Robert A. Barton
Inspector General

Office of the Inspector General

Salinas Valley State Prison
Medical Inspection Results
Cycle 4

November 2016

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

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Robert A. Barton
Inspector General

Roy W. Wesley
Chief Deputy Inspector General

Shaun R. Spillane
Public Information Officer

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EXECUTIVE SUMMARY

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

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

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

The OIG performed its Cycle 4 medical inspection at SVSP from March to May 2016. The inspection included in-depth reviews of 71 patient files conducted by clinicians, as well as reviews of documents from 399 patient files, covering 93 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 SVSP using 14 health care quality indicators applicable to the institution, made up of 12 primary clinical indicators and two secondary administrative indicators. To conduct clinical case reviews, the OIG employs a clinician team consisting of a physician and a registered nurse consultant, while compliance testing is done by a team of deputy inspectors general and registered nurses trained in monitoring medical policy compliance. Of the 12 primary indicators, seven were rated by both case review clinicians and compliance inspectors, three were rated by case review clinicians only, and two were rated by compliance inspectors only; both secondary indicators were rated by compliance inspectors only. See the *Health Care Quality Indicators* table on page *ii*. Based on that analysis, OIG experts made a considered and measured overall opinion that the quality of health care at SVSP was *inadequate*.

Health Care Quality Indicators

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

Overall Assessment: Inadequate

Overall Assessment Rating:

Inadequate

Based on the clinical case reviews and compliance testing, the OIG's overall assessment rating for SVSP was *inadequate*. Of the 12 primary (clinical) quality indicators applicable to SVSP, the OIG found none *proficient*, five *adequate*, and seven *inadequate*. Of the two secondary (administrative) quality indicators, the OIG found both *inadequate*. To determine the overall assessment for SVSP, the OIG considered individual clinical ratings and individual compliance question scores within each of the indicator categories, putting emphasis on the primary indicators. Based on that analysis, OIG experts made a considered and measured overall opinion about the quality of health care observed at SVSP.

Clinical Case Review and OIG Clinician Inspection Results

The clinicians' case reviews sampled patients with high medical needs and included a review of 1,609 patient care events.[1] Of the 12 primary indicators applicable to SVSP, ten were evaluated by clinician case review; none were *proficient*, four were *adequate*, and six were *inadequate*. When determining the overall adequacy of care, the OIG placed extra emphasis on the clinical nursing and provider quality indicators, as adequate health care staff can sometimes overcome suboptimal processes and programs. The opposite is not true, however; inadequate health care staff cannot provide adequate care, even though the established processes and programs onsite may be adequate.

Program Strengths — Clinical

- The institution had a daily provider handoff meeting prior to the morning huddle that was attended by all the medical providers, the Chief Medical Executive (CME), the Chief Physician and Surgeon (CP&S), and the utilization management nurse. Patients who were either currently pending discharge from an outside hospital or in the correctional treatment center (CTC) were discussed during this meeting. There was special emphasis on CTC patients who may need a higher level of care. In addition, providers received offsite laboratory, diagnostic, and specialists' reports to review and sign from the staff services analyst. Even though offsite reports were sometimes missing for review, this meeting helped mitigate any lapses in the transmission of medical information between SVSP and offsite locations.

Program Weaknesses — Clinical

- Processing diagnostic and specialty reports was problematic at SVSP. The specialty reports were often not retrieved or scanned into the electronic unit health record (eUHR). During the onsite inspection, the majority of providers reported having to call the offsite specialty

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

clinics or outside hospitals themselves in order to obtain hospital discharge summaries or specialist progress notes. The OIG clinicians also found some delays in the retrieval of diagnostic and specialty reports.

- The institution had difficulty with processing provider and nursing progress notes. Numerous cases were identified in which provider and nursing documents were missing from the eUHR.

- Medical service demands could not be met by the institution, as evidenced by severe problems with access to care found in nearly all aspects reviewed. Provider follow-ups regularly occurred late or did not occur at all. RN sick call access was inadequate, with delayed or missed visits. SVSP failed to provide timely access to care for patients or provide reliable follow-up care for those patients who had abnormal diagnostic test results. At the onsite inspection, the presence of severe backlogs on the provider schedules corroborated the case review findings.

- Clinical staff struggled to provide patients with follow-ups to specialty services within an acceptable time frame.

- The institution had a severe shortage of physicians. Despite its best efforts, SVSP has been unable to hire and retain qualified physicians. At the time of the onsite inspection, SVSP had three physician vacancies. Furthermore, SVSP had only three regular full time physicians and one full time registry physician onsite.

- Health Care leadership was not stable at SVSP. The current Chief Executive Officer (CEO) and the CP&S were both acting at the time of this case review. The current CME had been previously acting and had only become a full time regular CME a few weeks prior to the onsite inspection.

- Health care staff suffered from low morale. A few of the nurses attributed low morale to staffing shortages resulting in redirections and mandated overtime. Physicians attributed low morale to feelings of being overworked with perpetual scheduling backlogs with no end in sight. Physicians also complained of feelings of burnout. Several providers stated during the onsite inspection that they were considering leaving SVSP if the physician shortage did not improve.

- Nurses failed to consistently provide quality of care that was acceptable. Several cases were found in which nurses demonstrated an attitude of indifference toward patients' wellbeing. This occurred when nurses failed to act on or to implement provider orders.

- The institution did not have an adequate medication management process. The pharmacy did not consistently dispense medications as ordered by the provider. Medication nurses failed to implement orders in a timely manner and did not always reconcile medications with the

provider's order. As a result, medication errors as well as delays in patients receiving new or changed medications occurred.

- SVSP did not have a reliable process for communicating provider orders among departments, including medications and nursing care. Faxing was the primary method but there were problems with faxes, resulting in delays in notifying medication nurses of new orders, and notifying clinic nurses of orders for wound care and vital sign checks.

Compliance Testing Results

Of the 14 health care indicators applicable to SVSP, 11 were evaluated by compliance inspectors.[2] There were 93 individual compliance questions within those 11 indicators, generating 1,325 data points, testing SVSP's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[3] All 93 questions are detailed in *Appendix A — Compliance Test Results*. The institution's inspection scores in the 11 applicable indicators ranged from 45.2 percent to 92.0 percent, with the secondary (administrative) indicator *Internal Monitoring, Quality Improvement, and Administrative* Operations receiving the lowest score, and the primary indicator *Specialized Medical Housing (OHU, CTC, SNF, Hospice)* receiving the highest. Of the nine primary indicators applicable to compliance testing, the OIG rated one *proficient,* three *adequate,* and five *inadequate.* The two secondary indicators, which involve administrative health care functions, were both rated *inadequate*.

Program Strengths — Compliance

As the *SVSP Executive Summary Table* on page *viii* indicates, the institution's compliance ratings were *proficient,* scoring above 85 percent, in the following primary indicator: *Specialized Medical Housing (OHU, CTC, SNF, Hospice).* The following are some of SVSP's strengths based on its compliance scores on individual questions in all the primary health care indicators:

- Nursing staff reviewed patients' health care requests and conducted face-to-face visits with patients within required time frames.

- Patients received their radiology, laboratory, and pathology services within required time frames.

- Patients who transferred to SVSP from other CDCR facilities received their medication without interruption.

[2] The OIG's compliance inspectors are trained deputy inspectors general and 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.

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

- SVSP clinicians properly monitored patients taking tuberculosis medications.

The following is a strength identified within one of the secondary administrative indicators:

- SVSP's Quality Management Committee met monthly, evaluated program performance, and took action when improvement opportunities were identified, and there were methodologies in place to train staff collecting Dashboard data to ensure its accuracy.

Program Weaknesses — Compliance

The institution received ratings of *inadequate*, scoring below 75 percent, in the following five primary indicators: *Access to Care*, *Diagnostic Services*, *Health Care Environment*, *Pharmacy and Medication Management*, and *Specialty Services*. The institution also received *inadequate* scores in both secondary indicators. The following are some of the weaknesses identified by SVSP's compliance scores on individual questions in all the primary health care indicators:

- Providers did not conduct timely appointments with most of the patients the OIG sampled. This included patients who required a provider follow-up visit for chronic care conditions, patients who received a nurse referral to a provider upon transferring to SVSP, patients who had been referred to a provider by nursing staff due to the patient's request for service, and patients who returned from a specialty service appointment.

- Providers did not properly evidence their review of radiology reports, and did not always communicate the results to patients within required timeframes.

- Clinical health care staff did not always adhere to universal hand hygiene precautions, and control of exposure to blood-borne pathogens and contaminated waste in the institution's clinics was poor.

- Several clinics were lacking core equipment and essential supplies in the common areas and exam rooms, and they did not always have an environment conducive to providing adequate medical services.

- Several patients who suffered from chronic care conditions did not receive their medications as ordered, and half the patients sampled who were sent to an outside hospital and returned to the institution with new discharge medications did not receive their medication timely.

- Clinical staff assigned to clinical areas did not employ strong security controls over narcotic medications and did not follow proper protocols for storing non-narcotic medications. In

addition, the institution administrative controls and protocols when distributing medications to patients were poor.

- Providers did not timely review patients' high-priority and routine specialty service reports.

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

- The institution did not always complete required documentation for its Emergency Medical Response Review Committee meetings, and the warden and CEO did not always sign and date the approved meeting minutes.

- Providers did not receive performance appraisals or probation reports within required time frames.

The *SVSP Executive Summary Table* on the following page lists the quality indicators the OIG inspected and assessed during the clinical case reviews and objective compliance tests and provides the institution's rating in each area. The overall indicator ratings were based on a consensus decision by the OIG's clinicians and non-clinical inspectors.

SVSP Executive Summary Table

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

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

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

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

Population-Based Metrics

Population-based metrics showed that SVSP's State and national comparative performance was generally adequate for diabetes and for older adult influenza and pneumococcal vaccinations, but that SVSP has room for improvement regarding influenza vaccinations for younger adults and colorectal cancer screenings. Statewide, the institution outperformed Medi-Cal in all five diabetic measures and outperformed Kaiser, North Region, in four of the five diabetic measures, with Kaiser North outperforming SVSP in blood pressure control. However, SVSP only outperformed Kaiser South in three of five diabetic measures, with Kaiser South outperforming the institution in blood pressure control and eye exams. Nationally, SVSP outperformed Medicaid, commercial entities (based on data obtained from health maintenance organizations), and Medicare. The institution outperformed the United States Department of Veterans Affairs (VA) in two of four applicable measures, and matched the VA for blood pressure control, but performed less well in completing diabetic eye exams.

With regard to immunization measures, the institution had mixed results, performing poorly in comparison to all State and national health maintenance organizations for influenza immunizations for younger adults. SVSP outperformed both Medicare and the VA for influenza vaccinations to older adults. However, for pneumococcal vaccinations, the institution outperformed Medicare, but scored slightly below the VA. The institution was outperformed by all applicable State and national health care organizations for the colorectal cancer screening measure. However, the high patient refusal rates for both the influenza vaccinations for younger adults and colorectal cancer screening negatively affected the institution's performance.

Overall, SVSP's performance demonstrated by population-based metrics indicated that the comprehensive diabetes care and immunizations for older adults in comparison to State and national health care organizations was adequate. Immunizations for younger adults and colorectal cancer screenings were below average; however, the institution has room for improvement by making interventions to reduce the rate of patient refusals for these measures.

INTRODUCTION

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

Salinas Valley State Prison (SVSP) was the 25th medical inspection of Cycle 4. During the inspection process, the OIG assessed the delivery of medical care to patients for 12 primary clinical health care indicators and two secondary administrative health care indicators applicable to the institution. It is important to note that while the primary quality indicators represent the clinical care being provided by the institution at the time of the inspection, the secondary quality indicators are purely administrative and are not reflective of the actual clinical care provided.

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

ABOUT THE INSTITUTION

Salinas Valley State Prison primarily houses Levels 3 and 4, high-security inmates. The institution runs ten medical clinics where staff members handle non-urgent requests for medical services, and it treats inmates needing urgent or emergency care in the triage and treatment area (TTA), and provides inpatient care in the correctional treatment center (CTC). SVSP has been designated a "basic" care institution, located in a rural area away from tertiary care centers and specialty care providers whose services are likely to be used frequently by patients at higher medical risk. 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 reported by the institution, SVSP's vacancy rate among licensed medical mangers, primary care providers, supervisors, and nonsupervisory nurses was approximately 8 percent in March 2016, with the lowest vacancy rate being among nursing staff at 3 percent. However, vacancies among primary care providers were 33 percent. SVSP had three vacant nursing positions and nine additional nursing staff who were on long-term medical leave, as well as one redirected nurse. However, to help offset the staffing void, the institution employed ten registry nurses.

SVSP Health Care Staffing Resources as of March 2016

	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff		Totals	
Description	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Authorized Positions	5	4%	12	9%	11.5	8%	109.9	79%	138.4	100%
Filled Positions	2	40%	8	67%	10	87%	106.9	97%	126.9	92%
Vacancies	3	60%	4	33%	1.5	13%	3	3%	11.5	8%
Recent Hires (within 12 months)	2	100%	4	50%	6	60%	23	22%	35	28%
Staff Utilized from Registry	0	0%	2	25%	0	0%	10	9%	12	9%
Redirected Staff (to Non-Patient -Care Areas)	0	0%	0	0%	0	0%	1	1%	1	1%
Staff on Long-Term Medical Leave	0	0%	1	13%	2	20%	9	8%	12	9%

Note: SVSP's Health Care Staffing Resources data was not validated by the OIG.

As of March 7, 2016, the Master Registry for SVSP showed that the institution had a total population of 3,658. Within that total population, 3.2 percent were designated High-Risk, Priority 1 (High 1), and 7.9 percent were designated High-Risk, Priority 2 (High 2). The patients' assigned risk levels are based on the complexity of their required medical care related to their specific diagnoses, frequency of higher levels of care, age, and abnormal labs and procedures. High 1 has at least two high-risk conditions; High 2 has only one. High-risk patients are more susceptible to poor health outcomes than medium or low-risk patients. High-risk patients also typically require more health care services than do patients with lower assigned risk levels. The chart below illustrates the breakdown of the institution's medical risk levels at the start of the OIG medical inspection.

SVSP Master Registry Data as of March 7, 2016

Medical Risk Level	# of Inmate-Patients	Percentage
High 1	118	3.2%
High 2	290	7.9%
Medium	2,044	55.9%
Low	1,206	33.0%
Total	**3,658**	**100.0%**

Commonly Used Abbreviations

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

OBJECTIVES, SCOPE, AND METHODOLOGY

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

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

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

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

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

CASE REVIEWS

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

PATIENT SELECTION FOR RETROSPECTIVE CASE REVIEWS

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

1. The goal of retrospective chart review is to evaluate all aspects of the health care system. Statewide, high-risk and high-utilization patients consume medical services at a disproportionate rate; 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:* SVSP *Sample Sets*, the OIG clinicians evaluated medical charts for 71 unique inmate-patients. *Appendix B, Table B–4:* SVSP *Case Review Sample Summary*, clarifies that both nurses and physicians reviewed charts for 19 of those patients, for 90 reviews in total. Physicians performed detailed reviews of 30 charts, and nurses performed detailed reviews of 23 charts, totaling 53 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 37 inmate-patients. These generated 1,609 clinical events for review (*Appendix B, Table B–3:* SVSP *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 six chronic care patient records, i.e., three diabetes patients and three anticoagulation patients (*Appendix B, Table B–1: SVSP Sample Sets*), the 71 unique inmate-patients sampled included patients with 190 chronic care diagnoses, including 14 additional patients with diabetes (for a total of 17) and 2 additional anticoagulation patients (for a total of 5) (*Appendix B, Table B–2:* SVSP *Chronic Care Diagnoses*). The OIG's sample selection tool evaluated many chronic care programs because the complex and high-risk patients selected from the different categories often had multiple medical problems. While the OIG did not evaluate every chronic disease or health care staff member, the overall operation of the institution's system and staff were assessed for adequacy. The OIG's case review methodology and sample size matched other qualitative research. The empirical findings, supported by expert statistical consultants, showed adequate conclusions after 10 to 15 charts had undergone full clinician review. In qualitative statistics, this phenomenon is known as "saturation." The OIG asserts that the physician sample size of over 30 detailed reviews certainly far exceeds the saturation point necessary for an adequate qualitative review. With regard to reviewing charts from different providers, the case review is not intended to be a focused search for poorly performing providers; rather, it is focused on how the system cares for those patients who need care the most. Nonetheless, while not sampling cases by each provider at the institution, the OIG 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 *SVSP 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 March to May 2016, deputy inspectors general and registered nurses attained answers to 93 objective medical inspection test (MIT) questions designed to assess the institution's compliance with critical policies and procedures applicable to the delivery of medical care. To conduct most tests, inspectors randomly selected samples of inmate-patients for whom the testing objectives were applicable and reviewed inmate-patient 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 399 individual inmate-patients and analyzed specific transactions within their records for evidence that critical events occurred. Inspectors also reviewed management reports and meeting minutes to assess certain administrative operations. In addition, during the week of March 21, 2016, field inspectors conducted a detailed onsite inspection of SVSP's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,325 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 SVSP's plant infrastructure, protocols for tracking medical appeals and local operating procedures, and staffing resources.

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

SCORING OF COMPLIANCE TESTING RESULTS

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

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

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

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

After compiling the answers to the 93 questions, the OIG derived a score for each primary and secondary quality indicator identified above by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Based on those results, the OIG assigned a rating to each quality indicator of *proficient* (greater than 85 percent), *adequate* (between 75 percent and 85 percent), or *inadequate* (less than 75 percent).

DASHBOARD COMPARISONS

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

OVERALL QUALITY INDICATOR RATING FOR CASE REVIEWS AND COMPLIANCE TESTING

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

To derive an overall assessment rating 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 inmate-patients. Based on that analysis, OIG experts made a considered and measured overall opinion about the quality of health care observed.

POPULATION-BASED METRICS

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

MEDICAL INSPECTION RESULTS

PRIMARY (CLINICAL) QUALITY INDICATORS OF HEALTH CARE

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

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

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

The OIG physicians rated the overall adequacy of care for each of the 30 detailed case reviews they conducted. Of these 30 cases, 16 were *adequate*, and 14 were *inadequate*. In the 1,609 events reviewed, there were 624 deficiencies, of which 128 were considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

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

There were four adverse events identified in the case reviews at SVSP:

- In case 4, the patient had a known liver mass with abnormally elevated tumor markers. The oncologist recommended a referral to a specialty medical center for removal of the patient's liver mass. However, the provider ordered the evaluation with routine priority. Consequently, the patient was not seen at the tertiary treatment center for nearly two months. During this lengthy delay, the patient had a follow-up CT scan of the abdomen that showed his liver mass had increased in size. Due to the increased size, a surgical resection was no longer possible and had become surgically inoperable.

- In case 8, the patient was seen in the nurse line for a level-of-care assessment after he fell from his wheelchair. The nurse documented the patient was being cared for by three inmates. The nurse further documented the patient was unable to recognize his medications

and he was missing his eyeglasses, dentures, and most of his keep-on-person (KOP) medications. The patient was disoriented regarding time. He had an unsteady gait and needed a wheelchair. The nurse interviewed the patient's cellmate, who reported the patient was unable to clean himself after a bowel movement and he had stool on his clothes. Despite the nurse's own documentation and the cellmate's report, the patient was not sent to the triage and treatment area (TTA) to be evaluated for outpatient housing unit (OHU) placement. The nurse displayed an extreme departure from the standard of care when this staff member incorrectly documented the patient was stable and could return to housing. The nurse failed to act as an advocate for this patient. Due to this extreme lapse in medical care, the patient was not seen by any medical staff until five days later when he was sent to the TTA for a fall with head trauma. The patient died three weeks after his admission to the hospital.

- In case 12, the sick call triage nurse failed to recognize an emergent condition when the patient reported he had sudden loss of vision 17 days after his cataract surgery. The nurse made a routine referral to the primary care provider. Fortunately, the patient was seen by a provider two days later, and his vision was saved by an emergency corneal transplant.

- In case 29, the patient had recurring anemia. While the provider ordered an urgent lab test to check the patient's anemia, this test was never scheduled to be drawn at the laboratory. None of the providers noted this error, as this laboratory test was not reordered. As a result, the patient's anemia worsened and reached a critical level the following month, and required transfer to a community hospital for a blood transfusion.

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

ACCESS TO CARE

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

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(71.8%)

Overall Rating:
Inadequate

Case Review Results

The OIG clinicians reviewed 935 provider, nursing, specialty, and outside hospital encounters and identified 127 deficiencies relating to *Access to Care*. Of those, 89 were significant and placed the patient at risk of harm. Poor health care access affected nearly all aspects of health care delivery at SVSP. This access issue is discussed further in each relevant indicator. SVSP performed extremely poorly with regard to access to care, with a large number and high severity of deficiencies identified during this review. Therefore, this indicator was rated *inadequate*.

Provider-to-Provider Follow-up Appointments

SVSP performed poorly with provider-ordered follow-up appointments. These are among the most important aspects of the *Access to Care* indicator. Failure to accommodate provider-ordered appointments can often result in lapses in care or in patients being lost to follow-up. Not only was this deficiency identified in the vast majority of cases reviewed, but it often occurred several times in a single case. Follow-up appointments were not only late in many of cases, but dropped altogether. Very late or dropped follow-up appointments were identified in cases 10, 14, 17, 18, 19, 22, 28, 31, 32, and the following:

- In case 4, the patient was seen for a possible obstructive sleep disorder. The provider ordered a follow-up for later that month. The follow-up never occurred.

- In case 6, the patient was seen in the TTA for chest pain that radiated to the left side of his chest and neck. The provider ordered a next-day follow-up for the patient. This follow-up never occurred.

- In case 23, the provider ordered a one-month chronic care follow-up for the patient. The follow-up did not occur for more than two months.

- In case 26, the patient was seen in the TTA for elevated blood sugar. The provider ordered a five-day follow-up for the patient. The follow-up did not occur for almost three weeks.

RN Sick Call Access

RN assessments for sick call requests did not occur on the next business day in cases 6 (three times), 13, 14, 15, 16, 19, 36, 55, and 59.

RN-to-Provider Referrals

RN referrals to the provider did not occur within the requested time frame in cases 6, 15, 17, 43, 50 (twice), 58, 59, 60, and 66.

Provider-to-RN Referrals

- In case 4, the RN follow-up for the patient's cough never occurred.

- In case 14, the patient should have had an RN follow-up after he returned from surgery. This follow-up never occurred. The patient was only seen by an RN after he submitted a sick call request.

- In case 19, the patient should have had an RN daily visit for three days to monitor his condition while he awaited transfer to a higher level of care, but one of the RN daily visits never occurred. This placed the patient at risk of harm.

Provider Follow-up After Specialty Service

SVSP usually provided patients with a provider follow-up after specialty services. The OIG clinicians reviewed 110 diagnostic and consultative specialty services and found only one instance in which a provider follow-up did not occur or was delayed.

Intra-System Transfers

Nurses assessed newly transferred patients and always referred them to a provider. The OIG clinicians reviewed 12 transfer-in patients and found no deficiencies with access to care in this area.

Follow-up After Hospitalization

SVSP generally ensured that providers saw their patients after return from an outside hospital or an emergency department. Among 27 hospitalization and outside emergency events, there were two deficiencies regarding access to care: cases 6 and 22. In case 22, there were delays in provider follow-up, and in case 6, the provider failed to follow up with the patient.

Urgent/Emergent Care

SVSP had significant difficulty ensuring a provider follow-up appointment for patients who were seen in the TTA or for patients for whom the on-call physician ordered a follow-up appointment. Most of these patients had a change in medical status and were at higher risk for medical complications. SVSP's failure to deliver provider follow-up care in these situations placed the patient at even higher risk. The OIG clinicians reviewed 100 encounters, 46 of which required a provider follow-up. The OIG clinicians found provider follow-up either did not occur or was delayed in cases 19, 23, 28, 31, 32, as well as the following three cases:

- In case 6, the patient was seen in the TTA for chest wall pain. The provider ordered a two-day follow-up for the patient, which never occurred. Two days later, the patient's condition worsened and required transportation to an outside ER. The patient had a diagnosis of chest wall cellulitis (skin infection) around his pacemaker site. The ER physician recommended the patient follow-up with his provider in two days. This follow-up also never occurred.

- In case 22, the patient was seen in the TTA for severe hypotension (low blood pressure). The provider ordered a next-day follow-up for the patient, but it never occurred.

- In case 26, the on-call provider ordered a five-day follow-up for the patient after he was seen in the TTA for swelling and numbness of his foot. This follow-up did not occur for ten days.

Specialized Medical Housing

SVSP performed adequately with provider access during and after admission to the correctional treatment center (CTC). A provider usually saw CTC patients at appropriate intervals. The OIG clinicians reviewed eight CTC admissions with 97 CTC provider encounters. There were eight instances in which a provider did not timely perform CTC rounds within the every-72-hour policy requirement. All eight instances occurred in case 29.

Specialty Access

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

Clinician Onsite Inspection

Problems with access to care were widespread at SVSP. The most significant problem was with provider vacancies. This problem is discussed further in the *Quality of Provider Performance* indicator. SVSP had only three regular full-time physicians and one full-time registry physician at the time of the onsite inspection. The lack of providers posed significant challenges for the institution to provide adequate care. A tremendous backlog of patients had resulted from this problem. At the time of the onsite inspection, A and B yards had a significant backlog in patient appointments. During the meeting with the chief medical executive (CME) and the chief physician and surgeon (CP&S), the CME stated the overall institutional backlog of patients had been nearly

650 in January 2016. However, this backlog had decreased to around 400 patients at the time of the onsite inspection. The CME also stated that once a week, an additional provider went to A yard to help reduce the backlog of patient appointments.

Another problem identified at the onsite inspection was the poor performance of the scheduling staff. The majority of the schedulers interviewed were new to the position. Most of the staff were unable to provide the OIG clinicians a reason for the backlogs at SVSP. Staff were also uncertain as to how this issue could be resolved.

Clinician Summary

SVSP demonstrated a profound inability to provide patients with adequate access to care. The OIG clinicians found problems in virtually all areas, including critically important patient care areas. There were severe problems with provider follow-ups, sick call access, nurse-to-provider referrals, and TTA follow-ups. SVSP had identified several reasons for its poor performance in this indicator. Of critical importance was SVSP's shortage of providers and extreme difficulty with recruitment and retention of qualified physicians. This inadequate staffing at SVSP led to an institutional backlog of over 400 patients at the time of the onsite inspection, and contributed to the *inadequate* rating of this indicator.

Compliance Testing Results

The institution received an *inadequate* compliance score of 71.8 percent in the *Access to Care* indicator, scoring in the *inadequate* range in the following four tests:

- Of the 30 sampled patients who transferred into SVSP from other institutions and were referred to a provider for a routine appointment based on nursing staff's initial health care screening of the patient, only 11 (37 percent) were seen timely. Sixteen patients' appointments occurred from 7 to 121 days late. There was no evidence found in the eUHR that three other patients were seen by a provider (MIT 1.002).

- Inspectors sampled 29 patients who received a specialty service; only 12 of them (41 percent) received a timely follow-up appointment with a provider. Fifteen patients received an appointment from 2 to 37 days late. There was no evidence in the eUHR that a provider conducted follow-ups with two patients (MIT 1.008).

- When the OIG reviewed recent appointments for 30 patients with chronic care conditions, only 20 of the patients (67 percent) received timely routine appointments. Eight patients' appointments occurred from 4 to 60 days late. Two other patients did not receive a follow-up appointment (MIT 1.001).

- Among 21 health care service requests sampled on which nursing staff referred the patient for a provider appointment, only 14 of the patients (67 percent) received a timely appointment. For six patients, the follow-up appointment occurred from one to 21 days late.

For one other patient, there was no evidence found in the eUHR that an appointment occurred (MIT 1.005).

SVSP performed in the *adequate* range in the following tests:

- Inmates had access to Health Care Services Request forms (CDCR Form 7362) at five of the six housing location units inspected (83 percent) (MIT 1.101).

- Of the 30 sampled patients who had been discharged from a community hospital, 24 (80 percent) either received a timely follow-up appointment with a provider or refused the follow-up visit. The remaining six patients received a provider follow-up appointment from one to six days late (MIT 1.007).

- Of the nine patients whom nursing staff referred to a provider and for whom the provider subsequently ordered a follow-up appointment, seven of them (78 percent) received their follow-up appointments timely. One patient received his follow-up appointment one day late. For the other patient, there was no evidence in the eUHR that the provider had seen the patient (MIT 1.006).

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

- Inspectors sampled 30 CDCR Form 7362s submitted by patients across all facility clinics. Nursing staff reviewed all service request forms on the same day they were received (MIT 1.003).

- Nursing staff completed a sick-call face-to-face encounter within one business day of reviewing (or receiving) the request for 28 of 30 patients (93 percent). For one patient, inspectors were unable to locate the registered nurse SOAPE notes and nursing encounter form. For one other patient, the patient refused the appointment, but nursing staff did not complete a refusal form (MIT 1.004).

Recommendations

No specific recommendations.

DIAGNOSTIC SERVICES

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(65.6%)

Overall Rating:
Inadequate

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

Case Review Results

The OIG clinicians reviewed 223 diagnostic-related events and found 56 deficiencies. Of those 56 deficiencies, 31 were related to health information management and 18 were related to ordered tests not being completed. Further discussed in the *Health Information Management* indicator, test reports that were never retrieved or reviewed were considered just as severe a problem as tests that were not completed as ordered.

SVSP often failed to perform diagnostic services in a timely manner and to perform diagnostic tests as ordered by the provider. The failure to diagnostic tests is a serious deficiency that can potentially lead to significant delays or even lapses in medical care. SVSP errors that involved tests that were not completed as ordered were frequent, but were more likely to occur when tests had been ordered within a scheduled processing time frame.

In cases 4, 13, and the four cases below, laboratory tests were ordered by the provider but not performed; the orders for these lab tests were never processed by the laboratory:

- In case 20, the provider ordered a urinalysis on three separate occasions, but none of the tests were completed.

- In case 22, the provider ordered an electrolyte panel within four days after the patient was seen in the ER for hypotension (low blood pressure). This test was never completed.

- In case 24, the patient was on an anticoagulation medication (a blood thinner) to prevent further blood clots in his leg. The clinical pharmacist ordered an INR test (a laboratory test used to monitor patients on blood-thinning medications) in five days. This test never occurred. This failure increased the patient's risk of developing additional blood clots. Several additional INR tests ordered by the provider were also never completed.

- In case 29, a stat lab test (an urgent lab test performed and reported within hours) was ordered by the provider but was never drawn by the laboratory. This was a significant deficiency as the patient had advanced multiple myeloma (bone marrow cancer) with multiple episodes of severe anemia that required him to be transferred to the ER for blood transfusions. The patient's blood count was later found to have decreased to a critically low level.

Mild to moderate delays in the collection of labs were found in cases 4, 6, 23, 24, 27, and the following:

- In case 25, the clinical pharmacist ordered an INR test for a patient on an anticoagulation medication. The test was not completed within the time frame requested by the clinical pharmacist. When the test was eventually completed, the result showed the patient was above the therapeutic range for treatment. The patient's high level would have been discovered sooner if the INR test had been completed within the requested time interval.

Health Information Management

Laboratory reports were not retrieved and scanned into the eUHR in cases 4, 14, 15, and 20.

Diagnostic reports that were illegibly signed, lacked a provider signature, or incorrectly dated were found in cases 4, 5, 14, 20, 21, and 22. Misfiled lab reports were found in case 19.

Delayed scans of diagnostic reports into the eUHR were found in cases 6, 14, 19, 21, 23, 24, 26, and 29. While these delays were moderate to significant, the majority were due to SVSP providers failing to consistently review test results in a timely manner. The quality of care was significantly affected in the case provided below:

- In case 14, medical records staff failed to timely scan the patient's CT report into the eUHR. This was a significant deficiency as the CT scan revealed an enlargement in the patient's liver tumor indicating probable liver cancer. The CT report was not available to the provider at the time of follow-up, which delayed initial treatment of the patient's liver cancer. One month later, the patient had a high-resolution CT scan. Medical records staff again failed to retrieve and scan the report into the eUHR.

Clinician Onsite Inspection

The OIG clinicians inquired about the high, recurring rate of failure to laboratory tests at SVSP. While the laboratory supervisor was not present, the health program manager (HPM) met with the OIG clinicians. The HPM conceded that delays in the processing of laboratory requests had occurred as well as the failure to laboratory tests ordered by providers, but there were no immediate plans for improvement at the time of the onsite inspection. SVSP had recently implemented a new position, the LVN care coordinator, in each yard clinic. The responsibilities of the LVN care

coordinators included ensuring laboratory and diagnostic tests for high-risk patients were completed as ordered, reviewed by the provider, and scanned into the electronic unit health record.

Clinician Summary

The onsite radiology tests were typically timely retrieved and scanned into the eUHR. However, SVSP performed poorly in laboratory services. There was a high, recurring rate of the laboratory failing to complete laboratory requests. The failure to complete laboratory requests as well as to retrieve and scan offsite radiology reports into the eUHR presented significant and ongoing risks for lapses in patient care. Therefore, the OIG clinicians rated this indicator *inadequate.*

Compliance Testing Results

The institution received an *inadequate* compliance score of 65.6 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

- In all ten of the radiology services sampled, the services were timely performed (MIT 2.001). However, providers only reviewed and signed one of the ten sampled diagnostic reports timely (10 percent). For eight samples, the TTA provider, not the patient's provider as policy requires, reviewed the radiology results. A provider reviewed one other report four days late (MIT 2.002). Lastly, providers only communicated the radiology results timely to three of the ten patients (30 percent). Providers communicated the results to the patients one to seven days late for six patients, and one other patient never received his results (MIT 2.003).

Laboratory Services

- Nine of ten sampled laboratory services were performed timely. One patient received his service one day late (MIT 2.004). Providers reviewed only seven of the ten laboratory reports (70 percent) within the required time frame. Three other reports were reviewed one day late (MIT 2.005). Finally, providers timely communicated eight of ten laboratory reports to the patient (80 percent). A provider communicated results to two patients one day late (MIT 2.006).

Pathology Services

- The institution timely received the final pathology report for all ten patients sampled (2.007). In addition, providers documented sufficient evidence that they timely reviewed the final report results for eight of the ten patients (80 percent); for one patient, the provider review was one day late, and inspectors found no evidence in the eUHR that one other report was reviewed (MIT 2.008). However, providers timely communicated the final pathology

test results to only three of the ten patients sampled (30 percent). For seven patients, providers communicated the pathology results from three to ten days late (MIT 2.009).

Recommendations

The OIG recommends SVSP designate at least one staff member to retrieve and scan all future offsite radiology reports into the eUHR to avoid further lapses in patient care.

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, clinical condition, and need for a higher level of care. The OIG reviews emergency response services including first aid, basic life support (BLS), and advanced cardiac life support (ACLS) consistent with the American Heart Association guidelines for cardiopulmonary resuscitation (CPR) and emergency cardiovascular care, and the provision of services by knowledgeable staff appropriate to each individual's training, certification, and authorized scope of practice.

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

Case Review Results

The OIG clinicians reviewed 100 urgent/emergent events and found 71 deficiencies. The majority of deficiencies were minor and did not affect patient outcomes. In general, SVSP performed adequately with BLS care, but there were some delays in 9-1-1 activation times. Overall, patients requiring urgent or emergent services received timely and adequate care, resulting in the *adequate* rating for this indicator.

Provider Performance

Refer to the *Quality of Provider Performance* indicator for details.

Nursing Performance

The nursing care provided during emergency medical response incidents was generally adequate. The OIG clinicians found 25 nursing deficiencies out of the 100 events. Most of the nursing deficiencies were minor and did not affect the patient's outcome. The following are examples of minor deficiencies:

- In case 3, licensed vocational nurses (LVNs) responded to a patient reporting he fell from the toilet and hit his head. He also said he might have fainted, and he complained of dizziness, headache, vomiting, and chest pain. The LVNs called the TTA RN, who directed them to transfer the patient to the TTA. The RN should have instructed the LVNs to apply a cervical collar, immobilizing the neck to protect the spinal cord, before transporting the patient. After the patient arrived in the TTA, the RN documented "no injuries found".

- In case 7 also, nurses moved the patient without a cervical collar and did not document an adequate examination of the neck and spine.

In cases 2, 3, and 10, the TTA nurse delayed calling 9-1-1 (emergency medical services, EMS).

In cases 3 and 10, the custody transportation team arrived after EMS, delaying the patient's departure to the local community emergency department.

In cases 4, 5, 6, 19, and 20, the RN assessments were incomplete, or vital sign monitoring was inadequate.

Documentation

A failure to describe the emergency response, including a timeline of events, was found three times in case 4, twice in cases 5 and 19, and once each in cases 7 and 8. In most of these cases, the first medical responder data collection tool forms were missing.

Emergency Medical Response Review Committee

The OIG clinicians reviewed the committee minutes for 11 emergency responses addressed by the committee. The committee reviewed all cases timely and correctly identified training issues.

Clinician Onsite Inspection

The institution's TTA was able to accommodate three patients at one time. During the onsite visit, the OIG clinicians found the patient care environment to have an adequate number of nurses for the usual triage and treatment area activities. Four housing yards at SVSP each had two special rooms for patients on suicide watch. RNs in the TTA were responsible for these patients' nursing needs. This included administering medications, monitoring vital signs, and making nursing rounds every two hours. The extra responsibility was difficult when the TTA was busy. The TTA had adequate supplies and equipment.

Conclusion:

The OIG clinicians rated the *Emergency Services* indicator as *adequate*.

Recommendations

No specific recommendations.

HEALTH INFORMATION MANAGEMENT (MEDICAL RECORDS)

Case Review Rating:
Adequate
Compliance Score:
Adequate
(79.4%)

Overall Rating:
Adequate

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

Case Review Results

Inter-Departmental Transmission

The institution performed adequately with interdepartmental transmission of information. Provider orders were appropriately noted by nurses and processed to the appropriate department, except in cases 19 and 29. The most significant error was identified in case 23 when the clinical pharmacist failed to tell the medical provider about the patient's rectal bleeding or request an immediate provider follow-up for the patient.

SVSP demonstrated a moderate pattern of missing documents across various areas of the institution. Missing documents included clinic provider notes, emergency first responder notes, clinic nursing notes, and medication administration records (MARs). Missing documents were identified in cases 2, 3, 4, 5, 6, 7, 19, 20, 31, and 32.

Dictated Progress Notes

Most providers used handwritten or self-typed progress notes, but sometimes they used dictation. When providers used dictation, occasional transcription delays were found. These deficiencies were identified in cases 25 and 29. In addition to transcription delays in case 29, a provider's note was also never transcribed.

Hospital Records

SVSP did very well with the retrieval of emergency department (ED) physician reports and hospital discharge summaries. The OIG clinicians reviewed 15 ED events and 12 community hospital events. All ED reports and discharge summaries were retrieved and scanned in a timely manner, except in case 29.

All hospital records were appropriately reviewed, dated, signed by a provider, and scanned into the eUHR.

Specialty Services

The institution performed poorly in the retrieval of specialty reports. These findings are discussed in detail in the *Specialty Services* indicator.

Diagnostic Reports

The OIG clinicians found several problems in the retrieval and scanning of diagnostic reports. Oftentimes, diagnostic reports were not scanned timely. These findings are discussed in detail in the *Diagnostic Services* indicator.

Urgent/Emergent Records

SVSP nurses sometimes did not properly document urgent and emergent encounters. Missing nursing documentation was identified in cases 5, 6, 7, 8, and 19.

Scanning Performance

The OIG identifies mistakes in the document scanning process as either mislabeled or misfiled documents. Erroneously scanned documents can create delays or lapses in care by hindering providers' ability to find relevant clinical information. SVSP performed adequately in this area, with only four deficiencies. Case reviewers found mislabeled documents in the eUHR in cases 31 and 32. Misfiled documents (filed in the wrong chart) were found in cases 21 and 70.

Scanning times for documents were generally good. However, a few cases were identified in which SVSP performed poorly, with providers' progress notes not being scanned timely into the eUHR. The delay in scanning was related to either provider delays in signing the progress notes or transcription delays by the dictation service. These deficiencies were identified in cases 23 and 29.

Documentation Quality and Legibility

Provider documentation was scant at times, with providers failing to document their thought processes and reasoning in progress notes. This often resulted in inadequate care.

Illegible progress notes, signatures, or initials were identified in cases 4, 5, 7, 13, and 32. Illegible progress notes pose a significant medical risk to patients, especially when other medical staff must review the medical care, or if a patient is transferred to a different care team.

Providers failed to sign progress notes or diagnostic reports in cases 2, 14, 17, 20, 22, 25, 30, 31, and 33.

Providers documented the incorrect date after having reviewed either a progress note or diagnostic report in cases 2, 4, 5, 18, and 20.

Clinician Onsite Inspection

The OIG clinicians observed clinical information transmission during the daily morning huddles. In addition, they interviewed various health care staff regarding how information was handled, especially pertaining to clinical care occurring after-hours. The process by which important after-hours clinical information was distributed during morning huddle was not consistent among SVSP care teams. While each clinic utilized a standard huddle report agenda every morning, relevant and in-depth discussion about patients who required after-hours care did not occur at every clinic huddle. The huddle discussion observed at one of the care teams was superficial, and care team members only mentioned if patients had a follow-up appointment or not. Patients who needed after-hours assessment were not discussed, and there was no discussion about whether these patients needed further intervention during the day.

However, the OIG clinicians discovered that an additional provider handoff meeting occurred daily prior to the morning huddle at SVSP. This meeting included the CME, the CP&S, all the medical providers, and the utilization management nurse. During this meeting, they discussed patients who were either currently pending discharge from an outside hospital or in the correctional treatment center (CTC). They placed special emphasis on those CTC patients who may have needed a higher level of care. The staff services analyst was also present to give providers offsite laboratory and diagnostic reports to review and sign. Therefore, this provider handoff meeting also helped mitigate any lapses in the transmission of medical information between offsite locations and SVSP.

Clinician Summary

SVSP had difficulty with document retrieval, which led to missing documents throughout all clinical areas. Provider documentation was often scant with providers failing to document their decision-making or thought process. The transmission of important after-hours and offsite clinical information was not consistent between each clinic's morning huddles. However, SVSP performed well with the retrieval of outside ER reports and hospital discharge summaries. Scanning times were acceptable overall. Legibility was only a minor issue during the case review period. In addition, providers generally initialed and documented the correct date after reviewing hospital records. Therefore, this indicator was rated as *adequate.*

Compliance Testing Results

The institution received an *adequate* score of 79.4 percent in the *Health Information Management* indicator. The institution performed at either the *adequate* or *proficient* level in the following areas:

- SVSP scored 95 percent for the timely scanning of dictated or transcribed provider progress notes into patients' eUHR files. Of 20 sampled provider-dictated progress notes, 19 were scanned timely. The only exception was one document, scanned eight days late (MIT 4.002).

- The institution scored 90 percent for the timely scanning of specialty documents into the eUHR. Eighteen of 20 sampled specialty service consultant reports were in compliance. Two were scanned one and two days late (MIT 4.003).

- Institution staff timely scanned 17 of 20 miscellaneous non-dictated documents, including provider progress notes, nursing initial health screening forms, and patient requests for health care services into the eUHR within three calendar days of the patient encounter date (85 percent). Three documents were scanned from one to three days late (MIT 4.001).

- The OIG reviewed eUHR files for 30 patients sent or admitted to the hospital to determine if an SVSP provider reviewed the patients' hospital discharge reports or treatment records within three calendar days of discharge. Providers timely reviewed the discharge records for 26 patients (87 percent). The provider reviewed four patients' discharge reports from one to four days late. (MIT 4.008).

- SVSP medical records staff timely scanned MARs into the patient's eUHR files for 16 of the 20 patients sampled (80 percent). Four patient's MARs were scanned between one and 13 days late (MIT 4.005).

- For each of the 20 hospital discharge reports sampled, SVSP staff scanned 16 reports into the eUHR within the required time frame, resulting in a score of 80 percent. Four reports were scanned from one to four days late (MIT 4.004)

SVSP scored in the *inadequate* range in the following areas:

- The institution scored 50 percent in its labeling and filing of documents scanned into patient's eUHR. The most common errors were mislabeled documents, such as a physician's order scanned and labeled as a MAR (MIT 4.006).

- When OIG reviewed various medical documents (hospital discharge reports, initial health screening forms, certain MARs, and specialty service reports) to ensure that clinical staff legibly documented their names on the forms, only 22 of 32 samples (69 percent) showed compliance (MIT 4.007).

Recommendations

No specific recommendations.

HEALTH CARE ENVIRONMENT

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

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(50.6%)

Overall Rating:
Inadequate

Compliance Testing Results

The institution received an *inadequate* compliance score of 50.6 percent in the *Health Care Environment* indicator, scoring poorly in the following nine test areas:

- SVSP's non-clinic medical storage areas did not meet the supply management process and support needs of the medical program. Specifically, inspectors found the storage areas had items stored on the floor, the temperature in several conex boxes exceeded the recommend storage temperature for several items, and a lack of staff in the medical warehouse. The institution scored zero in this area (MIT 5.106).

- Clinic common areas and exam rooms were sometimes missing core equipment or other essential supplies necessary to conduct a comprehensive exam. Only one of the 12 clinic locations (8 percent) was compliant. Eleven of the non-compliant clinic locations had one or more of the following deficiencies: hemoccult cards were missing in nine different clinic locations; lubricating jelly, nebulization units and bio-hazard waste receptacles were missing in five different clinic locations; and a Snellen eye chart, tongue depressors, and an oto-ophthalmoscope, was missing in three different clinic locations. In addition, two clinics did not have a peak flow meter, and two other clinics did not have an established line for the Snellen eye chart. Lastly, one clinic did not have a medication refrigerator, another clinic did not have a weight scale, and one other clinic had an Ophthalmoscope that was non-operational for over two months (MIT 5.108).

- Inspectors examined emergency response bags to determine if the bags were inspected daily and inventoried monthly, and whether they contained all essential items. The institution's emergency response bags were compliant in only two of eight applicable clinic locations inspected (25 percent). Six other bags had one or more of the following issues: Two of the six bags had empty oxygen tanks *(Figure 1)*, and

Figure 1: Empty oxygen tank

another bag had an oxygen tank that was below the required range. Two bags were missing glucose gel packs, and one other bag had an expired glucose gel pack. One of the bags was missing a set of blood pressure cuffs, and another bag was missing an inventory seal verification. Lastly, three of the emergency response bags did not have a monthly inventory log completed for February and March 2016 (MIT 5.111).

- Clinicians followed good hand hygiene practices in only four of ten inspected clinics (40 percent). In six clinic locations, clinicians and nurses failed to wash their hands prior to examining patients (MIT 5.104).

- Only 6 of 12 clinic locations inspected followed adequate medical supply storage and management protocols (50 percent). Medical supplies at six locations were not orderly or clearly identifiable, and one of the six clinic locations had food items stored in the medical supply storage cabinet (MIT 5.107).

- Only 7 of 12 clinics (58 percent) were compliant regarding proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste. Five clinics' provider and nurse exam rooms lacked sharps containers. One of those five clinics also had no designated biohazard storage area (MIT 5.105).

- The OIG inspected various exam rooms in each of the institution's 12 clinics, observing patient encounters and interviewing clinical staff, to determine if appropriate space, configuration, supplies, and equipment allowed clinicians to perform proper clinical exams. The exam rooms or treatment spaces in only 7 of the 12 clinics (58 percent) were sufficient. Four clinics' exam tables had torn or cracked surfaces (*Figure 2*). One other clinic stored confidential medical records in an area that was visible and easily accessible (MIT 5.110).

Figure 2: Torn vinyl on exam table

- Eight of the 12 clinics examined (67 percent) were appropriately disinfected, cleaned, and sanitary. At four clinic locations, cleaning logs did not have a staff signature to confirm the clinic was cleaned for multiple days in February and March of 2016. (MIT 5.101).

- Only 8 of 12 clinics (67 percent) had adequate hygiene supplies available and operable sinks. Four clinics' inmate restrooms lacked antiseptic soap and disposable hand towels (MIT 5.103).

The institution scored well in the following tests:

- Health care staff at all 11 clinics using non-invasive medical equipment ensured the devices were properly sterilized and disinfected (MIT 5.102).

- Common areas at 10 of 12 clinics (83 percent) had an adequate environment conducive to providing medical services. Two clinics had only one bench in the waiting area, which was insufficient seating for patients during clinical appointments. For one of the two clinics, the vital signs station was also in close proximity to the patient waiting area, prohibiting auditory privacy (MIT 5.109).

Other Information Obtained from Non-Scored Results

The OIG gathered information to determine if the institution's physical infrastructure was maintained in a manner that supported health care management's ability to provide adequate health care. The OIG did not score this question. When OIG inspectors interviewed health care management, they did not identify any concerns. SVSP had two significant infrastructure projects underway. These two projects and anticipated completion dates are listed below (MIT 5.999):

- Statewide Medication Distribution Project: The project will provide appropriate space for medication storage and distribution. Construction began in March of 2015 with estimated completion in January 2017.

- Health Care Facility Improvement Project: Construction of a new ASU primary care clinic, pharmacy renovation and addition, and renovations of clinics for A, B, C, and D yards. Construction began in September 2015 with an estimated completion date of November 2016.

Recommendations

No specific recommendations.

INTER- AND INTRA-SYSTEM TRANSFERS

Case Review Rating:
Adequate
Compliance Score:
Adequate
(77.3%)

Overall Rating:
Adequate

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

Case Review Results

Clinicians reviewed 64 encounters for *Inter- and Intra-System Transfers*, including information from both the sending and receiving institutions. These included 50 hospitalization events, each of which resulted in a transfer back to the institution. The OIG identified 30 deficiencies, with six significant deficiencies (cases 3, 7, 14, 20, 21, and 22). In general, the inter- and intra-system transfer processes at SVSP were *adequate*. The following are examples of deficiencies in this indicator:

Transfers In

The RN did not weigh the patients in cases 34, 35, and 36.

- In case 34, the patient's diagnoses included high blood pressure, chronic obstructive pulmonary disease, and mouth pain. The nurse did not check the patient's blood pressure and pulse, did not measure peak flow (lung capacity), and did not examine the patient's mouth to ensure there were no signs of infection.

Transfers Out

The OIG clinicians found deficiencies with some transfer documents. Omissions of critical medical information were found in cases 39, 60, and the following:

- In case 38, the RN did not document on the intake forms the abnormal lab results that were reported to the institution the previous day, and did not list the patient's medical equipment. The RN did not list three pending specialty referrals, but all were completed on time at the receiving institution.

Intra-Facility Transfers

- In case 8, the patient's asthma medication inhalers were not sent with him when he transferred between yards at the prison.

- In case 10, the patient did not receive his KOP medications until four days after he transferred to another yard.

Hospitalizations

Patients returning from hospitalizations are often high risk because they have severe illnesses or injuries. They are at risk due to potential lapses in care that can occur during any transfer. The examples below reflect problems found in other indicators with medication management, wound care, and failure to implement provider orders:

- In case 14, the patient returned to SVSP after nine days in the hospital. Medications were ordered to be self-administered. The patient returned on a Thursday holiday, but the pharmacy dispensed the medications on the next Monday. The nurse failed to obtain his essential medications from the Omnicell (electronic medication storage), so the patient did not receive his medications for four days.

- In case 22, orders for a follow-up nursing visit, dressing changes and daily vital signs were not implemented.

- The nurse did not obtain wound care orders in cases 7, 20, and 22.

- Medication orders were not implemented correctly or timely after the patient's return in cases 3, 21, and 22.

Clinician Onsite Inspection

The nurse's room in the reception and receiving area was very small and cluttered. The room did not have an examination table. The nurse explained that if a patient needed a full assessment, the nurse sent the patient to the triage and treatment area for evaluation. If medications were needed, such as insulin or asthma medications, the RN obtained them from Omnicell or the correctional treatment center stock medications.

Conclusion

Overall, the transfer processes at SVSP were *adequate*. The failure of clinic nurses to implement orders received upon the patient's return from hospitalization is also discussed in the *Quality of Nursing Performance* indicator. The medication problems are also discussed in the *Pharmacy and Medication Management* indicator.

Compliance Testing Results

The institution obtained an *adequate* score of 77.3 percent in the *Inter- and Intra-System Transfers* indicator. SVSP performed in the *proficient* range in the following two tests:

- Nursing staff timely completed the assessment and disposition sections of the Initial Health Screening form (CDCR Form 7277) for 29 of the 30 sampled patients (97 percent). For one patient, nursing staff did not sign the form (MIT 6.002).

- Out of 30 sampled patients transferring into the institution, only 23 had an existing medication order upon arrival. Inspectors tested those patients' records to determine if they received their medications without interruption. Twenty-one patients (91 percent) received their medications timely. However, two patients missed the evening dose of their directly observed therapy (DOT) medication (MIT 6.003).

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

- The OIG tested ten patients who transferred out of the institution during the onsite inspection to determine whether their transfer packages included required medications and corresponding documentation; eight of the patients had prescribed medications and were, therefore, subject to the test. Based on the review, the transfer packages for six sampled patients (75 percent) were compliant. For the other two patients, nursing staff did not ensure the patients had their KOP medications prior to clearing the patients for transfer (MIT 6.101).

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

- The OIG tested 20 patients who transferred out of SVSP to another CDCR institution to determine whether scheduled specialty service appointments were listed on the Health Care Transfer Information form (CDCR Form 7371). Staff identified the scheduled appointments on the transfer forms for only 12 patients sampled (60 percent) (MIT 6.004).

- Inspectors sampled 30 patients who transferred into SVSP from other institutions to ensure that each patient received a timely health screening assessment upon arrival at the institution. Nursing staff properly completed the transfer information form for only 19 of the arriving patients (63 percent). For 11 patients, they either neglected to answer all screening

questions or neglected to document additional information required to supplement the answers to some questions (MIT 6.001).

Recommendations

No specific recommendations

PHARMACY AND MEDICATION MANAGEMENT

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(67.4%)

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 provider prescriber, staff, and patient.

Case Review Results

The OIG clinicians evaluated pharmacy and medication management as secondary processes as they relate to the quality of clinical care provided. There were significant problems at SVSP with implementing medication orders correctly and timely. There were 59 events with 59 deficiencies, 20 of which were significant. The OIG identified errors with pharmacists not dispensing medications as ordered and nurses not administering medications as ordered. These problems resulted in an *inadequate* rating for this indicator.

The institution demonstrated inconsistency in properly dispensing and administering medications:

- In case 3, the provider ordered nortriptyline (antidepressant and pain medication) 50 mg at bedtime discontinued, then 25 mg daily administered for three days, and then discontinued permanently. Instead, nurses incorrectly administered both doses on the first evening, for a total of 75 mg. Nurses then continued to administer 25 mg for two days after it should have been discontinued.

- In case 5, the TTA provider ordered dexamethasone (steroid) daily for three doses with the first dose to be given immediately. The TTA nurse administered the first dose, and nurses in the yard administered three more doses, one more than ordered.

- In case 7, the provider ordered the nurse to administer fluconazole (anti-fungal medication). The pharmacy filled the order as KOP, and the nurse gave the 30-day supply of medication to the patient. The nurse failed to reconcile the MAR with the order before giving the medication to the patient.

- In case 12, after the patient's emergency corneal transplant, the pharmacy did not dispense the anti-inflammatory eye medication needed after surgery. This delayed the patient

receiving the medication for five days. This delay placed the patient at risk of transplant rejection.

- In case 13, the patient requested a refill of medication for diarrhea, but the nurse obtained a refill of a stool softener. In addition, the nurses inappropriately offered the patient pain medication that had been discontinued. Fortunately, the patient refused the medication.

- In case 16, the pharmacy did not dispense the patient's rash cream until the provider rewrote the order 13 days later. In addition, after the provider wrote a second order, nurses failed to notify the provider when the patient refused treatment. The rash worsened and developed into a wound requiring twice-daily care.

- In case 18, the provider ordered an asthma inhaler to be administered by the nurse. The pharmacy dispensed the inhaler as KOP, and the medication nurse gave it to the patient. In addition, the pharmacy did not dispense the inhaler until six days after the provider ordered the medication.

- In case 19, both the pharmacy and the nurses were responsible for medication errors. A provider order increased lisinopril (blood pressure medication), but this was not implemented for three weeks. A later order decreasing lisinopril was not implemented for more than two weeks.

- In case 20, the provider ordered an antibiotic to start as soon as possible for a wrist infection. The one-day delay in starting the antibiotic may have led to the infection worsening and required hospitalization the next day.

- In case 21, the patient returned from hospitalization for a severe elevation in blood pressure. Upon his return, there was an inappropriate three-day delay in obtaining his blood pressure medication. In addition, the nurses failed to monitor his blood pressure upon his return.

- Also in case 21, nurses continued to administer the patient's blood pressure medication after the he had picked up his own KOP supply. The patient received twice the ordered amount for six days.

- In case 55, Humira (medication for ulcerative colitis (inflammation of the bowel)) was not administered as ordered. The specialty provider recommended Humira, but the patient did not receive the first dose for over two months. In addition, the nurse administered an incorrect initial dose, and the subsequent doses were not given every two weeks as ordered. Because of the delay, the patient experienced abdominal pain and rectal bleeding.

- In case 61, the patient had an ear infection. Despite two separate antibiotic orders, the patient did not receive the medication and was paroled with an active ear infection and no antibiotics.

- Nurses failed to notify the provider when the patient was non-compliant with his medications in cases 13, 14, and 16.

Medication Continuity

Problems with medication continuity occurred for patients who returned to the institution from a hospitalization or transferred from yard to yard within the institution, and when medications were ordered during a TTA visit. Lapses in medication continuity in these areas are further discussed in the *Inter- and Intra-System Transfers* and *Emergency Services* indicators.

Clinician Onsite Inspection

During staff interviews, the medication nurses reported low morale for nurses whose assignments had been changed from working directly with patients to administering medications. The nurses also reported working mandatory overtime.

SVSP did not have an effective process for communicating provider orders to the medication nurses. Staff in the clinics, reception and receiving area, triage and treatment areas, and other provider areas often faxed new orders to the pharmacy and the medication rooms on the yards. However, not every clinic had a fax machine and the fax machines alone were not reliable as they malfunctioned. The printed orders accumulated in a stack with other documents, and medication nurses were not notified when a faxed order was received. Medication nurses stated they always reconciled medications and MARs with the orders, however, case reviews showed that nursed did not always complete the reconciliations.

Conclusion

The pharmacy failed to consistently fill provider orders accurately and timely. Nurses failed to utilize the Omnicell after-hours to administer essential medications such as antibiotics, causing delays in treatment. Medication nurses failed to track new orders until the medication was received, and did not reconcile new medications with MARs and the provider orders. These significant deficiencies placed patients at SVSP at risk for harm and led to the *inadequate* rating for this indicator.

Compliance Testing Results

The institution received an *inadequate* compliance score of 67.4 percent in the *Pharmacy and Medication Management* indicator. For discussion purposes below, this indicator is divided into three sub-indicators: medication administration, observed medication practices and storage controls, and pharmacy protocols.

Medication Administration

For this sub-indicator, the institution received an *inadequate* average score of 50.3 percent.

- Nursing staff timely dispensed chronic care medications to only 10 of the 24 patients sampled, scoring 42 percent. Six patients missed or refused a dose of their directly observed therapy critical medication, and did not receive provider counseling. Three patients received their KOP medication from one to 28 days late. Inspectors could not determine if two patients received their KOP medication because the MAR was not properly signed. For another patient, the provider did not refill the patient's medication timely, and another patient continued to receive his medication as nurse-administered after the patient received the same medication as KOP. One other patient was a no show for his medication, but nursing staff did not attempt to contact custody to get the patient to the medication line or get a reason why the patient could not come to the medication line (MIT 7.001).

- The institution timely provided hospital discharge medications to only 15 of 30 patients sampled who had returned from a community hospital (50 percent). For 13 patients, nursing staff provided the medication from one to 20 days late, and for another patient, there was no evidence in the eUHR that he received his medication. One final patient received one of his medications one day late, and never received one other medication (MIT 7.003).

SVSP received an *adequate* score in the following areas:

- Among the 30 sampled patients at SVSP who had transferred from one housing unit to another, 25 (83 percent) received their prescribed medications without interruption. Five patients did not receive their nurse-administered or directly observed therapy medications by the next dosing interval after the transfer occurred (MIT 7.005).

- SVSP timely administered or delivered new medication orders to 23 of 30 patients (77 percent). Two patients received their medication from 3 to 86 days late, and there was no eUHR evidence that two other patients received their new medication orders. Two more patients were "no shows" for the medication pill line, but nursing staff did not make an effort to contact custody to have the patient come to the medication line. One other patient received a new dosage of an existing medication, and the provider discontinued the prior dosage; however, the patient received both the new and the prior medication doses on the same day (MIT 7.002).

Observed Medication Practices and Storage Controls

For this sub-indicator, the institution received a score of 43.1 percent, scoring in the *inadequate* range in the following five tests:

- The OIG interviewed nursing staff and inspected storage areas specifically for the storage of narcotics at eight applicable medication line locations to assess whether strong narcotics

security controls existed. All eight had exceptions related to missing signatures in the narcotics log books in February and March 2016, indicating a habitual lack of physical shift inventories performed by nursing staff who safeguard the narcotics storage areas (MIT 7.101).

- Non-Narcotic medications requiring refrigeration were properly stored at only 2 of 12 locations inspected (17 percent). Of the ten medication line locations that were deficient, eight locations did not have a designated area for refrigerated medication awaiting return to the pharmacy. At three medication line locations, refrigeration temperature logs were missing required daily entries, or the log was not completed for the month, and one other location had logs with missing temperature readings, and had temperature readings outside of the range required by policy (7.103).

- Only two of seven applicable medication preparation and administration locations (29 percent) employed appropriate administrative controls and protocols when distributing medications to patients. At the remaining five locations; the institution was not equipped with appropriate physical structures to protect patients waiting outside to receive their medications during periods of extreme heat or inclement weather at three of the locations (Figure 3). At two locations, nursing staff did not verify the patients' identity by a form of picture identification; and nursing staff did not properly observe patients when performing self-injections at one other location (MIT 7.106).

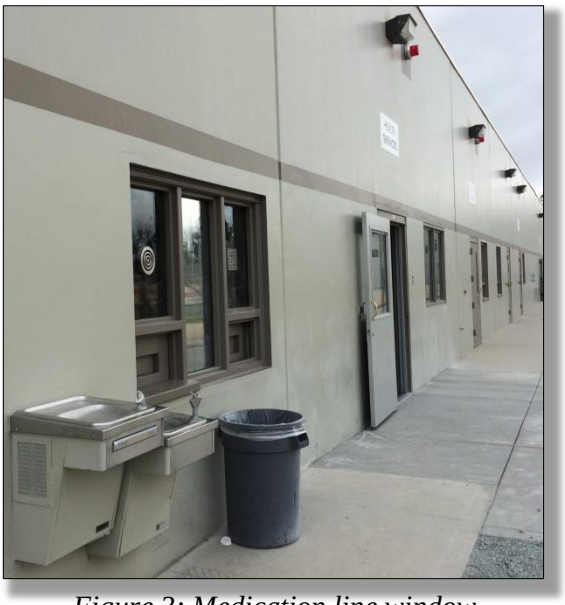

Figure 3: Medication line window without protection for patients from inclement weather

- Non-narcotic medications not requiring refrigeration were properly stored at only 8 of 19 applicable clinic and medication line storage locations (42 percent). Of the 11 deficient medication line locations, four locations had no system in place to temporarily store medications pending return to pharmacy. Four locations stored internal and external medications together, and four locations had medications stored in vials that had no "opened date" labels or had expired. Finally, one clinic had a broken locker for storing over-the-counter medication (MIT 7.102).

- Nursing staff at five of seven sampled medication preparation and administering locations (71 percent) followed proper hand hygiene contamination control protocols during the medication preparation and administration processes. Nursing staff at two medication line

locations did not sanitize their hands when required, such as prior to initially putting on gloves and before each subsequent re-gloving (MIT 7.104).

SVSP scored well on the following test:

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

Pharmacy Protocols

For this sub-indicator, the institution received *proficient* scores of 100 percent in the following tests:

- The institution's main pharmacy followed general security, organization, and cleanliness management protocols; properly stored non-refrigerated medications; and properly stored and monitored non-narcotic medications that require refrigeration (MIT 7.107, 7.108, 7.109).

- The SVSP pharmacist in charge documented and retained evidence of reviewed monthly narcotics inventory results for the institution's clinic and medication line storage locations (MIT 7.110). The pharmacist in charge also properly processed all 30 sampled medication error reports (MIT 7.111).

Non-Scored Tests

- In addition to testing reported medication errors, OIG inspectors follow up on significant medication errors found during the case reviews or compliance testing to determine whether errors were properly identified and reported. The OIG provides those results for information purposes only; however, at SVSP, the OIG did not find any applicable medication errors subject to 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 20 applicable inmates, and five claimed they did not have possession of their prescribed rescue medication. The OIG notified the institution that the five patients did not have their rescue inhalers, and the institution took steps to issue inhalers to the five patients (MIT 7.999).

Recommendations

No specific recommendations.

PREVENTIVE SERVICES

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

Case Review Rating:
Not Applicable
Compliance Score:
Adequate
(81.9%)

Overall Rating:
Adequate

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 *adequate* range in the *Preventive Services* indicator, with a compliance score of 81.9 percent. The institution performed in the *proficient* range on the following three tests:

- The institution was compliant in offering annual influenza vaccinations to all 30 sampled patients for the most recent influenza season (MIT 9.004).

- The institution offered colorectal cancer screenings to 26 of 30 patients aged 50 through 75 who were subject to the annual screening requirement (87 percent). Four patients were not offered a colon cancer-screening test within the previous 12 months (MIT 9.005).

- SVSP completed the required monthly tuberculosis (TB) monitoring for 19 of the 22 patients sampled (86 percent), but failed to be consistently document the patient's weight and applicable weight changes for two patients. For one other patient, there was no documentation of consultation for one month during the review period (MIT 9.002).

The institution scored in the *adequate* range in the following tests:

- The OIG tested whether patients who suffered from a chronic care condition were offered vaccinations for influenza, pneumonia, and hepatitis. At SVSP, 15 of 18 chronic care patients sampled (83 percent) received the recommended vaccinations at the required intervals for their chronic care conditions. For three patients, there was no evidence that pneumococcal vaccinations were offered within the last five years (MIT 9.008).

- SVSP scored 82 percent for timely administration of TB medications. Of the 22 patients sampled, 18 received all required doses of TB medication for the most recent three-month period. For three patients, there was no documentation to provide evidence the patients

received their medications. One patient was administered medication on the wrong day (MIT 9.001).

The institution showed room for improvement in the following area:

- OIG inspectors sampled 30 patients to determine whether they received a tuberculosis screening within the last year. Fifteen of the patients were classified as Code 34 (subject only to an annual signs and symptoms check), and 15 patients were classified as a Code 22 (requiring a skin test in addition to a signs and symptoms check). The institution scored only 53 percent for its ability to timely and properly conduct these annual tuberculosis screenings. More specifically, nurses timely screened 8 of 15 sampled Code 34 patients, leaving seven patients' history sections of the Tuberculin Testing/Evaluation Report (CDCR Form 7331) incomplete. For Code 22 patients, only 8 of 15 received properly completed nurse screenings. Four code 34 patients had their tuberculosis test read by a Licensed Psychiatric Technician, and CCHCS policy requires the test to be read by a registered nurse, public health nurse, or a provider; and nursing staff did not complete the history section of the CDCR Form 7331(MIT 9.003).

Recommendations

No specific recommendations.

QUALITY OF NURSING PERFORMANCE

***Case Review Rating**:*
Inadequate
***Compliance Score**:*
Not Applicable

Overall Rating:
Inadequate

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

Case Review Results

The OIG nursing clinicians rated the *Quality of Nursing Performance* indicator at SVSP *inadequate*. The OIG evaluated 473 nursing encounters, of which 280 were in the outpatient nursing setting. Overall, 98 quality of nursing deficiencies were found, with 22 deficiencies significant enough to place patients at risk for serious harm. In addition, several cases and patterns of deficiencies were found with the potential for or that actually caused adverse outcomes for patients.

The following is a significant deficiency that may have contributed to the patient's death.

- In case 8, the patient received extremely poor nursing care and indifference regarding his wellbeing. Soon after arrival, the patient developed an infection and the provider ordered a nursing visit to check on the patient the next day. The nurse visit did not occur. This was the first of several missed opportunities by nurses to assess the patient's mental and physical status as his condition deteriorated. When a nurse finally evaluated the patient, the nurse found he was confused and disoriented, was unable to care for himself, was not taking his medications, and was a high risk for falls. However, the nurse noted the patient was stable to remain in his current housing and did not notify the provider. Eventually, custody and a

mental health therapist informed the provider of the patient's condition. The provider planned to discuss the case with his supervisor to determine the appropriate level of care. The patient was still in regular housing when fell in his cell and sustained a head injury. He was admitted to a local hospital, where he died.

The following are examples of other significant deficiencies of outpatient nursing care that placed the patients at risk for harm:

- In case 12, nurses demonstrated poor judgment and did not provide adequate care. Three weeks after cataract surgery, the patient submitted a sick call request for an urgent eye problem. The nurse made a routine referral to the provider (to be seen within 14 days). The nurse's failure to recognize an urgent condition could have resulted in permanent loss of the patient's vision. Fortunately, the provider visit occurred two days later. The patient had a perforated cornea and required an emergency corneal transplant. Also, the evening prior to surgery, the nurse failed to advocate for the patient to be housed in the CTC so nurses could administer antibiotic eye drops throughout the night before the surgery. There was also a delay in administering eye drops after the surgery. This risked rejection of the corneal transplant. This error is also discussed in the *Pharmacy and Medication Management* indicator.

- In case 13, the TTA provider ordered daily nurse visits to monitor the patient's ankle cellulitis (skin infection). The first visit did not occur. After the patient submitted a sick call request on the second day, the nurse visited. The patient then required hospitalization for 11 days for wound treatment. After an initial stay in the CTC, he was discharged to regular housing with an order for daily dressing changes. Instead, nurses changed the dressing sporadically and then stopped altogether without a provider order, even though the wound had not healed. The provider ordered wound care again. Nurses did not implement the order until a week later, again after the patient submitted a sick call request. The provider ordered daily dressing changes the following month when there was still an open wound. The failure by the nurses to perform dressing changes as ordered likely contributed to the wound's slow healing, and placed the patient at risk for another wound infection.

- In case 14, the patient returned from a hospitalization for surgical treatment of liver cancer. Four days after his return, the patient submitted a sick call request for rectal bleeding. The nurse failed to assess the patient the same day for this urgent condition.

- In case 18, the nurse reviewed the patient's sick call request for another skin infection. The nurse failed to recognize the urgent/emergent symptom and did not assess the patient the same day. The patient then submitted a second sick call request, and the nurse performed a same-day assessment. The patient had cellulitis (infection of the skin), and three days later required hospitalization.

- In case 20, the patient was at high risk as he had recently completed treatment for prostate cancer. Nurses did not perform assessments for his complaints of urinary problems and did not follow up on urine lab tests. On the third sick call encounter, the nurse did not review the patient's medical record and so was not aware that his recent urine test showed a urinary tract infection. The nurse's failure to act resulted in a delay in treatment of the infection.

- In case 22, nurses did not provide adequate care. The patient had low blood pressure, dizziness, pain in his legs, and weakness. The nurse completed a level-of-care assessment and found the patient was at high risk for falls. The nurse failed to notify the provider or advocate for the patient to be transferred to housing that could provide a higher level of care for the patient's safety. When he returned from hospitalization for leg pain and inability to walk, he was sent back to regular housing. Nurses did not implement the provider's orders for daily vital signs, daily wound care, and another level-of-care assessment. The nurses demonstrated a significant departure from the standard of nursing care and placed the patient at significant risk for falls. This case is also discussed in the *Inter- and Intra-System Transfers* indicator.

- In case 61, the sick call nurse evaluated the patient for a recurrent ear infection with drainage and pain. The otoscope (instrument to visualize the eardrum) malfunctioned and the nurse could not properly examine the ear. The nurse called the medical supply department to have the otoscope repaired, and scheduled a follow-up nurse visit in two days. However, the nurse did not arrange to have the patient's ear examined the same day to ensure the eardrum had not ruptured.

The following cases had minor deficiencies in the quality of nursing care:

- In case 19, clinic nurses failed to follow up on an order to exchange the patient's cane with a walker. The provider had to write a second order 30 days later.

- In case 3, nurses did not assess the patient's sick call request regarding a finger injury nor the separate request for the complaint of new neck and knee pain.

- In case 6, nurses did not assess the patient's two sick call requests for evaluation of an abnormal growth on his back.

- In case 17, the nurse did not adequately assess the patient's sick call request for evaluation of stomach pain. In addition, the nurse noted that the patient appeared emaciated but did not weigh him.

Nurses also failed to perform adequate assessments for sick call requests in cases 7, 10, 19, 20, 21, 41, 44, 45, 46, and 53.

Wound care was not performed as frequently as ordered in cases 7, 18, and 20.

Nurses failed to implement provider orders, such as to check vital signs or remove sutures, in cases 5, 14, 19, and 21.

Nurse-to-provider referrals did not occur in cases 6, 50 (twice), 59, and 60.

Nurse-to-provider referrals occurred beyond the requested time frame in cases 15, 17, 43, 58, and 66.

Nurse sick call visits occurred beyond the required time frame in cases 13, 14, 15, 16, 36, and 55, and three times in case 6.

Clinician Onsite Inspection

The OIG clinicians visited all yard clinics with the exception of the minimum-security yard. The clinics were cluttered. Nurses reported that acquiring supplies and repairing equipment had improved with the hiring of new staff. Staff stated they received and sent orders and reports to other areas using several methods including fax, telephone, email, scan, and hand delivery. At least one clinic did not have a fax machine. The lack of an institution-wide process contributed to deficiencies whereby orders from the TTA were not implemented by clinic nurses, as well as other issues discussed in the *Pharmacy and Medication Management* indicator.

Most clinics had an RN and an LVN care coordinator to provide nursing care. During walking rounds, clinic nurses stated they were busy but were able to complete their work each day. One concern was the lack of consistency in nursing assignments. At least two nurses stated they were working that day in an area that was not their usual assignment. A few nurses stated they were recently required to work mandatory overtime. Nurses reported feeling supported by most supervising registered nurses and the chief nurse executive.

The care coordinator was a new position that had not been implemented during most of the OIG case review period. The care coordinator's responsibilities were to follow patients identified as high-risk. The coordinator ensured that provider and specialty visits occurred, lab specimens were collected, results were received, and orders were implemented. Care coordinators were expected to attend morning huddles and periodically meet with their patients. During the onsite inspection, the care coordinators described their responsibilities as resolving sick call requests for medication refills, performing dressing changes, taking vital signs, doing EKGs, administering injections, and generally assisting the RN as needed. The care coordinators were generally unclear about the responsibilities of their position due to a lack of specific written job descriptions defining their roles and responsibilities.

The nurses in the clinics reported there was no backlog of sick call requests. However, two sick call requests were found in the nurse's desk drawer on one of the yards. The requests were about a week old and had not been scanned, but the patients had been seen by a nurse.

Conclusion

Overall, the outpatient nursing care at SVSP was *inadequate*. Case reviews showed nurses failed to provide basic nursing care such as checking vital signs, changing dressings, and documenting the appearance of wounds. A lack of continuity in nurses' clinic assignments resulted in nurses who were not familiar with the patients in the yard. This likely contributed to many of the outpatient nursing deficiencies identified during case reviews. Most concerning, however, was the indifference shown by the nurses for the wellbeing of the patients, as shown in the examples included in this indicator.

Recommendations

No specific recommendations.

QUALITY OF PROVIDER PERFORMANCE

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

Case Review Rating:
Inadequate
Compliance Score:
Not Applicable

Overall Rating:
Inadequate

Case Review Results

The OIG clinicians reviewed 380 medical provider encounters and identified 137 deficiencies related to provider performance at SVSP. Of the 137 deficiencies identified, 29 were significant. As a whole, SVSP provider performance was rated *inadequate*.

Assessment and Decision-Making

The SVSP providers frequently failed to make sound assessments and accurate diagnoses. Poor assessment and misdiagnosis were found frequently throughout the cases reviewed. Many of the providers also made questionable medical decisions regarding patient care. Errors in provider assessment were identified in cases 4, 5, 6, 14, 20, 21, 23, 28, 31, and the following:

- In case 16, the provider failed to provide appropriate treatment for a patient with moderate, persistent asthma. Instead of following current guidelines for treating patients with poorly controlled asthma, the provider added only an allergy medication to the patient's asthma treatment.

- In case 19, the patient was given aspirin because the provider was concerned the patient was having a transient ischemic attack (transient stroke). However, the provider failed to first rule out a hemorrhagic stroke. If the patient had a hemorrhagic stroke, giving aspirin, a blood thinner, would worsen the patient's bleed.

- In case 22, the provider inappropriately discharged the patient back to the yard with orthostatic vital signs (unstable blood pressure). The patient was later transferred to the ER for very low blood pressure. This ER transfer was potentially preventable if the provider had transferred the patient to the CTC for further monitoring and treatment.

- In case 26, the provider failed to order an urgent MRI scan of the patient's foot and ankle. Instead, the MRI scan was ordered with routine priority. As a result, the patient was not timely diagnosed with an Achilles tendon tear, thereby increasing the patient's risk of more damage and a suboptimal recovery.

- In case 29, the provider failed to properly monitor or assess the patient's severe anemia. The provider should have ordered an urgent repeat lab test of the patient's blood count, at least. This failure to act placed the patient at an increased risk of an adverse event and resulted in a significant lapse in his medical care.

Review of Records

In cases 4, 21, and 30, the provider failed to thoroughly review the patient's medical record (eUHR). As a result, the provider unnecessarily repeated a laboratory test that the patient already received. There was also insufficient depth of review of medical records by providers in cases 4, 21, 24, 30, and the following:

- In case 18, on several encounters, the provider failed to review the patient's prior laboratory tests. Due to this oversight, the provider was not aware of the possibility of hepatitis, and this abnormal test result was never addressed in any of the patient's follow-up visits.

- In case 29, the provider incorrectly documented the patient's "anemia had improved steadily" when his anemia had actually worsened and his hemoglobin was critically low. The provider failed to order a repeat laboratory test of the patient's hemoglobin level. In addition, while the provider previously ordered this laboratory test, it was never completed. Other providers failed to recognize this error had occurred and were unaware of the patient's critically low hemoglobin.

Provider-Ordered Follow-up Intervals

The OIG clinicians found a strong pattern of providers not ordering appropriate follow-up intervals for their patients. This deficiency was found in cases 23, 28, 29, 31, and the following:

- In case 9, the provider ordered an inappropriate follow-up interval of one to two months when the patient should have been monitored more closely because he had significant pitting edema (swelling) of his leg, and he had recently started a diuretic.

- In case 16, the provider ordered an inappropriate follow-up interval of three months when the patient had moderate, persistent asthma that was not at goal.

- In case 18, the provider inappropriately ordered "follow-up as needed" when the patient still had forearm cellulitis (skin infection).

- In case 20, the medical provider ordered an inappropriate follow-up interval of one month when the patient required closer monitoring since he had cellulitis of his wrist with an associated fever.

- In case 30, the patient had surgical pins removed from his finger. Providers failed to order appropriate follow-up intervals after discovering the patient's wound site was not healing

properly. Furthermore, providers failed to order nurse follow-ups to monitor the patient's non-healing wound more closely. Due to the inappropriately long follow-up intervals and lack of monitoring, the patient developed a post-operative wound infection that resulted in osteomyelitis (bone infection) of that finger. The patient subsequently had to undergo a surgical debridement (removal of infected tissue). This case is also discussed in *Specialty Services* indicator.

Emergency Care

SVSP provider emergency care was marginally adequate. While assessments and decision-making were sometimes inaccurate and questionable, the providers in the TTA usually made appropriate decisions and sent patients to higher levels of care when indicated. This is further discussed in the *Emergency Services* indicator. Of the 100 TTA encounters reviewed, 20 errors in this category were attributable to providers, and 6 were significant (cases 4, 13, 19, 22 (twice), and 26).

- In case 4, the provider was considering a diagnosis of pulmonary embolism (blood clot in lung) in the patient, evidenced by the provider's ordering of a D-dimer (nonspecific laboratory test for blood clots). However, if the provider was concerned the patient had a pulmonary embolism, then the patient should have been given an injection of Lovenox (blood thinner) and transferred to an ER for a full evaluation. A negative D-dimer does not rule out a pulmonary embolism, so the patient was at serious risk of harm returning to his general housing area. The provider also failed to order a chest x-ray when the patient had been coughing and had shortness of breath.

- In case 20, the provider documented the patient had dangerously rapid heart rate and low blood pressure. The nurse in the TTA also documented the patient had a fever and required oxygen support. However, the provider failed to perform any intervention while the patient was in the TTA and discharged him back to general housing. The provider also failed to order a chest x-ray to further evaluate the patient's symptoms. Furthermore, the provider should have ordered nurse follow-ups to monitor the patient's blood pressure and heart rate while he was in general housing.

- In case 26, the provider failed to document a thorough exam of the patient's left foot and, therefore, failed to diagnose the patient with a left Achilles tendon tear while the patient was in the TTA.

Chronic Care

Chronic care performance was marginally adequate. SVSP providers demonstrated fair skill and knowledge in caring for patients even though a few providers struggled with patients who had complicated chronic medical issues. The majority of patients at SVSP were of low medical complexity and did not require management of HIV or hepatitis C treatment. Patients were properly

monitored and assessed with providers intervening when appropriate. The following cases demonstrated significant deficiencies:

- In case 23, the provider failed to recheck the patient's tachycardia (fast heart rate). Also, the provider failed to recognize the patient's tachycardia may have been caused by narcotics withdrawal since his morphine had not been renewed. Furthermore, the provider was aware the patient had a critically high triglyceride level, but never scheduled the patient for an immediate follow-up. Due to this failure, the patient's abnormally high triglyceride level was never addressed by any other provider during this period of review.

- In case 31, the provider failed to address or document the patient's tachycardia in multiple provider follow-ups. The provider should have assessed the patient to determine if he was symptomatic from his tachycardia and considered a work-up that included at least a laboratory test for hyperthyroidism, an EKG to capture the patient's heart rhythm, and a urine drug screen.

The following cases demonstrated minor deficiencies only:

- In case 19, the provider failed to monitor or address all of the patient's chronic medical issues, including asthma, glaucoma, coronary artery disease, and diabetes, during chronic care follow-ups.

- In case 22, providers failed to monitor or treat the patient's diabetes during this period of review. Annual surveillance exams, such as a diabetic eye or foot exams, were not ordered for this patient.

- In case 24, the provider failed to order a routine laboratory test to check if the patient's phenytoin (anticonvulsant) was at a therapeutic level to control his seizures. Other SVSP providers also failed to order a laboratory test to check the patient's phenytoin level during this period of review. Therefore, these providers failed to do a thorough review of the eUHR.

- In case 28, the provider failed to recognize the patient had a history of diabetes. This patient's diabetes increased his risk for heart disease and the need for cholesterol-lowering medication. By not following current guidelines for diabetes treatment, the provider increased the patient's risk of heart attack.

- In case 33, providers never addressed the patient's chronic care issues, such as his hepatitis C and glaucoma.

Diabetic management at SVSP was inadequate based on the limited number of events available for review. SVSP providers generally demonstrated poor diabetic management skills.

- In case 26, the provider should not have repeatedly increased the patient's insulin even though he was noncompliant with his diet and insulin. If the patient had become compliant with his diet, he was at risk of developing hypoglycemia on such high doses of insulin.

- In case 28, the patient's diabetes was poorly controlled as indicated by his progressively worsening blood sugar levels. Despite these test results, the provider ordered inappropriately long follow-up intervals for the patient. The first follow-up was in 60 days and the next was in 90 days. These follow-up intervals are typically used only for patients with well-controlled diabetes and not for patients with out-of-control diabetes who are at risk of associated harm.

Anticoagulation at SVSP was typically managed by the clinical pharmacist in the anticoagulation clinic. Both the clinical pharmacist and the providers monitored the patients' anticoagulation levels. The OIG clinicians did not identify any significant deficiencies with anticoagulation management by providers. However, a few errors in medication management were found. These findings are discussed separately in the *Pharmacy and Medication Management* indicator.

Specialty Services

SVSP providers appropriately referred patients for specialty services. Please refer to the *Specialty Services* indicator for further details.

Documentation Quality

Numerous instances of insufficient documentation were identified, the most common of which were failure to address one or more medical problems, acute medical issues, inadequate discussion to support the medical decision, or the lack of documentation altogether. Some of these errors negatively affected patient care. Insufficient documentation was identified in cases 4, 5, 6, 7, 14, 16, 18, 20, 21, 23, 24, 28, 31, 33, and the following:

- In case 13, the patient developed cellulitis of his foot, which required hospitalization and surgical debridement. The provider failed to document a thorough exam of the patient's wound after the patient was discharged from the hospital following his surgical procedure.

- In case 19, the provider inappropriately documented the patient's exam as normal when he actually had a lower leg fracture that required a controlled ankle motion walking boot and the use of a walker. The provider also should have performed a neurological exam since the patient had an elevated blood pressure and was complaining of headaches.

- In case 22, the provider incorrectly documented on the telephone-consultation progress note the patient had a normal physical exam when he actually had a hip wound that required nursing care. Furthermore, the provider failed to note the patient's blood pressure, which was important for a patient returning from the ER with orthostatic hypotension (unstable blood pressure).

- In case 30, the provider failed to document an exam of the patient's finger after he had surgical pins removed. The hand specialist later found the patient required surgical debridement because he had developed osteomyelitis of that finger.

- In case 32, the provider failed to document a physical exam of the tumor located on the right side of the patient's head.

The OIG clinicians also found evidence of "cloned" progress notes, on which outdated medical information was inappropriately carried forward to a current progress note. These cloned progress notes were identified in cases 4, 13, 19, 23, 29, and 32.

Provider Continuity

Case review found provider continuity to be adequate in a majority of the outpatient cases reviewed. However, poor provider continuity was demonstrated in cases 4, 17, and 26. Provider continuity in the CTC was also adequate, except in case 29, when the patient was not seen according to the every-72-hour policy requirement.

Health Information Management

SVSP providers generally documented patient encounters on the same day they occurred. However, the OIG clinicians found a few problems with providers that did not dictate or transcribe progress notes timely, which caused a delay in scanning progress notes into the eUHR. There were also a few delays in certain providers and onsite specialists signing progress notes. Please refer to the *Health Information Management* indicator for further details.

Clinician Onsite Inspection

The OIG clinicians observed both the daily morning huddles and the provider handoff meetings that occurred daily before regular huddles in the morning. Please refer to the *Health Information Management* indicator for further details.

Onsite interviews with providers revealed that a few of the providers found the nursing staff difficult to work with in certain clinics at specific yards. These providers felt many of the regular nurses at those yards were unable to handle basic nursing issues. One provider even stated that a few of the nurses were incompetent at dressing changes and required regular provider supervision, which affected the ability of the provider to complete other duties.

The majority of providers at SVSP described their own morale as poor and were generally d00issatisfied with their jobs. SVSP was severely short-staffed, and many providers felt overworked due to the understaffing. A few of the providers even stated they would leave SVSP if the institution continued to lose providers. The chief medical executive (CME), the chief physician and surgeon (CP&S), and the other providers were all extremely concerned about physician recruitment and retention. At the time of the onsite inspection, SVSP had three vacant physician positions with two new potential providers in the hiring process. However, SVSP could also potentially lose two of its

telemedicine physicians in the near future as well. Overall, only three full-time medical physicians and one full-time registry physician were onsite at SVSP seeing patients. The CME stated she had interviewed many candidates, and had extreme difficulty in hiring and retaining physicians. The CME also stated that at least two registry physicians left SVSP within one to two days of their start date due to the behavioral issues of inmates at this level 4 (highest security level) institution in the past.

The lack of physicians also placed a heavy burden on the mid-level providers at SVSP. Although SVSP is categorized as a basic institution, there were some medically complex patients present at SVSP. The nurse practitioners (NPs) were seeing many of the high-risk patients due to the understaffing at SVSP and felt they were caring for these patients beyond their scope of practice. Due to the NPs' seeing the medically complex patients in yard A and B, they were unable to complete their own duties and were forced to reschedule many of their patients.

Overall, the SVSP provider group felt the CME was a good and approachable leader who tried hard to provide the necessary support the providers needed to give quality care to the patients at SVSP. At the time of the onsite inspection, the CME had been the full-time CME for only a few weeks but had been the acting CME before that. The CEO and the CP&S were both acting at the time of the inspection. The providers felt their job performance was adequately monitored through various means, such as annual chart reviews and provider meetings. The onsite review of the SVSP provider personnel files confirmed that all but one of the provider annual performance appraisals were up to date.

Clinician Summary

As a whole, SVSP provider performance was *inadequate*. The case reviews demonstrated strong patterns of deficiencies in assessment and decision-making, insufficient documentation, cursory review of records, and inappropriately long follow-up intervals. In many of the cases in which SVSP had medically complex patients, the NPs care was inadequate. Due to the high volume of medically complex patients seen by the NPs and the errors generated with these encounters, the patients at SVSP were placed at a higher risk of adverse outcomes. The provider group as a whole did a poor job in documentation and often ignored or overlooked many acute medical issues. The strong pattern of deficiencies identified whereby providers ordered inappropriately long follow-up intervals, performed cursory review of records, and documented the records poorly was likely reflective of low provider morale and feelings of being overworked and understaffed. All levels of SVSP staff were extremely concerned about their inability to recruit and retain qualified physicians.

In an attempt to improve continuity of care, SVSP patients were assigned to an individual provider by the last two digits of their CDCR identification number. Case reviews found this practice to be rarely successful in promoting continuity of care. This process also inadvertently assigned many of the medically complex patients to the NPs, which in turn generated a huge backlog in yards A and B. In yard A, the backlog consisted of over 200 patients. While in yard B, over 90 patients were backlogged.

Recommendation

The OIG recommends that SVSP assign the majority of its physicians to yards A and B to address the significant backlog and medically complex patients, and reassign the nurse practitioners (mid-level providers) to the other two yards with the less medically complex patients.

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

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

Case Review Rating:
Adequate
Compliance Score:
Proficient
(92.0%)

Overall Rating:
Adequate

For this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance testing resulting in a *proficient* score. While each area's results are discussed in detail below, the result variance is due to the different testing approaches. Because the case review process contained a more detailed review, the OIG inspection team determined the final overall rating was *adequate*.

Case Review Results

SVSP had 12 medical beds and 10 mental health crisis beds. The patient count on the medical side during the OIG onsite visit was 11 patients. Nurses generally checked vital signs, implemented provider orders, and administered medications timely and accurately. The OIG reviewed 228 events and identified 84 deficiencies with 14 significant deficiencies. The care provided in the CTC was *adequate*. In two of the cases reviewed, the patients did not receive adequate nursing care:

- In case 5, nurses in the CTC did not adequately monitor the patient for a brain or spine injury on two occasions after the patient fell and hit his head. Nurses did not perform the neurological checks ordered by the provider on two encounters. On another, the RN did not assess a new complaint of severe abdominal pain. Nurses in the CTC rarely listened to the patient's lung sounds or measured peak flow (lung volume) when assessing the patient's breathing difficulties and effectiveness of treatments. On another day, the patient was given a lunch tray with peanut butter while he was in the CTC on suicide watch. The patient was allergic to peanut butter and knowingly ate it. This resulted in an emergency transfer to the local emergency department. Nursing staff was responsible for checking meal trays before giving them to patients to ensure each patient receives the correct diet. In addition, the patient did not receive all his medications that day. Nurses did not check the patient's room while he was at the hospital. The patient had more peanut butter in his room and consumed some of it when he returned.

- In case 71, the patient's decubitus ulcer (bedsore) increased in size and did not heal. This resulted in the need for surgical debridement. The primary care provider noted that the patient's behavior contributed to the failure of the wound to heal. Nurses in the CTC did not always describe the appearance of the decubitus ulcer. Nurses repeatedly encouraged the

patient to spend less time in the shower each day and to reposition himself every two hours. Although the patient agreed to comply, he did not change his behavior. The CTC nurses failed to collect pertinent information by tracking the actual time the patient was in the shower each day and noting his position every two hours. The nurses then should have analyzed the information, identified an expected outcome, and developed interventions with input from the provider and patient. Instead of taking an active role in shaping the patient's compliance, the nurses passively allowed the patient to continue behavior that was preventing his bedsore from healing. The nurses also failed to weigh the patient. In addition, nurses did not monitor whether the patient complied with performing range of motion exercises. This was especially important because SVSP did not have onsite physical therapy during the period reviewed.

The following are examples of minor deficiencies:

- Nurses did not weigh the patient in case 5.

- In case 70, the RN completed a level of care assessment but did not document whether the patient met criteria to continue in the CTC. The RN assessments on two occasions were not adequate. Nurses' documentation did not reflect the patient's diet was changed to high fiber, as ordered.

Documentation

Nurses' documentation displayed several instances of cloned notes and illegible handwriting.

Clinician Onsite Inspection

The OIG clinicians found the CTC rooms to be clean and generally free of clutter. There was one designated observation room, and two other rooms close to the nurses' station for close monitoring. The emergency cart was kept in an area where the nurses could quickly move it to the necessary patient area. The cart did not have a cardiac monitor and defibrillator, but an RN in the triage and a treatment area always responded with the TTA cart when necessary.

Compliance Testing Results

The institution received a *proficient* compliance score of 92.0 percent in the *Specialized Medical Housing* indicator, which focused on the institution's correctional treatment center (CTC). As discussed below, the following test areas scored 100 percent:

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

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

- When the OIG observed the working order of a sample of call buttons in CTC patient rooms, inspectors found the call buttons were working properly. According to staff during interviews, all custody officers and clinicians respond and access patients' rooms within one minute when an emergent event occurs (MIT 13.101).

SVSP performed poorly in the follow test:

- Providers completed SOAPE notes for six of the ten sampled patients (60 percent). Providers missed one required three-day interval for each of three patients by three days. For one other patient, there was no SOAPE documentation found (MIT 13.004).

Recommendations

No specific recommendations.

SPECIALTY SERVICES

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(65.8%)

Overall Rating:
Inadequate

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

Case Review Results

The OIG clinicians reviewed 220 events related to *Specialty Services,* which included 137 specialty consultations and procedures and 34 nursing encounters. The OIG found 57 deficiencies in this category, with 17 significant deficiencies.

Access to Specialty Services

Follow-ups with specialty services were not generally provided within adequate time frames for routine and urgent services. The majority of initial referrals to specialty services at SVSP were completed within an acceptable time frame, except in cases 17 and 33. However, numerous delays in specialist follow-ups were found. Case reviews found delays in specialty provider follow-ups in cases 4, 13, 14, 17, 22, 23, 30, 32, 33, 34, and 56. A few of these delays had a significant effect on patient care. Finally, specialist follow-ups that did not occur were identified in cases 12 and 17. The following examples were found during case review:

- In case 12, the patient should have had a follow-up with ophthalmology the day after his surgery. However, this follow-up never occurred. Furthermore, the nurses continued to administer a discontinued eye medication to the patient. If the follow-up had occurred, the provider could have clarified the medication order.

- In case 17, the six-week follow-up requested by the neurosurgeon after the patient's neck surgery did not occur. Consequently, the patient wore a cervical collar longer than indicated, which may have affected his rehabilitation. In addition, the physical medicine and rehabilitation specialist did not evaluate the patient for six months after his neck surgery.

- In case 30, the one-month follow-up requested by the hand surgeon after surgical pins were removed from the patient's finger did not occur for nearly three months. The patient developed a post-operative wound infection that resulted in osteomyelitis (infection

spreading into the bone), which required surgical treatment. This case is also discussed in the *Quality of Provider Performance* indicator.

- In case 33, the patient was never scheduled to see the physical therapist after his shoulder fracture. As a result, the patient had not regained full function of his shoulder at the time of this review.

Nursing Performance

In cases 14, 20, and 22, the nurse failed to check the patient's vital signs when he returned from offsite care.

- In case 14, the nurse should have tried to obtain recommendations from the specialty provider when the patient returned without information from the consultant.

- In case 29, the nurse documented the patient had refused his vitals, but the RN failed to complete a refusal form.

Provider Performance

SVSP providers generally made appropriate referrals for specialty services. The OIG clinicians identified only one deficiency whereby a referral was submitted without proper priority:

- In case 14, the oncologist recommended a tertiary treatment center for possible resection of the patient's liver tumor that was concerning for liver cancer. However, the provider ordered the referral with only a routine priority. Consequently, the tertiary treatment center did not see the patient for over two months. During this lengthy delay, the patient's follow-up CT scan revealed his tumor had increased in size. A surgical resection was no longer possible, and the patient's tumor was surgically inoperable.

Health Information Management

There were problems with the processing of specialty reports. Specialty reports and onsite specialty notes were either not retrieved or not timely scanned into the eUHR. As a result, providers did not have the patient's relevant information available. Even if the ordering provider were notified and had reviewed the report, that information would not be readily available to any subsequent medical staff. Therefore, the absence of specialty reports created a significant barrier for any provider or nurse to providing quality and continuity of care to patients. This deficiency was identified in cases 13, 29, 38, and the following:

- In case 14, medical records staff failed to retrieve and scan the oncology report from the outside hospital into the eUHR. This resulted in a significant lapse in medical care as the patient had a diagnosis of liver cancer and the provider needed this report to guide the patient's care plan. This is also discussed in the *Health Information Management* indicator.

If specialty reports were retrieved, they were often not retrieved timely. Delays in the retrieval of specialty reports significantly increased the risk of delays or lapses in care. This deficiency was identified in cases 22, 29, and 60.

If available, providers appropriately reviewed the majority of specialty reports. Specialty reports that a provider did not sign or initial were identified in cases 17, 19, 20, 30, 31, and 33.

Specialty reports with an illegible signature or that were not signed timely were identified in cases 32 and 60. Specialty reports that lacked a date of review were found in case 32.

Utilization Management

The OIG clinicians did not identify any significant problems with SVSP's utilization management program as it related to specialty services.

Clinician Onsite Inspection

The telemedicine clinic was clean and adequate. The nurse kept an organized tracking and scheduling system for all telemedicine appointments. No appointment backlog for telemedicine was reported. Providers received some of their clinic's offsite reports for review and signing during the provider handoff meetings that took place before morning huddles, but reports were sometimes missing. Some of the providers reported having to call the offsite specialist or hospitals in order to obtain these reports.

Clinician Summary

SVSP did not perform well in the *Specialty Services* indicator. While providers did an adequate job identifying and initially referring patients when needed, major issues with delays in specialist follow-ups were identified that affected patient care. Specialty report handling was marginal, with failures and delays in the retrieval of specialty reports, which also affected patient care. The OIG clinicians thus rated this indicator *inadequate*.

Compliance Testing Results

The institution received an *inadequate* compliance score of 65.8 percent in the *Specialty Services* indicator. SVSP showed room for improvement, scoring in the *inadequate* range, in the following test areas:

- Of the 19 sampled patients who had a specialty service denied by the institution's health care management, only six patients (32 percent) received timely notification of the denied service. For eight patients sampled, this requirement was not met at all; five others received follow-up visits ranging from one to 53 days late (MIT 14.007).

- When a patient is approved or scheduled for a specialty service appointment at one institution and then transfers to another institution, policy requires that the receiving

institution ensure that the patient's appointment is timely rescheduled or scheduled, and held. Of the 19 sampled patients who transferred to SVSP with an approved appointment, only 11 (58 percent) timely received their specialty services upon arrival. Six patients received their specialty service appointments from 6 to 74 days late, and another patient never received his specialty service. One other patient received one of his specialty service appointments 26 days late, and never received one other appointment for a different service (MIT 14.005).

- The institution received and providers timely reviewed specialists' reports for 9 of 15 sampled patients who received a high-priority specialty service (60 percent). For five patients, the high-priority specialty service was reviewed one to four days late, and for one other patient, the institution received the report eight days late (MIT 14.002).

- Ten of the 15 patients sampled (67 percent) received their high-priority specialty services appointment or service within 14 calendar days of the provider's order. Five patients received their service from 7 to 30 days late (MIT 14.001).

- Providers timely reviewed specialists' reports for only 10 of 14 patients sampled who received a routine specialty service (71 percent). Providers reviewed the routine specialty service report from one to five days late for three patients, and there was no eUHR evidence that a provider reviewed the report for one other patient (MIT 14.004).

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

- The institution timely denied 16 of 20 sampled providers' specialty services requests (80 percent). The institution denied four specialty service requests from one to 14 days late (MIT 14.006).

The institution performed within the *proficient* range in the following test:

- For 14 of the 15 sampled patients (93 percent), routine specialty services were held within 90 calendar days of the provider's order. However, for one patient, inspectors did not find evidence that the patient received the specialty service (MIT 14.003).

Recommendation

The OIG recommends SVSP dedicate at least one staff member to track all offsite specialty visits in order to retrieve all offsite specialty reports and ensure all reports are scanned timely into the eUHR.

SECONDARY (ADMINISTRATIVE) QUALITY INDICATORS OF HEALTH CARE

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

To test both the scored and non-scored areas within these two secondary quality indicators, OIG inspectors interviewed key institutional employees and reviewed documents during the onsite visit to SVSP in March 2016. They also reviewed documents obtained from the institution and from CCHCS prior to the start of the inspection. Of these two secondary indicators, OIG compliance inspectors rated both *inadequate.* The test questions used to assess compliance for each indicator are detailed in *Appendix A.*

INTERNAL MONITORING, QUALITY IMPROVEMENT, AND ADMINISTRATIVE OPERATIONS

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(45.2%)

Overall Rating:
Inadequate

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

Compliance Testing Results

The institution received an *inadequate* score of 45.2 percent in this indicator, performing poorly in the following areas:

- Inspectors reviewed drill packages for three medical emergency response drills conducted in the prior quarter; none of them contained all required summary reports and related documentation. As a result, SVSP scored a zero on this test (MIT 15.101).

- The OIG reviewed the only adverse/sentinel event (ASE) that occurred at SVSP during the prior six-month period for which CCHCS required a root cause analysis. The event was reported to CCHCS's ASE Committee four days late; policy requires staff to report all ASEs within 24 hours of occurrence. The institution received a score of zero on this test (MIT 15.002).

- The institutions 2015 Performance Improvement Work Plan identified five initiatives, but failed to meet any of the objectives for the initiatives identified, and received a zero score for this test (MIT 15.005).

- The institution's local governing body (LGB) met quarterly during the 12-month period ending December 2015; however, none of the four meetings' minutes were properly signed by the CEO, as required by CCHCS policy. Specifically, the CEO did not date the meeting minutes to confirm when the LGB approved the prior meeting's minutes (MIT 15.006).

- The OIG inspected documentation for 12 emergency medical response incidents reviewed by SVSP's Emergency Medical Response Review Committee (EMRRC) during the prior six-month period, and none of the sampled incident packages complied with policy. All 12

demonstrated the same problems: the committee did not use the EMRRC Review Checklist, there was no documentation of the committee's decision, and the meeting minutes were not properly signed. As a result, the institution scored zero for this test (MIT 15.007).

- Medical staff reviewed and timely submitted the Initial Inmate Death Report (CDCR Form 7229A) to CCHCS's Death Review Unit for three of five cases tested, resulting in a score of 60 percent. The CEO or chief medical executive (CME) failed to review and initial the death report for one patient. For another patient, SVSP did not complete the Initial Inmate Suicide Report (CDCR Form 7229B) (MIT 15.103).

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

- During the 12 months preceding the compliance inspection, SVSP timely processed inmate medical appeals for 11 of 12 months. However, 8 percent of appeals for February 2015 were not timely resolved. As a result, the institution scored 92 percent for this test (15.001). In addition, based on a sample of ten second-level medical appeals, the institution's responses addressed all of the patients' appealed issues (MIT 15.102).

- The institution's QMC regularly met during each of the most recent six months to evaluate program performance, and the committee took action when staff identified improvement opportunities (MIT 15.003). Additionally, SVSP had taken adequate steps to ensure the accuracy of its Dashboard data reporting (MIT 15.004).

Other Information Obtained from Non-Scored Areas

- The OIG gathered data regarding the completion of death review reports. During the OIG's review period, the CCHCS's Death Review Committee (DRC) was required to complete a death review summary within 30 business days of a patient's death and to submit it to the institution's CEO within five additional business days for four samples tested. For one additional sample, the DRC was required to complete a death review summary within 60 calendar days of the inmate death, and submit it to the institution's CEO within seven additional calendar days. The DRC completed three summary reports from 9 to 128 days late (51 to 170 calendar days after the deaths). CCHCS did not timely submit any of these reports to the institution's CEO, resulting in all five deaths being 5 to 157 days late (or 53 to 206 calendar days after the deaths) (MIT 15.996).

- Inspectors met with the institution's CEO to inquire about SVSP's protocols for tracking medical appeals. The CEO reported that SVSP management used daily summary reports to track the number of appeals received, the numbers of appeals triaged as emergencies, and pending/overdue completions. SVSP's reports did not include a listing of subject areas ranked by number of appeals filed; however, a new appeals report had been implemented to categorize patient's complaints, types of services, and types of medication errors. The report included informative graphs categorized by yard. The CEO reported that at one time appeals

were sent to multiple staff for resolution; however, the appeals were getting lost and became overdue, and appeals were not being resolved. In response to this issue, the CEO reviewed all appeals and had implemented training to correct the accountability and timeliness problems (MIT 15.997).

- The OIG gathered non-scored data regarding the institution's practices for implementing local operating procedures (LOPs). The data indicated that the institution had an effective process in place for developing LOPs. According to the institution's health program manager, the department heads and health program specialist were responsible for reviewing changes to statewide policies and procedures and determining what, if any, impact they had on SVSP's established LOPs. Program subcommittees and the CME decided if newly proposed LOPs were required. The LOPs then went to the local governing body for final approval. LOPs updates were communicated to staff through annual meetings, and forwarded via email to staff. At the time of the OIG's inspection, SVSP had implemented 38 of the 49 applicable stakeholder-recommended LOPs (78 percent) (MIT 15.998).

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

Recommendations

No specific recommendations.

JOB PERFORMANCE, TRAINING, LICENSING, AND CERTIFICATIONS

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

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(70.1%)

Overall Rating:
Inadeauate

Compliance Testing Results

The institution received an *inadequate* compliance score of 70.1 percent in this indicator, scoring poorly in the following three tests:

- One nurse employee hired within the past year did not complete new employee orientation training within 60 days of hire. As a result, SVSP scored zero on this test (MIT 16.107).

- Only one of the seven providers had a proper clinical performance appraisal completed (14 percent). Two providers' first probation reports were not completed, and one of the two providers' Unit Health Record Clinical Appraisal was not completed. One provider's second and third probation reports were overdue. One other provider did not receive a core competency based evaluation. Two providers had 13 months elapse since their last annual review (MIT 16.103).

- The OIG tested provider, nursing, and custody staff records to determine if SVSP ensures that those staff members have current emergency response certifications. SVSP's provider and nursing staff were all compliant, but custody managers were not. While the California Penal Code exempts custody manager who primarily perform managerial duties from medical emergency response certification training, CCHCS policy does not allow for such an exemption. As a result, the institution received a score of 67 percent for this test (MIT 16.104).

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

- When inspectors examined records to determine if nursing supervisors were completing the required number of monthly case reviews on subordinate nurses and discussing the results of those reviews, four of five sampled nurse supervisors properly completed their reviews (80 percent). One of the supervising registered nurses did not complete a review of nursing staff for one month (MIT 16.101).

The institution did perform well (scoring 100 percent) in the following areas:

- All providers were current with their professional licenses. Nursing staff and the pharmacist in charge were current with their professional licenses and certification requirements (MIT 16.001, 16.105).
- All ten nurses sampled were current on their clinical competency validations (MIT 16.102).
- The institution's pharmacy and providers who prescribed controlled substances were all current with their Drug Enforcement Agency registrations (MIT 16.106).

Recommendations

No specific recommendations.

POPULATION-BASED METRICS

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

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

Methodology

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

Comparison of Population-Based Metrics

For Salinas Valley State Prison, nine HEDIS measures were selected and are listed in the following *SVSP 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.

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. SVSP performed well with its management of diabetes in the available HEDIS measures when compared to other reporting entities.

Statewide, SVSP significantly outperformed Medi-Cal in all five diabetic measures selected. SVSP outperformed Kaiser North in four of the five diabetic measures; but did not perform, as well as Kaiser North in blood pressure control. SVSP outperformed Kaiser South in three of the five diabetic measures, but scored 7 and 10 percentage points lower for blood pressure control and eye exams, respectively.

Compared nationally, SVSP outperformed Medicaid, Medicare, and commercial health plans in all five listed diabetic measures. SVSP outperformed the U.S. Department of Veterans Affairs (VA), in two of the four applicable diabetic care monitoring areas reported by the VA, and matched the VA for blood pressure control. However, SVSP scored 19 percentage points lower than the VA for conducting dilated eye exams.

Immunizations

Comparative data for immunizations was only fully available for the VA, and partially available for Kaiser Permanente, Medicare, and commercial plans. With regard to administering influenza shots to younger adults, SVSP performed more poorly than all State and national health plans. However, SVSP's poor score was a direct result of the 64 percent refusal rate among the sampled patients. Had the refusals not occurred, the SVSP would have had a higher comparative score than all other State and national comparative figures. However, with regard to administering influenza shots to older adults, SVSP slightly outperformed both Medicare and the VA. Finally, with regard to pneumococcal vaccinations, SVSP outperformed Medicare, but scored 2 percentage points less than the VA.

Cancer Screening

With respect to colorectal cancer screening for older patients, SVSP's score of 58 percent was significantly lower than the only other statewide comparative figures, which were 80 percent and 82 percent for Kaiser, Northern California and Southern California, respectively. Nationally, SVSP also performed worse than commercial plans, Medicare, and the VA. Again, patient refusals directly impacted the institution's performance in this cancer screening measure. Specifically, 38 percent of SVSP patients sampled refused the cancer screening. The cancer screening score for SVSP would have been significantly higher if not for the high refusal rate.

Summary

Based on the institution's comparative HEDIS results, SVSP's performance reflects an adequate chronic care program. The institution scored comparatively well in the areas of comprehensive diabetes care and influenza shots to older adults, and pneumococcal vaccinations. However, the institution has room for improvement for administering influenza vaccinations to younger adults, and colorectal cancer screenings. The institution can improve its scores by increasing patient education to reduce refusals.

SVSP Results Compared to State and National HEDIS Scores

Clinical Measures	California				National			
	SVSP Cycle 4 Results[1]	HEDIS Medi-Cal 2015[2]	HEDIS Kaiser (No. CA) 2015[3]	HEDIS Kaiser (So.CA) 2015[3]	HEDIS Medicaid 2015[4]	HEDIS Com-mercial 2015[4]	HEDIS Medicare 2015[4]	VA Average 2014[5]
Comprehensive Diabetes Care								
HbA1c Testing (Monitoring)	**100%**	86%	95%	94%	86%	91%	93%	99%
Poor HbA1c Control (>9.0%) [6,7]	**10%**	39%	18%	24%	44%	31%	25%	19%
HbA1c Control (<8.0%) [6]	**80%**	49%	70%	62%	47%	58%	65%	-
Blood Pressure Control (<140/90)	**78%**	63%	84%	85%	62%	65%	65%	78%
Eye Exams	**71%**	53%	69%	81%	54%	56%	69%	90%
Immunizations								
Influenza Shots: Adults (18–64)	**35%**	-	54%	55%	-	50%	-	58%
Influenza Shots: Adults (65+)	**77%**	-	-	-	-	-	72%	76%
Immunizations: Pneumococcal	**91%**	-	-	-	-	-	70%	93%
Cancer Screening								
Colorectal Cancer Screening	**58%**	-	80%	82%	-	64%	67%	82%

1. Unless otherwise stated, data was collected in May 2016 by reviewing medical records from a sample of SVSP's population of applicable inmate-patients. These random statistical sample sizes were based on a 95 percent confidence level with a 15 percent maximum margin of error.
2. HEDIS Medi-Cal data was obtained from the California Department of Health Care Services 2015 *HEDIS Aggregate Report for the Medi-Cal Managed Care Program*.
3. Data was obtained from Kaiser Permanente November 2015 reports for the Northern and Southern California regions.
4. National HEDIS data for Medicaid, commercial plans, and Medicare was obtained from the 2015 *State of Health Care Quality Report*, available on the NCQA website: www.ncqa.org. 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.
6. For this indicator, the entire applicable SVSP 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

Salinas Valley State Prison Range of Summary Scores: 45.17% - 92.00%	
Indicator	**Compliance Score (Yes %)**
Access to Care	71.76%
Diagnostic Services	65.56%
Emergency Services	Not Applicable
Health Information Management (Medical Records)	79.43%
Health Care Environment	50.61%
Inter- and Intra-System Transfers	77.26%
Pharmacy and Medication Management	67.36%
Prenatal and Post-Delivery Services	Not Applicable
Preventive Services	81.92%
Quality of Nursing Performance	Not Applicable
Quality of Provider Performance	Not Applicable
Reception Center Arrivals	Not Applicable
Specialized Medical Housing (OHU, CTC, SNF, Hospice)	92.00%
Specialty Services	65.84%
Internal Monitoring, Quality Improvement, and Administrative Operations	45.17%
Job Performance, Training, Licensing, and Certifications	70.12%

Reference Number	*Access to Care*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
1.001	**Chronic care follow-up appointments:** Was the inmate-patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter?	20	10	30	66.67%	0
1.002	**For endorsed inmate-patients received from another CDCR institution:** If the nurse referred the inmate-patient to a provider during the initial health screening, was the inmate-patient seen within the required time frame?	11	19	30	36.67%	0
1.003	**Clinical appointments:** Did a registered nurse review the inmate-patient's request for service the same day it was received?	30	0	30	100.00%	0
1.004	**Clinical appointments:** Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed?	28	2	30	93.33%	0
1.005	**Clinical appointments:** If the registered nurse determined a referral to a primary care provider was necessary, was the inmate-patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter?	14	7	21	66.67%	9
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?	7	2	9	77.78%	21
1.007	**Upon the inmate-patient's discharge from the community hospital:** Did the inmate-patient receive a follow-up appointment within the required time frame?	24	6	30	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	17	29	41.38%	1
1.101	**Clinical appointments:** Do inmate-patients have a standardized process to obtain and submit health care services request forms?	5	1	6	83.33%	0
Overall percentage:					**71.76%**	

Reference Number	*Diagnostic Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
2.001	**Radiology:** Was the radiology service provided within the time frame specified in the provider's order?	10	0	10	100.00%	0
2.002	**Radiology:** Did the primary care provider review and initial the diagnostic report within specified time frames?	1	9	10	10.00%	0
2.003	**Radiology:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	3	7	10	30.00%	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 inmate-patient within specified time frames?	8	2	10	80.00%	0
2.007	**Pathology:** Did the institution receive the final diagnostic report within the required time frames?	10	0	10	100.00%	0
2.008	**Pathology:** Did the primary care provider review and initial the diagnostic report within specified time frames?	8	2	10	80.00%	0
2.009	**Pathology:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	3	7	10	30.00%	0
Overall percentage:					**65.56%**	

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

Reference Number	*Health Information Management (Medical Records)*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated progress notes, initial health screening forms, and health care service request forms scanned into the eUHR within three calendar days of the inmate-patient encounter date?	17	3	20	85.00%	0
4.002	Are dictated / transcribed documents scanned into the eUHR within five calendar days of the inmate-patient encounter date?	19	1	20	95.00%	0
4.003	Are specialty documents scanned into the eUHR within the required time frame?	18	2	20	90.00%	0
4.004	Are community hospital discharge documents scanned into the eUHR within three calendar days of the inmate-patient date of hospital discharge?	16	4	20	80.00%	0
4.005	Are medication administration records (MARs) scanned into the eUHR within the required time frames?	16	4	20	80.00%	0
4.006	During the eUHR review, did the OIG find that documents were correctly labeled and included in the correct inmate-patient's file?	6	6	12	50.00%	0
4.007	Did clinical staff legibly sign health care records, when required?	22	10	32	68.75%	0
4.008	**For inmate-patients discharged from a community hospital:** Did the preliminary hospital discharge report include key elements and did a PCP review the report within three calendar days of discharge?	26	4	30	86.67%	0
Overall percentage:					**79.43%**	

Reference Number	*Health Care Environment*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
5.101	**Infection Control:** Are clinical health care areas appropriately disinfected, cleaned, and sanitary?	8	4	12	66.67%	0
5.102	**Infection control:** Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	11	0	11	100.00%	1
5.103	**Infection Control:** Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	8	4	12	66.67%	0
5.104	**Infection control:** Does clinical health care staff adhere to universal hand hygiene precautions?	4	6	10	40.00%	2
5.105	**Infection control:** Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	7	5	12	58.33%	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	**Clinical areas:** Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	6	6	12	50.00%	0
5.108	**Clinical areas:** Do clinic common areas and exam rooms have essential core medical equipment and supplies?	1	11	12	8.33%	0
5.109	**Clinical areas:** Do clinic common areas have an adequate environment conducive to providing medical services?	10	2	12	83.33%	0
5.110	**Clinical areas:** Do clinic exam rooms have an adequate environment conducive to providing medical services?	7	5	12	58.33%	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?	2	6	8	25.00%	4
Overall percentage:					**50.61%**	

Reference Number	*Inter- and Intra-System Transfers*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
6.001	**For endorsed inmate-patients received from another CDCR institution or COCF:** Did nursing staff complete the initial health screening and answer all screening questions on the same day the inmate-patient arrived at the institution?	19	11	30	63.33%	0
6.002	**For endorsed inmate-patients received from another CDCR institution or COCF:** When required, did the RN complete the assessment and disposition section of the health screening form; refer the inmate-patient to the TTA, if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening?	29	1	30	96.67%	0
6.003	**For endorsed inmate-patients received from another CDCR institution or COCF:** If the inmate-patient had an existing medication order upon arrival, were medications administered or delivered without interruption?	21	2	23	91.30%	7
6.004	**For inmate-patients transferred out of the facility:** Were scheduled specialty service appointments identified on the Health Care Transfer Information Form 7371?	12	8	20	60.00%	0
6.101	**For inmate-patients transferred out of the facility:** Do medication transfer packages include required medications along with the corresponding Medical Administration Record (MAR) and Medication Reconciliation?	6	2	8	75.00%	0
Overall percentage:					**77.26%**	

Reference Number	*Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.001	Did the inmate-patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows?	10	14	24	41.67%	6
7.002	Did health care staff administer or deliver new order prescription medications to the inmate-patient within the required time frames?	23	7	30	76.67%	0
7.003	**Upon the inmate-patient's discharge from a community hospital:** Were all medications ordered by the institution's primary care provider administered or delivered to the inmate-patient within one calendar day of return?	15	15	30	50.00%	0
7.004	**For inmate-patients received from a county jail:** Were all medications ordered by the institution's reception center provider administered or delivered to the inmate-patient within the required time frames?	Not Applicable				
7.005	**Upon the inmate-patient's transfer from one housing unit to another:** Were medications continued without interruption?	25	5	30	83.33%	0
7.006	**For inmate-patients en route who lay over at the institution:** If the temporarily housed inmate-patient had an existing medication order, were medications administered or delivered without interruption?	Not Applicable				
7.101	**All clinical and medication line storage areas for narcotic medications:** Does the institution employ strong medication security controls over narcotic medications assigned to its clinical areas?	0	8	8	0.00%	11
7.102	**All clinical and medication line storage areas for non-narcotic medications:** Does the institution properly store non-narcotic medications that do not require refrigeration in assigned clinical areas?	8	11	19	42.11%	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?	2	10	12	16.67%	7
7.104	**Medication preparation and administration areas:** Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes?	5	2	7	71.43%	12
7.105	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when preparing medications for inmate-patients?	7	0	7	100.00%	12
7.106	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when distributing medications to inmate-patients?	2	5	7	28.57%	12
7.107	**Pharmacy:** Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and satellite pharmacies?	1	0	1	100.00%	0

7.108	**Pharmacy:** Does the institution's pharmacy properly store non-refrigerated medications?	1	0	1	100.00%	0
7.109	**Pharmacy:** Does the institution's pharmacy properly store refrigerated or frozen medications?	1	0	1	100.00%	0
7.110	**Pharmacy:** Does the institution's pharmacy properly account for narcotic medications?	1	0	1	100.00%	0
7.111	**Pharmacy:** Does the institution follow key medication error reporting protocols?	30	0	30	100.00%	0
7.998	**For Information Purposes Only:** During eUHR compliance testing and case reviews, did the OIG find that medication errors were properly identified and reported by the institution?	Information Only				
7.999	**For Information Purposes Only:** Do inmate-patients in isolation housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications?	Information Only				
Overall percentage:						**67.36%**

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

Reference Number	*Preventive Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
9.001	**Inmate-patients prescribed TB Medications:** Did the institution administer the medication to the inmate-patient as prescribed?	18	4	22	81.82%	0
9.002	**Inmate-patients prescribed TB Medications:** Did the institution monitor the inmate-patient monthly for the most recent three months he or she was on the medication?	19	3	22	86.36%	0
9.003	**Annual TB Screening:** Was the inmate-patient screened for TB within the last year?	16	14	30	53.33%	0
9.004	Were all inmate-patients offered an influenza vaccination for the most recent influenza season?	30	0	30	100.00%	0
9.005	**All inmate-patients from the age of 50 through the age of 75:** Was the inmate-patient offered colorectal cancer screening?	26	4	30	86.67%	0
9.006	**Female inmate-patients from the age of 50 through the age of 74:** Was the inmate-patient offered a mammogram in compliance with policy?	Not Applicable				
9.007	**Female inmate-patients from the age of 21 through the age of 65:** Was the inmate-patient offered a pap smear in compliance with policy?	Not Applicable				
9.008	Are required immunizations being offered for chronic care inmate-patients?	15	3	18	83.33%	12
9.009	Are inmate-patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	Not Applicable				
Overall percentage:					**81.92%**	

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

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

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

Reference Number	*Specialized Medical Housing (OHU, CTC, SNF, Hospice)*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	**For all higher-level care facilities:** Did the registered nurse complete an initial assessment of the inmate-patient on the day of admission, or within eight hours of admission to CMF's Hospice?	10	0	10	100.00%	0
13.002	**For OHU, CTC, & SNF only:** Did the primary care provider for OHU or attending physician for a CTC & SNF evaluate the inmate-patient within 24 hours of admission?	10	0	10	100.00%	0
13.003	**For OHU, CTC, & SNF only:** Was a written history and physical examination completed within 72 hours of admission?	10	0	10	100.00%	0
13.004	**For all higher-level care facilities:** Did the primary care provider complete the Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes on the inmate-patient at the minimum intervals required for the type of facility where the inmate-patient was treated?	6	4	10	60.00%	0
13.101	**For OHU and CTC Only:** Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter inmate-patient's cells?	1	0	1	100.00%	0
Overall percentage:					**92.00%**	

Reference Number	*Specialty Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	Did the inmate-patient receive the high-priority specialty service within 14 calendar days of the PCP order?	10	5	15	66.67%	0
14.002	Did the PCP review the high priority specialty service consultant report within the required time frame?	9	6	15	60.00%	0
14.003	Did the inmate-patient receive the routine specialty service within 90 calendar days of the PCP order?	14	1	15	93.33%	0
14.004	Did the PCP review the routine specialty service consultant report within the required time frame?	10	4	14	71.43%	1
14.005	**For endorsed inmate-patients received from another CDCR institution:** If the inmate-patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames?	11	8	19	57.89%	1
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	16	4	20	80.00%	0
14.007	Following the denial of a request for specialty services, was the inmate-patient informed of the denial within the required time frame?	6	13	19	31.58%	1
Overall percentage:					**65.84%**	

Reference Number	*Internal Monitoring, Quality Improvement, and Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.001	Did the institution promptly process inmate medical appeals during the most recent 12 months?	11	1	12	91.67%	0
15.002	Does the institution follow adverse/sentinel event reporting requirements?	0	1	1	0.00%	0
15.003	Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified?	6	0	6	100.00%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	1	0	1	100.00%	0
15.005	For each initiative in the Performance Improvement Work Plan (PIWP), has the institution performance improved or reached the targeted performance objective(s)?	0	5	5	0.00%	1
15.006	**For institutions with licensed care facilities:** Does the Local Governing Body (LGB), or its equivalent, meet quarterly and exercise its overall responsibilities for the quality management of patient health care?	0	4	4	0.00%	0
15.007	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	0	12	12	0.00%	0
15.101	Did the institution complete a medical emergency response drill for each watch and include participation of health care and custody staff during the most recent full quarter?	0	3	3	0.00%	0
15.102	Did the institution's second level medical appeal response address all of the inmate-patient's appealed issues?	10	0	10	100.00%	0
15.103	Did the institution's medical staff review and submit the initial inmate death report to the Death Review Unit in a timely manner?	3	2	5	60.00%	0
15.996	**For Information Purposes Only:** Did the CCHCS Death Review Committee submit its inmate death review summary to the institution timely?	Information Only				
15.997	**For Information Purposes Only:** Identify the institution's protocols for tracking medical appeals.	Information Only				
Overall percentage:					**45.17%**	

Reference Number	*Job Performance, Training, Licensing, and Certifications*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
16.001	Do all providers maintain a current medical license?	10	0	10	100.00%	0
16.101	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	4	1	5	80.00%	0
16.102	Are nursing staff who administer medications current on their clinical competency validation?	10	0	10	100.00%	0
16.103	Are structured clinical performance appraisals completed timely?	1	6	7	14.29%	0
16.104	Are staff current with required medical emergency response certifications?	2	1	3	66.67%	0
16.105	Are nursing staff and the Pharmacist-in-Charge current with their professional licenses and certifications?	5	0	5	100.00%	1
16.106	Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	1	0	1	100.00%	0
16.107	Are nursing staff current with required new employee orientation?	0	1	1	0.00%	0
Overall percentage:					**70.12%**	

APPENDIX B — CLINICAL DATA

Table B-1: SVSP Sample Sets	
Sample Set	**Total**
Anticoagulation	3
CTC/OHU	2
Death Review/Sentinel Events	5
Diabetes	3
Emergency Services – CPR	2
Emergency Services – Non-CPR	5
High Risk	5
Hospitalization	5
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	30
Specialty Services	5
	71

Table B-2: SVSP Chronic Care Diagnoses	
Diagnosis	**Total**
Anemia	4
Anticoagulation	5
Arthritis/Degenerative Joint Disease	9
Asthma	19
COPD	5
Cancer	2
Cardiovascular Disease	12
Chronic Kidney Disease	4
Chronic Pain	16
Cirrhosis/End-Stage Liver Disease	2
Coccidioidomycosis	1
DVT/PE	1
Diabetes	17
Gastroesophageal Reflux Disease	8
Hepatitis C	17
Hyperlipidemia	12
Hypertension	33
Mental Health	8
Seizure Disorder	8
Sleep Apnea	4
Thyroid Disease	3
	190

Table B-3: SVSP Event - Program	
Program	**Total**
Diagnostic Services	234
Emergency Care	160
Hospitalization	50
Intra-System Transfers In	25
Intra-System Transfers Out	6
Outpatient Care	692
Specialized Medical Housing	226
Specialty Services	216
	1,609

Table B-4: SVSP Case Review Sample Summary	
	Total
MD Reviews Detailed	30
MD Reviews Focused	0
RN Reviews Detailed	23
RN Reviews Focused	37
Total Reviews	90
Total Unique Cases	71
Overlapping Reviews (MD & RN)	19

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

Salinas Valley State Prison			
Quality Indicator	**Sample Category (number of samples)**	**Data Source**	**Filters**
Access to Care			
MIT 1.001	Chronic care patients (30)	Master Registry	• Chronic care conditions (at least one condition per inmate-patient—any risk level) • **Randomize**
MIT 1.002	Nursing Referrals (30)	OIG Q: 6.001	• See ***Intra-system Transfers***
MITs 1.003-006	Nursing sick call (5 per clinic) 30	MedSATS	• Clinic (each clinic tested) • Appointment date (2–9 months) • **Randomize**
MIT 1.007	Returns from community hospital (30)	OIG Q: 4.008	• 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 (20)	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	(20)	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: 4.008	• Community hospital discharge documents • First 20 IPs selected
MIT 4.005	(20)	OIG Q: 7.001	• MARs • First 20 IPs selected
MIT 4.006	(12)	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (12 or more = No)
MIT 4.007	Legible signatures & review (32)	OIG Qs: 4.008, 6.001, 6.002, 7.001, & 14.002	• First 8 IPs sampled • One source document per IP
MIT 4.008	Returns from community hospital (30)	Inpatient claims data	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • **Randomize** (each month individually) • First 5 inmate-patients from each of the 6 months (if not 5 in a month, supplement from another, as needed)
Health Care Environment			
MIT 5.101-105 MIT 5.107–111	Clinical areas (12)	OIG inspector onsite review	• Identify and inspect all onsite clinical areas.
Inter- and Intra-System Transfers			
MIT 6.001-003	Intra-system transfers (30)	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 (8)	OIG inspector onsite review	• R&R IP transfers with medication

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
Pharmacy and Medication Management			
MIT 7.001	Chronic care medication (30)	OIG Q: 1.001	*See* ***Access to Care*** • At least one condition per inmate-patient—any risk level • **Randomize**
MIT 7.002	New Medication Orders (30)	Master Registry	• Rx count • **Randomize** • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns from Community Hospital (30)	OIG Q: 4.008	• 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 (30)	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • **Randomize**
MIT 7.006	En Route (0)	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 (7)	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 (30)	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 (20)	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 patients)	Data Source	Filters
Preventive Services			
MITs 9.001–002	TB medications (22)	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 (30)	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 (30)	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 (30)	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 patients)	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 Access			
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 (12)	InterQual	• Review date (3–9 months) • **Randomize**
	(8)	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • **Randomize**

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
Internal Monitoring, Quality Improvement, & Administrative Operations			
MIT 15.001	Medical appeals (all)	Monthly medical appeals reports	• Medical appeals (12 months)
MIT 15.002	Adverse/sentinel events (1)	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	Performance improvement work plans (PIWP) (5)	Institution PIWP	• PIWP with updates (12 months) • Medical initiatives
MIT 15.006	LGB (4)	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.007	EMRRC (12)	EMRRC meeting minutes	• Monthly meeting minutes (6 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 (5)	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.996	Death Review Committee (5)	OIG summary log - deaths	• Between 35 business days & 12 months prior • CCHCS death reviews
MIT 15.998	Local operating procedures (LOPs) (all)	Institution LOPs	• All LOPs

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Job Performance, Training, Licensing, and Certifications			
MIT 16.001	Provider licenses (10)	Current provider listing (at start of inspection)	• Review all
MIT 16.101	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 16.102	Nursing Staff Validations (10)	Onsite nursing education files	• On duty one or more years • Nurse administers medications • **Randomize**
MIT 16.103	Provider Annual Evaluation Packets (all)	OIG Q:16.001	• All required performance evaluation documents

MIT 16.104	Medical Emergency Response Certifications
	(all)
		Onsite certification tracking logs	• All staff
			  ○ Providers (ACLS)
			  ○ Nursing (BLS/CPR)
			  ○ Custody (CPR/BLS)

MIT 16.105	Nursing staff and Pharmacist in charge Professional Licenses and Certifications (all)	Onsite tracking system, logs, or employee files	• All required licenses and certifications
MIT 16.106	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations (all)	Onsite listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 16.107	Nursing Staff New Employee Orientations (all)	Nursing staff training logs	• New employees (hired within last 12 months)

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

October 28, 2016

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

Dear Mr. Barton:

The purpose of this letter is to inform you that the Office of the Receiver has reviewed the draft report of the Office of the Inspector General (OIG) Medical Inspection Results for Salinas Valley State Prison (SVSP) conducted from March to May 2016. California Correctional Health Care Services (CCHCS) acknowledges all OIG findings.

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

Sincerely,

Janet Lewis

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

cc: Clark Kelso, Receiver
Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Richard Kirkland, Chief Deputy Receiver
Roy Wesley, Chief Deputy Inspector General, OIG
Christine Berthold, Senior Deputy Inspector General, OIG
Ryan Baer, Senior Deputy Inspector General (A), OIG
Scott Heatley, M.D., Ph.D., CCHP, Chief Physician and Surgeon, OIG
Penny Horper, R.N., MSN, CPHQ, Nurse Consultant Program Review, OIG
Yulanda Mynhier, Director, Health Care Policy and Administration, CCHCS
Roscoe Barrow, Chief Counsel, CCHCS Office of Legal Affairs, CCHCS
R. Steven Tharratt, M.D., MPVM, FACP, Director, Health Care Operations, CCHCS
Renee Kanan, M.D., Deputy Director, Medical Services, CCHCS
Cheryl Schutt, R.N., Deputy Director, Nursing Services, CCHCS
Michael Hutchinson, Regional Health Care Executive, Region II, CCHCS
David Ralston, M.D., Regional Deputy Medical Executive, Region II, CCHCS
Laura Schaper, R.N., Regional Nursing Executive, Region II, CCHCS
Brittany Brizendine, Psy.D., MBA, CCHP-MH, Chief Executive Officer, SVSP
Annette Lambert, Deputy Director (A), Quality Management, Clinical Information and Improvement Services, CCHCS
Dawn DeVore, Staff Services Manager II, Program Compliance Section, CCHCS