensure all test results are reviewed timely and that providers notify patients of test results.

- The OIG recommends SOL and CCHCS modify the process currently used to cancel orders after a patient is absent from the institution for more than 48 hours. Since the vast majority of these are outpatients, not all orders should be automatically canceled. SOL and CCHCS should consider subjecting only medication orders to the automatic cancellation process.

- If the existing automatic cancellation process is not modified as recommended, then SOL will need to implement a process where all canceled orders are systematically reviewed for renewal when patients return to the institution. At the time of the onsite inspection, SOL providers were not aware of the automatic order cancellation process, their responsibility to review and renew those canceled orders, or a method of how to identify them.

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 the public (including employers, the Centers for Medicare and Medicaid Services, and researchers) has the information it needs to accurately compare the performance of health care plans. Healthcare Effectiveness Data and Information Set data is often used to produce health plan report cards, analyze quality improvement activities, and create performance benchmarks.

Methodology

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

When compared statewide, SOL outperformed Medi-Cal in all five diabetic measures, and Kaiser in four of five measures, with Kaiser North and South scoring slightly higher than the institution in eye exams. When compared nationally, SOL outperformed Medicaid and commercial health plans in all five diabetic measures, and Medicare in four of five diabetic measures. However, the institution outperformed the United States Department of Veteran Affairs (VA) in only two of the diabetic measures, with VA outperforming SOL for diabetic monitoring and eye exams.

Immunizations

Comparative data for immunizations was only fully available for the VA and partially available for Kaiser Permanente, commercial health plans, Medicaid, and Medicare. SOL outperformed all applicable health care plans with regard to influenza vaccinations for younger adults. With respect to administering influenza and pneumococcal vaccinations to older adults, SOL scored lower than both Medicare and the VA. The high patient refusal rate of 32 percent for influenza vaccinations and 18 percent for pneumococcal vaccinations negatively affected the institutions score.

Cancer Screening

With respect to colorectal cancer screening, SOL scored higher than commercial health plans and Medicare, and matched Kaiser (North). The institution performed slightly less well when compared to Kaiser (South) and the VA.

Summary

SOL's population-based metrics performance reflected a good chronic care program in comparison to all other state and national health care plans reviewed. The institution may improve its scores for immunizations by reducing patient refusals through patient education.

SOL Results Compared to State and National HEDIS Scores

Clinical Measures	California					National		
	SOL Cycle 5 Results[1]	HEDIS Medi-Cal 2015[2]	HEDIS Kaiser (No. CA) 2016[3]	HEDIS Kaiser (So.CA) 2016[3]	HEDIS Medicaid 2016[4]	HEDIS Com-mercial 2016[4]	HEDIS Medicare 2016[4]	VA Average 2015[5]
Comprehensive Diabetes Care								
HbA1c Testing (Monitoring)	**97%**	86%	94%	94%	86%	90%	93%	98%
Poor HbA1c Control (>9.0%)[6, 7]	**18%**	39%	20%	23%	45%	34%	27%	19%
HbA1c Control (<8.0%)[6]	**71%**	49%	70%	63%	46%	55%	63%	-
Blood Pressure Control (<140/90)[6]	**85%**	63%	83%	83%	59%	60%	62%	74%
Eye Exams	**67%**	53%	68%	81%	53%	54%	69%	89%
Immunizations								
Influenza Shots - Adults (18–64)	**64%**	-	56%	57%	39%	48%	-	55%
Influenza Shots - Adults (65+)	**68%**	-	-	-	-	-	72%	76%
Immunizations: Pneumococcal	**68%**	-	-	-	-	-	71%	93%
Cancer Screening								
Colorectal Cancer Screening	**79%**	-	79%	82%	-	63%	67%	82%

1. Unless otherwise stated, data was collected in March 2017 by reviewing medical records from a sample of SOL's population of applicable patients. These random statistical sample sizes were based on a 95 percent confidence level with a 15 percent maximum margin of error.

2. HEDIS Medi-Cal data was obtained from the California Department of Health Care Services *2015 HEDIS Aggregate Report for Medi-Cal Managed Care*.

3. Data was obtained from Kaiser Permanente November 2016 reports for the Northern and Southern California regions.

4. National HEDIS data for Medicaid, commercial plans, and Medicare was obtained from the 2016 *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 VA's website, www.va.gov.
For the Immunizations: Pneumococcal measure only, the 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.

APPENDIX A — COMPLIANCE TEST RESULTS

California State Prison, Solano Range of Summary Scores: 64.15% – 92.50%	
Indicator	**Compliance Score (Yes %)**
1 – ***Access to Care***	74.48%
2 – ***Diagnostic Services***	69.26%
3 – ***Emergency Services***	Not Applicable
4 – ***Health Information Management (Medical Records)***	86.25%
5 – ***Health Care Environment***	66.14%
6 – ***Inter- and Intra-System Transfers***	67.29%
7 – ***Pharmacy and Medication Management***	64.15%
8 – ***Prenatal and Post-Delivery Services***	Not Applicable
9 – ***Preventive Services***	69.47%
10 – ***Quality of Nursing Performance***	Not Applicable
11 – ***Quality of Provider Performance***	Not Applicable
12 – ***Reception Center Arrivals***	Not Applicable
13 – ***Specialized Medical Housing (OHU, CTC, SNF, Hospice)***	92.50%
14 – ***Specialty Services***	70.03%
15 – ***Administrative Operations***	70.42%

Reference Number	1 – *Access to Care*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
1.001	Chronic care follow-up appointments: Was the patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter?	16	8	24	66.67%	1
1.002	For endorsed patients received from another CDCR institution: If the nurse referred the patient to a provider during the initial health screening, was the patient seen within the required time frame?	8	17	25	32.00%	0
1.003	Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received?	30	0	30	100%	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?	26	4	30	86.67%	0
1.005	Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter?	12	3	15	80.00%	15
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?	6	2	8	75.00%	22
1.007	Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame?	20	5	25	80.00%	0
1.008	Specialty service follow-up appointments: Do specialty service primary care physician follow-up visits occur within required time frames?	12	12	24	50.00%	6
1.101	Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms?	6	0	6	100%	0
Overall percentage:					**74.48%**	

Reference Number	2 – *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?	9	1	10	90.00%	0
2.002	Radiology: Did the primary care provider review and initial the diagnostic report within specified time frames?	9	1	10	90.00%	0
2.003	Radiology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	9	1	10	90.00%	0
2.004	Laboratory: Was the laboratory service provided within the time frame specified in the provider's order?	9	1	10	90.00%	0
2.005	Laboratory: Did the primary care provider review and initial the diagnostic report within specified time frames?	7	3	10	70.00%	0
2.006	Laboratory: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	6	4	10	60.00%	0
2.007	Pathology: Did the institution receive the final diagnostic report within the required time frames?	5	5	10	50.00%	0
2.008	Pathology: Did the primary care provider review and initial the diagnostic report within specified time frames?	2	4	6	33.33%	4
2.009	Pathology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	3	3	6	50.00%	4
Overall percentage:					**69.26%**	

3 – *Emergency Services*

This indicator is evaluated only by case review clinicians. There is no compliance testing component.

Reference Number	4 – *Health Information Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated healthcare documents (provider progress notes) scanned within 3 calendar days of the patient encounter date?	10	0	10	100%	0
4.002	Are dictated/transcribed documents scanned into the patient's electronic health record within five calendar days of the encounter date?	1	0	1	100%	0
4.003	Are High-Priority specialty notes (either a Form 7243 or other scanned consulting report) scanned within the required time frame?	16	4	20	80.00%	0
4.004	Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge?	18	2	20	90.00%	0
4.005	Are medication administration records (MARs) scanned into the patient's electronic health record within the required time frames?	Not Applicable				
4.006	During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files?	21	3	24	87.50%	0
4.007	For patients discharged from a community hospital: Did the preliminary hospital discharge report include key elements and did a primary care provider review the report within three calendar days of discharge?	15	10	25	60.00%	0
Overall percentage:					**86.25%**	

Reference Number	5 – *Health Care Environment*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
5.101	Are clinical health care areas appropriately disinfected, cleaned and sanitary?	8	1	9	88.89%	0
5.102	Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	9	0	9	100%	0
5.103	Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	6	3	9	66.67%	0
5.104	Does clinical health care staff adhere to universal hand hygiene precautions?	5	3	8	62.50%	1
5.105	Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	8	1	9	88.89%	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?	0	1	1	0.00%	0
5.107	Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	9	0	9	100%	0
5.108	Do clinic common areas and exam rooms have essential core medical equipment and supplies?	5	4	9	55.56%	0
5.109	Do clinic common areas have an adequate environment conducive to providing medical services?	9	0	9	100%	0
5.110	Do clinic exam rooms have an adequate environment conducive to providing medical services?	2	7	9	22.22%	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?	3	4	7	43.86%	2
Overall percentage:					**66.14%**	

Reference Number	6 – *Inter- and Intra-System Transfers*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
6.001	For endorsed 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 patient arrived at the institution?	20	5	25	80.00%	0
6.002	For endorsed 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 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?	24	0	24	100%	1
6.003	For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption?	10	4	14	71.43%	11
6.004	For patients transferred out of the facility: Were scheduled specialty service appointments identified on the patient's health care transfer information form?	17	3	20	85.00%	0
6.101	For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents?	0	4	4	0.00%	0
Overall percentage:					**67.29%**	

Reference Number	7 – *Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.001	Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows?	6	14	20	30.00%	5
7.002	Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames?	13	12	25	52.00%	0
7.003	Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames?	15	10	25	60.00%	0
7.004	For patients received from a county jail: Were all medications ordered by the institution's reception center provider administered, made available, or delivered to the patient within the required time frames?	Not Applicable				
7.005	Upon the patient's transfer from one housing unit to another: Were medications continued without interruption?	17	8	25	68.00%	0
7.006	For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption?	2	2	4	50.00%	0
7.101	All clinical and medication line storage areas for narcotic medications: Does the Institution employ strong medication security over narcotic medications assigned to its clinical areas?	2	5	7	28.57%	2
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?	3	6	9	33.33%	0
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?	4	5	9	44.44%	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?	4	1	5	80.00%	4
7.105	Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients?	5	0	5	100%	4
7.106	Medication preparation and administration areas: Does the Institution employ appropriate administrative controls and protocols when distributing medications to patients?	4	1	5	80.00%	4

Reference Number	7 – *Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
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%	0
7.108	Pharmacy: Does the institution's pharmacy properly store non-refrigerated medications?	0	1	1	0.00%	0
7.109	Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications?	1	0	1	100%	0
7.110	Pharmacy: Does the institution's pharmacy properly account for narcotic medications?	1	0	1	100%	0
7.111	Does the institution follow key medication error reporting protocols?	25	0	25	100%	0
Overall percentage:					**64.15%**	

8 – *Prenatal and Post-Delivery Services*

The institution has no female patients, so this indicator is not applicable.

Reference Number	9 – *Preventive Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
9.001	Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed?	8	2	10	80.00%	0
9.002	Patients prescribed TB medication: Did the institution monitor the patient monthly for the most recent three months he or she was on the medication?	3	7	10	30.00%	0
9.003	Annual TB Screening: Was the patient screened for TB within the last year?	18	12	30	60.00%	0
9.004	Were all patients offered an influenza vaccination for the most recent influenza season?	24	1	25	96.00%	0
9.005	All patients from the age of 50 - 75: Was the patient offered colorectal cancer screening?	17	7	24	70.83%	0
9.006	Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy?	Not Applicable				
9.007	Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy?	Not Applicable				
9.008	Are required immunizations being offered for chronic care patients?	12	3	15	80.00%	9
9.009	Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	Not Applicable				
Overall percentage:					**69.47%**	

10 – *Quality of Nursing Performance*

This indicator is evaluated only by case review clinicians. There is no compliance testing component.

11 – *Quality of Provider Performance*

This indicator is evaluated only by case review clinicians. There is no compliance testing component.

12 – *Reception Center Arrivals*

The institution has no reception center, so this indicator is not applicable.

Reference Number	13 – *Specialized Medical Housing*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient on the day of admission, or within eight hours of admission to CMF's Hospice?	9	1	10	90.00%	0
13.002	For CTC and SNF only: Was a written history and physical examination completed within the required time frame?	10	0	10	100%	0
13.003	For OHU, CTC, SNF, and Hospice: Did the primary care provider complete the Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes on the patient at the minimum intervals required for the type of facility where the patient was treated?	8	2	10	80.00%	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 patient's cells?	1	0	1	100%	0
Overall percentage:					**92.50%**	

Reference Number	14 – *Specialty Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	Did the patient receive the high priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service?	15	0	15	100%	0
14.002	Did the primary care provider review the high priority specialty service consultant report within the required time frame?	14	1	15	93.33%	0
14.003	Did the patient receive the routine specialty service within 90 calendar days of the primary care provider order or Physician Request for Service?	14	1	15	93.33%	0
14.004	Did the primary care provider review the routine specialty service consultant report within the required time frame?	11	3	14	78.57%	1
14.005	For endorsed patients received from another CDCR institution: If the 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?	7	13	20	35.00%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	13	7	20	65.00%	0
14.007	Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame?	5	15	20	25.00%	0
Overall percentage:					**70.03%**	

Reference Number	15 – *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%	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%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	0	1	1	0.00%	0
15.005	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	8	4	12	66.67%	0
15.006	For institutions with licensed care facilities: Does the Local Governing Body (LGB), or its equivalent, meet quarterly and exercise its overall responsibilities for the quality management of patient health care?	2	2	4	50.00%	0
15.101	Did the institution complete a medical emergency response drill for each watch and include participation of health care and custody staff during the most recent full quarter?	1	2	3	33.33%	0
15.102	Did the institution's second level medical appeal response address all of the patient's appealed issues?	10	0	10	100%	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	1	3	66.67%	0
15.104	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	0	5	5	0.00%	0
15.105	Are nursing staff who administer medications current on their clinical competency validation?	10	0	10	100%	0
15.106	Are structured clinical performance appraisals completed timely?	1	9	10	10.00%	2
15.107	Do all providers maintain a current medical license?	12	0	12	100%	0
15.108	Are staff current with required medical emergency response certifications?	2	0	2	100%	1
15.109	Are nursing staff and the Pharmacist-in-Charge current with their professional licenses and certifications, and is the pharmacy licensed as a correctional pharmacy by the California State Board of Pharmacy?	6	0	6	100%	0

Reference Number	15 – *Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.110	Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	1	0	1	100%	1
15.111	Are nursing staff current with required new employee orientation?	1	0	1	100%	0
Overall percentage:					**70.42%**	

APPENDIX B — CLINICAL DATA

Table B-1: SOL Sample Sets	
Sample Set	**Total**
Anticoagulation	3
CTC/OHU	4
Death Review/Sentinel Events	3
Diabetes	3
Emergency Services – Non-CPR	3
High Risk	5
Hospitalization	4
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	16
Specialty Services	4
	51

Table B-2: SOL Chronic Care Diagnoses	
Diagnosis	**Total**
Anemia	8
Anticoagulation	6
Arthritis/Degenerative Joint Disease	6
Asthma	7
COPD	13
Cancer	11
Cardiovascular Disease	10
Chronic Kidney Disease	9
Chronic Pain	12
Cirrhosis/End-Stage Liver Disease	5
Deep Venous Thrombosis/Pulmonary Embolism	5
Diabetes	19
Gastroesophageal Reflux Disease	14
Hepatitis C	16
Hyperlipidemia	26
Hypertension	36
Mental Health	10
Migraine Headaches	1
Rheumatological Disease	1
Seizure Disorder	3
Sleep Apnea	3
Thyroid Disease	2
	223

Table B-3: SOL Event — Program

Program	Total
Diagnostic Services	168
Emergency Care	56
Hospitalization	39
Intra-System Transfers in	13
Intra-System Transfers out	5
Outpatient Care	438
Specialized Medical Housing	110
Specialty Services	260
	1,089

Table B-4: SOL Case Review Sample Summary

	Total
MD Reviews, Detailed	25
MD Reviews, Focused	1
RN Reviews, Detailed	15
RN Reviews, Focused	31
Total Reviews	72
Total Unique Cases	51
Overlapping Reviews (MD & RN)	21

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

California State Prison, Solano

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Access to Care			
MIT 1.001	Chronic Care Patients (25)	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • **Randomize**
MIT 1.002	Nursing Referrals (25)	OIG Q: 6.001	• See ***Intra-system Transfers***
MITs 1.003–006	Nursing Sick Call (6 per clinic) (30)	MedSATS	• Clinic (each clinic tested) • Appointment date (2–9 months) • **Randomize**
MIT 1.007	Returns from Community Hospital (25)	OIG Q: 4.007	• See ***Health Information Management (Medical Records)*** (returns from community hospital)
MIT 1.008	Specialty Services Follow-up (30)	OIG Q: 14.001 & 14.003	• See ***Specialty Services***
MIT 1.101	Availability of Health Care Services Request Forms (6)	OIG onsite review	• Randomly select one housing unit from each yard
Diagnostic Services			
MITs 2.001–003	Radiology (10)	Radiology Logs	• Appointment date (90 days–9 months) • **Randomize** • Abnormal
MITs 2.004–006	Laboratory (10)	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • **Randomize** • Abnormal
MITs 2.007–009	Pathology (10)	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • **Randomize**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Health Information Management (Medical Records)			
MIT 4.001	Timely Scanning (10)	OIG Qs: 1.001, 1.002, & 1.004	• Non-dictated documents • 1st 10 IPs MIT 1.001, 1st 5 IPs MITs 1.002, 1.004
MIT 4.002	(1)	OIG Q: 1.001	• Dictated documents • First 20 IPs selected
MIT 4.003	(20)	OIG Qs: 14.002 & 14.004	• Specialty documents • First 10 IPs for each question
MIT 4.004	(20)	OIG Q: 4.007	• Community hospital discharge documents • First 20 IPs selected
MIT 4.005	(0)	OIG Q: 7.001	• MARs • First 20 IPs selected
MIT 4.006	(6)	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.007	Returns From Community Hospital (25)	Inpatient claims data	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • **Randomize** (each month individually) • First 5 patients from each of the 6 months (if not 5 in a month, supplement from another, as needed)
Health Care Environment			
MIT 5.101–105 MIT 5.107–111	Clinical Areas (9)	OIG inspector onsite review	• Identify and inspect all onsite clinical areas.
Inter- and Intra-System Transfers			
MIT 6.001–003	Intra-System Transfers (25)	SOMS	• Arrival date (3–9 months) • Arrived from (another CDCR facility) • Rx count • **Randomize**
MIT 6.004	Specialty Services Send-Outs (20)	MedSATS	• Date of transfer (3–9 months) • **Randomize**
MIT 6.101	Transfers Out (4)	OIG inspector onsite review	• R&R IP transfers with medication

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Pharmacy and Medication Management			
MIT 7.001	Chronic Care Medication (25)	OIG Q: 1.001	*See* ***Access to Care*** • At least one condition per patient—any risk level • **Randomize**
MIT 7.002	New Medication Orders (25)	Master Registry	• Rx count • **Randomize** • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns from Community Hospital (25)	OIG Q: 4.007	• See ***Health Information Management (Medical Records)*** *(returns from community hospital)*
MIT 7.004	RC Arrivals – Medication Orders *N/A at this institution*	OIG Q: 12.001	• See ***Reception Center Arrivals***
MIT 7.005	Intra-Facility Moves (25)	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • **Randomize**
MIT 7.006	En Route (4)	SOMS	• Date of transfer (2–8 months) • Sending institution (another CDCR facility) • **Randomize** • NA/DOT meds
MITs 7.101–103	Medication Storage Areas (varies by test)	OIG inspector onsite review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–106	Medication Preparation and Administration Areas (varies by test)	OIG inspector onsite review	• Identify and inspect onsite clinical areas that prepare and administer medications
MITs 7.107–110	Pharmacy (1)	OIG inspector onsite review	• Identify & inspect all onsite pharmacies
MIT 7.111	Medication Error Reporting (25)	Monthly medication error reports	• All monthly statistic reports with Level 4 or higher • Select a total of 5 months
MIT 7.999	Isolation Unit KOP Medications (10)	Onsite active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in isolation units
Prenatal and Post-Delivery Services			
MIT 8.001–007	Recent Deliveries *N/A at this institution*	OB Roster	• Delivery date (2–12 months) • **Most recent** deliveries (within date range)
	Pregnant Arrivals *N/A at this institution*	OB Roster	• Arrival date (2–12 months) • **Earliest** arrivals (within date range)

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Preventive Services			
MITs 9.001–002	TB Medications (10)	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • **Randomize**
MIT 9.003	TB Code 22, Annual TST (15)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (22) • **Randomize**
	TB Code 34, Annual Screening (15)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (34) • **Randomize**
MIT 9.004	Influenza Vaccinations (25)	SOMS	• Arrival date (at least 1 year prior to inspection) • **Randomize** • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening (25)	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • **Randomize**
MIT 9.006	Mammogram *N/A at this institution*	SOMS	• Arrival date (at least 2 yrs prior to inspection) • Date of birth (age 52–74) • **Randomize**
MIT 9.007	Pap Smear *N/A at this institution*	SOMS	• Arrival date (at least three yrs prior to inspection) • Date of birth (age 24–53) • **Randomize**
MIT 9.008	Chronic Care Vaccinations (25)	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • **Randomize** • Condition must require vaccination(s)
MIT 9.009	Valley Fever (number will vary) *N/A at this institution*	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • **All**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Reception Center Arrivals			
MITs 12.001–008	RC *N/A at this institution*	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • **Randomize**
Specialized Medical Housing			
MITs 13.001–004	CTC (10)	CADDIS	• Admit date (1–6 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • **Randomize**
MIT 13.101	Call Buttons CTC (all)	OIG inspector onsite review	• Review by location
Specialty Services			
MITs 14.001–002	High-Priority (15)	MedSATS	• Approval date (3–9 months) • **Randomize**
MITs 14.003–004	Routine (15)	MedSATS	• Approval date (3–9 months) • Remove optometry, physical therapy or podiatry • **Randomize**
MIT 14.005	Specialty Services Arrivals (20)	MedSATS	• Arrived from (other CDCR institution) • Date of transfer (3–9 months) • **Randomize**
MIT 14.006–007	Denials (11)	InterQual	• Review date (3–9 months) • **Randomize**
	(9)	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • **Randomize**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Administrative Operations			
MIT 15.001	Medical Appeals (all)	Monthly medical appeals reports	• Medical appeals (12 months)
MIT 15.002	Adverse/Sentinel Events (0)	Adverse/sentinel events report	• Adverse/sentinel events (2–8 months)
MITs 15.003–004	QMC Meetings (6)	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.005	EMRRC (12)	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.006	LGB (4)	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills (3)	Onsite summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	2nd Level Medical Appeals (10)	Onsite list of appeals/closed appeals files	• Medical appeals denied (6 months)
MIT 15.103	Death Reports (3)	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.104	RN Review Evaluations (5)	Onsite supervisor periodic RN reviews	• RNs who worked in clinic or emergency setting six or more days in sampled month • **Randomize**
MIT 15.105	Nursing Staff Validations (10)	Onsite nursing education files	• On duty one or more years • Nurse administers medications • **Randomize**
MIT 15.106	Provider Annual Evaluation Packets (10)	OIG Q:16.001	• All required performance evaluation documents
MIT 15.107	Provider licenses (12)	Current provider listing (at start of inspection)	• Review all

MIT 15.108	Medical Emergency Response Certifications (all)	Onsite certification tracking logs	• All staff
			  ○ Providers (ACLS)
			  ○ Nursing (BLS/CPR)
			• Custody (CPR/BLS)

MIT 15.109	Nursing staff and Pharmacist in Charge Professional Licenses and Certifications (all)	Onsite tracking system, logs, or employee files	• All required licenses and certifications

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Administrative Operations			
MIT 15.110	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations (all)	Onsite listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 15.111	Nursing Staff New Employee Orientations (all)	Nursing staff training logs	• New employees (hired within last 12 months) •
MIT 15.998	Death Review Committee (3)	OIG summary log - deaths	• Between 35 business days & 12 months prior • CCHCS death reviews

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

September 5, 2017

Roy Wesley, Inspector General (A)
Office of the Inspector General
10111 Old Placerville Road, Suite 110
Sacramento, CA 95827

Dear Mr. Wesley:

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 (SOL) conducted from February 2017 to April 2017. California Correctional Health Care Services (CCHCS) acknowledges all OIG findings.

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

Sincerely,

Janet Lewis

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

cc: Clark Kelso, Receiver
Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Richard Kirkland, Chief Deputy Receiver
Ryan Baer, Senior Deputy Inspector General, OIG
Stephen Tseng, M.D., Chief Physician and Surgeon, OIG
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