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Office of the Inspector General

Valley State Prison
Medical Inspection Results
Cycle 4

February 2016

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

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Cycle 4

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EXECUTIVE SUMMARY

Under the authority of California Penal Code Section 6126, which assigns the Office of the Inspector General (OIG) responsibility for oversight of the California Department of Corrections and Rehabilitation (CDCR), the OIG conducts a comprehensive inspection program to evaluate the delivery of medical care at each of CDCR's 35 adult prisons. The OIG **explicitly** makes no determination regarding the constitutionality of care in the prison setting. That determination is left to the Receiver and the federal court. The assessment of care by the OIG is just one factor in the court's determination whether care in the prisons meets constitutional standards. The court may find that an institution 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 *inadequat*e 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 Valley State Prison (VSP).

The OIG performed its Cycle 4 medical inspection at VSP from August to October 2015. The inspection included in-depth reviews of 65 inmate-patient files conducted by clinicians as well as reviews of documents from 388 inmate-patient files conducted by deputy inspectors general, covering 91 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 VSP using 14 health care quality indicators applicable to the institution, made up of 12 primary clinical indicators and two secondary administrative indicators. To conduct clinical case reviews, the OIG employs a clinician team consisting of a physician and a registered nurse consultant, while compliance testing is done by a team of deputy inspectors general trained in monitoring medical compliance. Of the 12 primary indicators, seven were rated by both case review clinicians and compliance inspectors, three were rated by case review clinicians only, and two were rated by compliance inspectors only; both secondary indicators were rated by compliance inspectors only. See the *Health Care Quality Indicators* table on page ii. Based on that analysis, OIG experts made a considered and measured overall opinion that the quality of health care at VSP was ***inadequate***.

Health Care Quality Indicators

Fourteen Primary Indicators (Clinical)	All Institutions–Applicability	VSP 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	N/A
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	N/A
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**	**VSP 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 VSP was *inadequate*. For the 12 primary (clinical) quality indicators applicable to VSP, the OIG found one *proficient*, four *adequate*, and seven *inadequate*. For the two secondary (administrative) quality indicators, the OIG found both *inadequate*. To determine the overall assessment for VSP, 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 VSP.

Clinical Case Review and OIG Clinician Inspection Results

The clinicians' case reviews sampled patients with high medical needs and included a review of 1,072 patient care events.[1] For the 12 primary indicators applicable to VSP, ten were evaluated by clinician case review; one was *proficient*, four were *adequate*, and five were *inadequate*. When determining the overall adequacy of care, the OIG paid particular attention to the clinical nursing and provider quality indicators, as adequate health care staff can sometimes overcome suboptimal processes and programs. However, the opposite is not true; inadequate health care staff cannot provide adequate care, even though the established processes and programs onsite may be adequate. The OIG clinicians identify inadequate medical care based on the risk of significant harm to the patient, not on the actual outcome.

Program Strengths — Case Review

- VSP had efficient *Specialty Services* staff and processes. Staff assigned to Specialty Services were knowledgeable of their roles and responsibilities and had a tracking process to ensure specialty appointments were completed.

- VSP had strong provider performance, and the chief physician and surgeon contributed by providing clinical support in difficult cases.

Program Weaknesses — Case Review

- VSP provided ineffective *Access to Care*. There were provider-ordered follow-up appointments that did not occur. Numerous nurse-to-provider appointments did not occur timely or did not occur at all. There were several months of backlog for provider appointments.

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

- The *Quality of Nursing Performance* was *inadequate*. There were failures to perform providers' orders, failures to triage requests for health care services, and failures to recognize patients' needs for some same-day assessments.

- The poor nursing performance was responsible for the *inadequate* case review rating of the *Specialized Medical Housing* indicator. There were failures to communicate the patients' abnormal vital signs to providers and inadequate or missing nursing assessments. Nurses did not use the appropriate nursing process to identify individual patient needs and did not always fully implement providers' orders. Furthermore, incomplete or illegible documentation compounded the risk for poor patient care.

- The *Pharmacy and Medication Management* was *inadequate*. There were failures to timely renew medications and failures to timely provide medications after hospitalization.

- The *Health Information Management* was *inadequate*. Frequently, medical records were unavailable or misfiled. Additionally, many provider and nursing progress notes were illegible and difficult to follow.

Compliance Testing Results

Of the 14 total indicators of health care applicable to VSP, compliance inspectors evaluated 11.[2] There were 91 individual compliance questions within those 11 applicable indicators, generating 1,214 data points, that tested VSP's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[3] Those 91 questions are detailed in *Appendix A—Compliance Test Results*. The institution's compliance scores for the 11 applicable indicators ranged from 45.6 percent to 94.0 percent, with the secondary (administrative) indicator *Internal Monitoring, Quality Improvement, and Administrative Operations* receiving the lowest score, and the primary (clinical) indicator *Specialized Medical Housing* receiving the highest. For the nine primary indicators applicable to compliance testing, the OIG rated one *proficient,* three *adequate,* and five *inadequate.* For the two secondary indicators, which involve administrative health care functions, both were rated *inadequate*.

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

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

Program Strengths — Compliance Testing

As the *Executive Summary Table* on page viii indicates, the institution's compliance rating was *proficient* for only one primary indicator: *Specialized Medical Housing* (94.0 percent). The following are some of VSP's strengths based on its compliance scores for individual questions in all the primary health care indicators:

- Patients had a standardized process to obtain and submit request forms for health care services, and nursing staff timely reviewed patients' requests and timely completed face-to-face visits with patients.

- Patients timely received their radiology, laboratory, and pathology services.

- When patients transferred into VSP from another institution, nursing staff timely completed the assessment and disposition sections of the patients' health screening forms.

- All observed nursing staff followed proper administrative controls and protocols when distributing medications to patients.

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

- Patients timely received their routine and high-priority specialty services, and providers timely reviewed specialists' reports.

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

- All providers, nursing staff, and the pharmacist-in-charge were current with their professional licenses and certifications, and the pharmacy and authorized providers who prescribe controlled substances maintained current Drug Enforcement Agency registrations.

- All providers, nurses, and custody officers had current medical emergency response certifications.

Program Weaknesses — Compliance Testing

The institution received ratings in the *inadequate* range for the following five primary indicators: *Access to Care* (66.3 percent), *Health Information Management (Medical Records)* (56.6 percent); *Health Care Environment* (59.4 percent); *Pharmacy and Medication Management* (72.5 percent); and *Preventive Services* (66.1 percent). The institution also received an *inadequate* rating in both of the secondary indicators; *Internal Monitoring, Quality Improvement, and Administrative Operations* (45.6 percent), and *Job Performance, Training, Licensing, and Certifications* (71.1 percent). The following are examples of some weaknesses identified during the OIG's testing of specific compliance questions in all the primary indicators:

- Primary care providers (PCPs) did not conduct timely appointments with most of the patients the OIG sampled. This included patients who required a PCP follow-up visit for chronic care conditions; patients who required a follow-up sick call appointment; and patients who had been referred to a PCP by nursing staff due to the patient's request for service, or upon a patient's transfer to VSP from another institution.

- Health records staff often failed to timely scan documents into patients' electronic health records, and did not always properly label or file them. Clinicians' signatures on health care records were often illegible.

- Bulk medical supplies located in storage rooms and Conex boxes were unorganized; many items were inappropriately stored on the ground or in non-temperature-sensitive areas.

- In most clinics, core equipment and essential supplies were missing in the common areas and exam rooms; and in most clinics' common areas where blood draws and patient triage services were provided, patients lacked adequate auditory privacy. Deficiencies were also found with several clinics' emergency response bags.

- Exam rooms in several clinics were missing sharps containers, which are needed to mitigate exposure to blood-borne pathogens and contaminated waste. Also, most clinic exam rooms did not have an adequate environment conducive to providing adequate medical services.

- Most of the patients sampled who transferred out of VSP with approved pending specialty service appointments did not have the approved services identified on their health care transfer forms.

- Nursing staff did not always timely administer medications to patients with chronic care conditions, patients who tested positive for tuberculosis, patients returning from a community hospital, and patients who transferred from one VSP housing unit to another. Also, nursing staff did not follow required protocols for administering and reading annual tuberculosis skin tests.

- Providers often failed to offer or provide required immunizations for patients diagnosed with chronic care conditions.

- Providers did not always perform required history and physical examinations for patients admitted to the OHU.

- Providers did not provide timely specialty service appointments for many sampled patients who transferred into VSP from other institutions with previously approved or scheduled appointments.

Some low-scoring questions addressing secondary indicators resulted in the following administrative deficiencies:

- The chief executive officer for health care services (CEO) did not always sign the EMRRC minutes, and incident packages did not include all required information. In all three medical emergency response drills tested in the prior quarter, custody staff did not participate, and one drill package did not include all required documentation.

- Nursing supervisors did not always complete nor discuss the results of required periodic reviews of their nursing staff.

- Three of the nursing staff hired during the prior 12 months did not receive new employee orientation training in a timely manner.

The *VSP 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.

VSP Executive Summary Table

Primary Indicators (Clinical)	Case Review Rating	Compliance Rating	Overall Indicator Rating
Access to Care	Inadequate	Inadequate	Inadequate
Diagnostic Services	Adequate	Adequate	Adequate
Emergency Services	Adequate	Not Applicable	Adequate
Health Information Management (Medical Records)	Inadequate	Inadequate	Inadequate
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	Inadequate	Inadequate
Quality of Nursing Performance	Inadequate	Not Applicable	Inadequate
Quality of Provider Performance	Adequate	Not Applicable	Adequate
Specialized Medical Housing (OHU, CTC, SNF, Hospice)	Inadequate	Proficient	Inadequate
Specialty Services	Proficient	Adequate	Proficient

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

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

Population-Based Metrics

In general, Valley State Prison performed well for population-based metrics. In four of the five comprehensive diabetes care measures, VSP outperformed or matched other State and national organizations. This included Medi-Cal as well as Kaiser Permanente, typically one of the highest-scoring health organizations in California; and Medicaid, Medicare, national commercial health plans (based on data obtained from health maintenance organizations), and the U.S. Department of Veterans Affairs (VA). For the fifth measure, diabetic patient eye exams, VSP's rate was lower than that of the VA, but higher than that of all other entities.

With regard to influenza immunizations for patients under the age of 65, VSP's rate was higher than those reported by Kaiser and national commercial health plans, but lower than the VA's. For adults aged 65 and older, the institution's rate was higher than Medicare's and matched the VA's. For pneumococcal immunizations to older adults, VSP's rate was higher than that of Medicare, but significantly lower than that of the VA. With regard to colorectal cancer screening, VSP's rate was lower than both Kaiser's and the VA's, but higher than rates reported by commercial plans and Medicare. All of VSP's immunization and cancer screening rates were negatively impacted by patients' refusal to receive the service. Overall, VSP's performance demonstrated by the population-based metrics indicated that the chronic care program was well run and operating as intended.

INTRODUCTION

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

Valley State Prison (VSP) was the 11th medical inspection of Cycle 4. During the inspection process, the OIG assessed the delivery of medical care to patients using 12 primary clinical health care indicators and two secondary administrative health care indicators applicable to the institution. It is important to note that while the primary quality indicators represent the clinical care being provided by the institution at the time of the inspection, the secondary quality indicators are purely administrative and are not reflective of the actual clinical care provided.

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

ABOUT THE INSTITUTION

The mission of Valley State Prison is multi-fold. VSP functions as a Level II, General Population institution housing inmates requiring Sensitive Needs Yard placement. VSP also houses inmates assigned to the Enhanced Outpatient Program (EOP). The EOP provides a higher level of mental health treatment. VSP is also a re-entry hub for CDCR. As a re-entry hub, the institution focuses on needs-based rehabilitative services, including substance abuse treatment and cognitive behavioral training. The institution runs five medical clinics where staff members handle non-urgent requests for medical services. VSP also treats inmates needing urgent or emergency care in its triage and treatment area (TTA), treats inmate-patients requiring additional assistance in the outpatient housing unit (OHU), provides services in a specialty service telemedicine clinic, and screens patients in its receiving and release clinic. CCHCS has designated VSP as a "basic" care institution. Basic institutions are located in a rural area away from tertiary care centers and specialty care providers whose services would likely be used frequently by higher-risk patients. Basic institutions have capability to provide limited specialty medical services and consultation for a generally healthy inmate-patient population.

At the time of the inspection, VSP had not yet received a review 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. However, the institution's first review is planned for April 2016.

Based on staffing data obtained from the institution, VSP's average vacancy rate among medical managers, primary care providers, supervisors, and rank-and-file nurses was only 2 percent in August 2015; primary care providers had the highest vacancy rate, at 13 percent. The institution reported that one PCP was under disciplinary review and two non-supervisory nursing staff were on long-term medical leave.

VSP Health Care Staffing Resources — August 2015

	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff		Totals	
Description	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Authorized Positions	1	1%	8	9%	10.5	12%	71.4	79%	90.9	100%
Filled Positions	1	100%	7	88%	10	95%	71	99%	89	98%
Vacancies	0	0%	1	13%	0.5	5%	0.4	1%	1.9	2%
Recent Hires (within 12 months)	0	0%	1	14%	5	50%	6	8%	12	13%
Staff Utilized from Registry	0	0%	1.5	21%	0	0%	0	0%	1.5	2%
Redirected Staff (to Non-Patient Care Areas)	0	0%	0	0%	0	0%	0	0%	0	0%
Staff on Long-term Medical Leave	0	0%	0	0%	0	0%	2	3%	2	2%

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

As of August 10, 2015, CCHCS Master Registry data showed that VSP had 3,502 inmate-patients. Within that total population, 3.3 percent were designated High-Risk, Priority 1 (High 1), and 7.6 percent were designated High-Risk, Priority 2 (High 2). Patients' assigned risk levels are based on the complexity of their required medical care related to their specific diagnoses, frequency of higher levels of care, age, and abnormal labs and procedures. High 1 has at least two high-risk conditions; High 2 has only one. High-risk patients are more susceptible to poor health outcomes than medium- or low-risk patients. High-risk patients also typically require more health care services than do patients with lower assigned risk levels. The chart below illustrates the breakdown of the institution's medical risk levels at the start of the OIG medical inspection.

VSP Master Registry Data as of August 10, 2015

Medical Risk Level	# of Inmate-Patients	Percentage
High 1	116	3.31%
High 2	266	7.60%
Medium	1,990	56.82%
Low	1,130	32.27%
Total	**3,502**	**100.0%**

Commonly Used Abbreviations

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

OBJECTIVES, SCOPE, AND METHODOLOGY

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

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

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

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

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

CASE REVIEWS

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

PATIENT SELECTION FOR RETROSPECTIVE CASE REVIEWS

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

1. The goal of retrospective chart review is to evaluate all aspects of the health care system. Statewide, high-risk and high-utilization patients consume medical services at a disproportionate rate; 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 (an unexpected occurrence 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, VSP Sample Sets*, the OIG clinicians evaluated medical charts for 65 unique patients. *Appendix B, Table B–4, VSP Case Review Sample Summary,* clarifies that both nurses and physicians reviewed charts for 17 of those patients, for 82 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 29 inmate-patients. These generated 1,072 clinical events for review (*Appendix B, Table B–3, VSP Event-Program*). The reporting format provides details on whether the encounter was adequate or had significant deficiencies, and identifies deficiencies by programs and processes to help the institution focus on improvement areas.

While the sample method specifically pulled only six chronic care patient records, i.e., three diabetes patients and three anticoagulation patients (*Appendix B, Table B–1, VSP Sample Sets*), the 65 unique inmate-patients sampled included patients with 211 chronic care diagnoses, including 13 additional patients with diabetes (for total of 16), and one additional anticoagulation patient (for a total of four) (*Appendix B, Table B–2, VSP 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 PCPs care for the less

complicated, low-utilizing, and lower-risk patients. The OIG concluded that the case review sample size was more than adequate to assess the quality of services provided.

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

COMPLIANCE TESTING

SAMPLING METHODS FOR CONDUCTING COMPLIANCE TESTING

From August to October 2015, deputy inspectors general attained answers to 91 objective medical inspection test (MIT) questions designed to assess the institution's compliance with critical policies and procedures applicable to the delivery of medical care. To conduct most tests, inspectors randomly selected samples of inmate-patients for whom the testing objectives were applicable and reviewed their electronic unit health records. In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed health records for 388 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 August 24, 2015, field inspectors conducted a detailed onsite inspection of VSP's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,214 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 VSP'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 91 questions, the OIG derived a score for each primary and secondary quality indicator identified above by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Based on those results, the OIG assigned a rating to each quality indicator of *proficient* (greater than 85 percent), *adequate* (between 75 percent and 85 percent), or *inadequate* (less than 75 percent).

CCHCS DASHBOARD COMPARISON

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

OVERALL QUALITY INDICATOR RATING FOR CASE REVIEWS AND COMPLIANCE TESTING

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

To derive an overall assessment rating for the institution's medical inspection, the OIG evaluated the various rating categories assigned to each of the quality indicators applicable to the institution, giving more weight to the rating results for the primary quality indicators, which directly relate to

the health care provided to inmate-patients. Based on that analysis, OIG experts made a considered and measured overall opinion about the quality of health care observed.

POPULATION-BASED METRICS

The OIG identified a subset of Healthcare Effectiveness Data Information Set (HEDIS) measures applicable to the CDCR inmate-patient population. To identify outcomes for VSP, the OIG reviewed some of the compliance testing results, randomly sampled additional inmate-patients' records, and obtained VSP 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 VSP. Of those 12 indicators, seven were rated by both the case review and compliance components of the inspection, three were rated by the case review component alone, and two were rated by the compliance component alone.

Summary of Case Review Results: The clinical case review component assessed 10 of the 12 primary (clinical) indicators applicable to VSP. For these ten indicators, one was *proficient*, four were *adequate*, and five were *inadequate*. The OIG physicians rated the adequacy of care for each of the 30 detailed case reviews they conducted. Of these 30 cases, one was *proficient*, 24 were *adequate*, and five were *inadequate*. For the 1,072 events reviewed, there were 355 deficiencies, of which 37 were considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

Adverse Events Identified During Case Review:

Case review identified no adverse events at VSP during the review period.

Summary of Compliance Results: The compliance component assessed 9 of the 12 primary (clinical) indicators applicable to VSP. For 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
(66.3%)

Overall Rating:
Inadequate

Case Review Results

The OIG clinicians reviewed 648 provider and nurse encounters. Forty deficiencies relating to *Access to Care* were identified. There were deficiency patterns identified in nurse-to-provider sick call referrals and provider-to-provider follow-ups. The case review rating for *Access to Care* was *inadequate.*

Provider-to-Provider Follow-up Appointments

VSP performed poorly with provider-ordered follow-up appointments. These appointments are very important elements of the *Access to Care* indicator. The OIG clinicians identified the following significant deficiencies:

- In case 20, the provider requested a follow-up in seven days for a patient with hyponatremia (insufficient blood sodium), but the visit did not occur. Three weeks later, the patient had a seizure due to severe hyponatremia and required life-support measures with mechanical ventilation and admission to an outside hospital's intensive care unit.

- Also in case 20, a provider requested another 15-day follow-up appointment, but it did not occur.

Valley State Prison had a procedure clinic where a provider performed minor procedures such as joint injections, debridement, and ingrown toenail and callus removal.

- In case 20, a provider referred the patient to the procedure clinic for ingrown toenail removal. The appointment did not occur.

- In case 50, the patient was scheduled for callus removal. The appointment was 11 days late.

Nurse-to-Provider Referrals

VSP performed poorly with nurse-to-provider appointments. The OIG identified 18 deficiencies where provider appointments did not occur timely or did not occur at all.

- In case 3, a nurse evaluated the patient for eye, neck, and arm pain and requested a routine 14-day provider follow-up. However, the provider appointment did not occur. On another encounter, a nurse evaluated the patient for right eye pain with "floaters" (spots in the patient's vision) and requested a routine provider follow-up. This visit did not occur until 28 days later. On another encounter, a nurse evaluated the patient for severe burning pain in his left shoulder and bumps on his hands and inner forearm, and requested a routine 14-day provider follow-up. The appointment occurred 32 days later.

- In case 11, a nurse assessed the patient for swelling of the left lower leg suggestive of deep vein thrombosis and requested a routine, instead of urgent, provider follow-up. This appointment did not occur until 20 days later.

- In case 20, a nurse assessed the patient for urinary incontinence and requested a routine provider follow-up. This appointment did not occur.

- In case 35, a nurse evaluated the patient for a skin rash and requested a routine provider follow-up. This appointment did not occur.

- In case 36, a nurse evaluated the patient for shortness of breath and requested a routine provider follow-up. This appointment did not occur.

- In case 39, a nurse evaluated the patient for arm and shoulder pain and requested a routine provider follow-up. This appointment did not occur.

- In case 44, a nurse evaluated the patient for possible medication side effects and requested a routine provider follow-up. This appointment did not occur.

- In case 46, a nurse assessed the patient for abdominal hernia and requested a routine provider follow-up. This appointment did not occur.

- In case 48, a nurse assessed the patient for leg pain and requested a routine provider follow-up. This appointment did not occur.

- In case 50, a nurse assessed the patient for foot pain and requested a routine provider follow-up. This appointment did not occur.

- In case 55, a nurse evaluated the patient for ingrown toenail and requested a routine provider follow-up. This appointment did not occur.

- In case 56, a nurse assessed the patient for chest pain and requested a provider follow-up in ten days. The appointment occurred 13 days later.

- In case 57, a nurse assessed the patient for neck and leg pain and requested a routine provider follow-up. The appointment occurred 16 days later.

- In case 60, a nurse evaluated the patient for occipital headaches and requested a routine provider follow-up. This appointment did not occur. Two weeks later, a nurse evaluated the patient for throbbing headaches that kept the patient awake at night and verified that an appointment was scheduled. The appointment did not occur.

- In case 63, a nurse assessed the patient for ringing in his ears and requested a 14-day routine provider follow-up. This visit occurred three weeks later.

Provider Follow-up After Specialty Service

VSP consistently provided patients with a timely provider follow-up after specialty services.

Intra-System Transfer

Nurses appropriately evaluated all 20 patients transferred into VSP and referred them to a provider. The provider assessed the patients timely.

Follow-up After Hospitalization

Twenty-four hospital or outside emergency department events were reviewed. The providers timely assessed all patients after returning from a higher level of care.

Urgent and Emergent Care

A provider generally assessed patients timely after the patients were evaluated in the triage and treatment area (TTA). Fifty-five urgent and emergent encounters were reviewed; there were two *Access to Care* deficiencies:

- In case 23, there was a 35-minute delay in bringing the patient to the TTA. The reason for the delay was not documented.

- In case 30, the first responder (custody) did not call 9-1-1 immediately upon finding an unresponsive patient. Emergency medical services were activated six minutes later.

Specialized Medical Housing

The providers assessed patients in the outpatient housing unit (OHU) appropriately and timely. There was one deficiency related to *Access to Care*:

- In case 6, the patient was admitted to the OHU and was not evaluated by the provider until 18 days after admission.

Unproductive Provider Appointments

- In case 7, a provider rescheduled a follow-up to an endocrinology consultation as the consultant's dictated note was not available for review.

- In case 20, a provider evaluated the patient for difficulty with urination. The provider was unable to perform a prostate exam because lubricating gel was unavailable. The provider instead requested a 15-day follow-up.

Clinician Onsite Inspection

During the onsite visit, the OIG clinicians noted that provider chronic care and follow-up visits were backlogged from 5 to 26 days past the CCHCS policy timelines. The A Yard clinic was 25 days behind schedule, and 261 patients awaited a provider follow-up visit. The B Yard clinic was five to seven days behind schedule, and 200 patients awaited a provider follow-up visit. The C Yard clinic was 25 to 26 days behind schedule, and 448 patients awaited a provider follow-up visit. The D Yard clinic was 13 days behind schedule, and 135 patients awaited a provider follow-up visit.

The OIG clinicians identified areas that may have affected the poor *Access to Care* performance. Only two office technicians worked at the central medical office and scheduled appointments for all four medical clinics. The office technicians did not attend all morning huddles. In addition, combining multiple patient encounters, "bundling," was not used in scheduling to effectively manage the backlog. In addition, there had been one provider vacancy, but it was recently filled.

Conclusion

VSP performed poorly with regard to *Access to Care*. The OIG clinicians rated VSP *inadequate* for this indicator.

Compliance Testing Results

The institution performed in the *inadequate* range for the *Access to Care* indicator, with a compliance score of 66.3 percent and scoring low in the areas described below:

- Of the four patients sampled who were referred to and seen by a PCP and for whom the PCP subsequently ordered a follow-up appointment, only one patient (25 percent) received his follow-up appointment timely. One patient received his appointment one day late; two other patients never received their PCP follow-up visit (MIT 1.006).

- For 18 health care service requests sampled in which nursing staff referred the inmate-patient for a PCP appointment, only six of the patients (33 percent) received a timely

appointment. Eleven patients received their routine appointments from 2 to 32 days late; one other patient did not receive an appointment at all (MIT 1.005).

- Only 10 of the 26 patients sampled (38 percent) who transferred into VSP from another institution and were referred to a PCP, based on nursing staff's initial health care screening, were seen timely. Providers saw 12 patients from 2 to 56 days late; four other patients never received their PCP visit at all (MIT 1.002).

- Among the 30 sampled inmate-patients who suffered with one or more chronic care conditions, only 13 (43 percent) received timely PCP follow-up appointments. Eleven patients received their appointments between 2 and 28 days late; six other patients' follow-up appointments were from one to four months late (MIT 1.001).

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

- Of 20 sampled inmate-patients discharged from a community hospital, 16 (80 percent) received or were offered a follow-up appointment with a PCP within five days of discharge. Providers conducted visits with four other patients from one to 15 days late (MIT 1.007).

The institution scored within the *proficient* range for the following four tests:

- Inmates had access to Health Care Services Request forms (CDCR Form 7362) at all six housing units inspected (MIT 1.101).

- Inspectors sampled 30 Health Care Services Request forms (CDCR Form 7362) submitted by patients across all facility clinics. For 28 of the sampled patients (93 percent), nursing staff reviewed the patient's service request form the same day they received it. For two other patients, nursing staff neglected to document the date they initially reviewed the service request form and, as a result, inspectors could not verify the forms were reviewed timely (MIT 1.003).

- For sampled patients who submitted sick call requests, nursing staff timely completed a patient triage encounter with all but two of the patients (93 percent). For the two remaining patients, nursing staff did not conduct a face-to-face visit with the patient at all. Inspectors noted that one of those two patients had a previously scheduled specialty service appointment; for the other patient, the nurse noted that his request for service was discussed in the clinic's morning nursing huddle (MIT 1.004).

- Inspectors sampled 29 inmate-patients who received a high-priority or routine specialty service; 26 of them (90 percent) received a timely PCP follow-up appointment. The three exceptions related to routine specialty service follow-up appointments. Specifically, for two patients, the institution provided follow-up appointments late by one and 31 days. For a third patient, a specialty service PCP follow-up visit never occurred (MIT 1.008).

Recommendations

The OIG recommends that VSP implement the following:

- Provide each clinic with a dedicated office technician who is familiar with the clinic setting, its providers, and its nurses to ensure all patient appointments are met.
- Ensure the office technicians attend all morning huddles to communicate with the providers and nurses in decision-making and scheduling for urgent follow-ups.
- Use a bundling method to alleviate backlog in scheduling appointments. For example, an appointment could be scheduled to address both a specialty follow-up and a nursing referral.
- Ensure the clinic supervising nurse evaluates existing backlogs and prioritizes the patients with more serious illnesses so they see the providers first.
- Ensure that medical records and specialty services staff timely retrieve necessary records for all hospitalization and specialty follow-up appointments, allowing scheduled provider follow-up to occur without a need for rescheduling due to unavailable medical records.

DIAGNOSTIC SERVICES

Case Review Rating:
Adequate
Compliance Score:
Adequate
(81.1%)

Overall Rating:
Adequate

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

Case Review Results

The OIG clinicians reviewed 165 diagnostic related events and found 11 deficiencies. Of those 11 deficiencies, seven were related to the health information management process. Other diagnostic tests were performed as ordered, reviewed timely by providers, and relayed quickly to patients. Case review rating for *Diagnostic Services* was *adequate.*

Staff performed most laboratory, x-ray, and electrocardiograms (EKGs) as ordered; however, laboratory orders were not done in the following cases.

- In case 19, a basic metabolic panel was not done.
- In case 23, a complete blood count and complete metabolic panel were not done.

Health information management contributed to the deficiency of *Diagnostic Services*. Some diagnostic reports were not properly signed by providers or scanned into the eUHR.

- In case 3, some laboratory reports were not reviewed by the provider or scanned into the eUHR, and a notification of diagnostic test results was not completed.
- In cases 3 and 11, laboratory reports were reviewed by a provider, but not scanned into the eUHR.
- In cases 10, a laboratory result was not appropriately initialed to evidence the provider's review.
- In case 18, an EKG was not scanned into the eUHR.

The providers generally reviewed diagnostic reports timely except on one occasion:

- In case 62, diagnostic test results were reviewed, signed, and dated by a provider six days late.

Conclusion

The OIG rated *Diagnostic Services* at VSP *adequate* since the improperly processed laboratory orders and failures to retrieve diagnostic reports were infrequent, and those failures did not significantly affect patient care.

Compliance Testing Results

The institution received an *adequate* compliance score of 81.1 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

- For nine of the ten radiology services sampled (90 percent), the service was timely performed; one patient received the radiology service one day late (MIT 2.001). Providers initialed and dated the radiology report, evidencing they reviewed it within two business days of receipt, for only six of those ten patients (60 percent). For one patient, the provider reviewed the report results three days late, and for another, seven days late. Two additional patients' eUHRs included evidence of a provider's radiology report review signature but the report lacked a review date. As a result, inspectors were unable to determine the timeliness of the review (MIT 2.002). In a related area, inspectors found that providers timely communicated radiology results to nine of the ten sampled patients (90 percent). For one patient, the provider communicated the results three days late (MIT 2.003).

Laboratory Services

- For all ten of the laboratory services sampled, the patients' laboratory services were timely performed, the ordering provider timely reviewed the diagnostic report results, and those results were timely communicated to the patients (MIT 2.004, 2.005, 2.006).

Pathology Services

- The institution received the final pathology report for all ten patients sampled (MIT 2.007). However, providers only timely reviewed the final reports for four of those ten patients (40 percent); for six patients, providers did not initial and date the reports to evidence their timely review of the final results (MIT 2.008). Providers timely communicated the final pathology results to only five of the ten sampled patients (50 percent). For two patients, the provider communicated the pathology test results from 7 to 19 days late; for three other

patients, there was no evidence the provider communicated the test results to the patient at all (MIT 2.009).

Recommendation

The OIG recommends that the institution implement a system that tracks all diagnostic services from the provider's initial order to the completion of the process, including communicating the test results to the patient.

EMERGENCY SERVICES

Case Review Rating:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

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

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

Case Review Results

The OIG clinicians reviewed 55 urgent or emergent events and found 22 deficiencies, mainly in nursing care. These minor deficiencies did not significantly affect patient care. In general, VSP performed well with emergency response times, basic life support (BLS) care, and 9-1-1 activation times. Even with the deficiencies noted, patients requiring urgent or emergent services received timely and adequate care in the majority of the cases reviewed.

Provider Performance

Providers generally evaluated patients timely and made appropriate assessments and plans during urgent or emergent events. The OIG identified one minor deficiency:

- In case 18, the provider ordered the patient transferred to a community hospital for chest pain, which the patient refused. Though the provider recognized a potentially serious condition, the provider failed to provide next-day follow-up.

Nursing Performance

Emergency Services nursing deficiencies often related to inadequate assessment and documentation. Nursing documentation entries must be accurate, valid, complete, authenticated (truthful), dated, timed, and legible, and they must contain standardized terminology. One of the essential principles of basic nursing practice is that anything not documented is considered not done. Based on these important standards, the OIG clinicians found some triage and treatment area (TTA) nursing documentation incomplete, disorganized, and illegible. The OIG clinicians identified 20 minor nursing deficiencies. The following selected cases demonstrate areas for improvement:

- In case 3, the patient was seen in the TTA for chest pain. The nursing assessment and documentation of the findings were inadequate. The TTA nurse failed to document the quality of the pain and any accompanying symptoms at the time of chest pain. The TTA nurse did not obtain a thorough objective assessment, including inspection and palpation of the chest wall, inspection of the neck for distention and tracheal deviation, inspection and palpation of lower extremities for swelling and calf tenderness, or inspection of the face for symmetry.

- In case 18, the patient was seen in the clinic for chest pain. There was a 30-minute delay in notifying the TTA staff of this patient's condition, and the clinic nurse took only one set of vital signs during the entire time the patient was treated for chest pain. This nurse also failed to document the effectiveness of the pain medication after administration.

- In case 19, nursing staff evaluated the patient for joint pain and chest pain. The patient was in the TTA for 36 minutes before he was transferred to a community hospital; however, the TTA nurse obtained only one set of vital signs. The nurse gave sublingual nitroglycerin and aspirin, but did not document the effectiveness of the medications. There was also inconsistent documentation on the size of the needle inserted to gain intravenous access.

- In case 30, the patient was found unresponsive, and 9-1-1 was activated six minutes after discovery. The nursing documentation was written in a non-detailed format. It was difficult for the reviewer to determine what really happened and when. The documentation was not dated, some entries had missing signatures, and nurses' handwriting was illegible. There were inconsistent documentations of timelines, and with multiple staff on the scene, no one checked the patient's blood glucose level.

- In case 31, nursing staff evaluated the patient for headache, vomiting, dizziness, and weakness. The nursing assessment was inadequate, since the nurse failed to palpate the patient's abdomen for tenderness and did not document bowel sounds. The nurse's handwriting was illegible.

Emergency Medical Response Review Committee (EMRRC)

The committee generally reviewed all emergency medical response incidents and took necessary actions to improve the institution's emergency medical response. There was one minor deficiency:

- In case 30, the committee failed to identify that custody first responders failed to activate the emergency medical services (EMS) upon discovery of an unresponsive patient.

Onsite Clinician Inspection

The TTA had ample space for patient evaluation and working areas for both nurses and providers. There was adequate lighting, and it was appropriately stocked with medications and medical equipment, such as an automated external defibrillator and a crash cart. VSP staff ensured adequate privacy for patients' medical examinations.

Recommendations

No specific recommendations.

HEALTH INFORMATION MANAGEMENT (MEDICAL RECORDS)

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(56.6%)

Overall Rating:
Inadequate

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

Case Review Results

The OIG clinicians identified 115 *Health Information Management* deficiencies. Overall, the *Health Information Management* processes were *inadequate.*

Hospital Records

- While most hospital records were timely retrieved, reviewed, and scanned into the eUHR, some severe deficiencies still occurred when hospitals records (specifically discharge summaries) were not retrieved or scanned into the eUHR. These types of records contain the most vital information for the continuity of care between the inpatient and outpatient settings. In case 21, the hospital discharge summary was not retrieved or found in the eUHR.

- Many hospital discharge summaries were not properly initialed by a provider to indicate review. This deficiency occurred in cases 2, 3, 13, 19, 20, 23, 31, 32, 33, and 34.

Missing Documents (Progress Notes and Forms)

- Most nursing and provider progress notes were scanned into the eUHR; however, in cases 18, 24, 61, 63, and 64, progress notes were missing. In case 18, there was no provider progress note documenting the decision-making for a patient with chest pain.

- There were missing documents in cases 43 and 62. In case 43, there was no documentation showing that medications were given as ordered.

Scanning Performance

- There were mislabeled or misfiled documents in cases 8, 18, and 23. These errors can greatly hinder users' ability to find relevant clinical information. In case 23, the hospital discharge summary of a different patient was scanned into the eUHR.

Specialty Services Reports

- Deficiencies in the processing of specialty reports occurred frequently. In 19 cases, specialty reports were not properly signed by a provider.

- Specialty reports were not scanned into the eUHR in cases 2 and 9.

Diagnostic Reports

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

Legibility

- Illegible progress notes, signatures, or initials were found from both nurses and providers. Illegible progress notes pose a significant medical risk to patients, especially when the medical care must be reviewed by other staff or when the patient transfers to another team.

Compliance Testing Results

The institution received an *inadequate* compliance score of 56.6 percent in the *Health Information Management (Medical Records)* indicator and has room for improvement in the following areas:

- The institution scored zero in its labeling and filing of documents scanned into patients' eUHRs. The most common errors were incorrectly labeled documents and patients' health care documents being scanned into another patient's eUHR file (MIT 4.006).

- Inspectors tested four PCP-dictated progress notes to determine if staff scanned the documents within five calendar days of the patient encounter; only one document (25 percent) was scanned timely. Staff scanned the other three documents between one and three days late (MIT 4.002).

- The OIG reviewed various medical documents, such as hospital discharge reports, initial health screening forms, certain medication administration records, and specialty service reports, to ensure that clinical staff legibly documented their names on the forms. Only 20 of 32 samples (63 percent) showed compliance; inspectors determined the other 12 samples did not have legible information to identify the clinician (MIT 4.007).

- For 13 of 20 specialty service consultant reports sampled (65 percent), VSP staff scanned the reports into the patient's eUHR file within five calendar days. For seven patients, the reports were scanned between one and 13 days late (MIT 4.003).

- Medical records staff did not always timely scan medication administration records (MARs) into patients' eUHR files, scanning only 14 of 20 sampled documents within the required

time frame (70 percent). Staff scanned the other six MARs between one and seven days late (MIT 4.005).

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

- The OIG reviewed hospital discharge records for 20 sampled patients who were sent or admitted to the hospital. The community hospital discharge records were complete and timely reviewed for only 15 of the sampled patients (75 percent). For five patients, the provider reviewed the hospital discharge reports between 2 and 15 days late (MIT 4.008).

- For 15 of 20 hospital discharge reports sampled (75 percent), VSP staff scanned the reports into the patient's eUHR file within three days of the patient's discharge. For five patients, staff scanned the discharge documents between one and eight days late (MIT 4.004).

- Medical records staff timely scanned 16 of 20 miscellaneous non-dictated documents sampled into the patient's eUHR within three calendar days of the patient's encounter (80 percent). These documents included providers' progress notes, patients' initial health screening forms, and health care services request forms. Medical records staff scanned four other documents between one and four days late (MIT 4.001).

Recommendation

The OIG recommends that all clinical staff, particularly providers who sign hospital discharge reports and nurses who sign KOP MAR documents, demonstrate that they timely reviewed documents by consistently and legibly signing (or initialing) and dating medical records. To improve legibility on all health care documents, the OIG recommends that VSP health care management require clinical staff to utilize name stamps and encourage the use of dictation.

HEALTH CARE ENVIRONMENT

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

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(59.4%)

Overall Rating:
Inadequate

Clinician Comments

Although the OIG clinicians did not rate the health care environment at VSP, they obtained the following information during their onsite visit in October 2016:

- VSP medical clinic exam rooms had adequate space needed to provide patient care with visual privacy, as all exam rooms had tinted glass windows. However, auditory privacy was inadequate since nursing staff and providers shared the exam room. The clinics had ample lighting and were well stocked with medications and medical equipment.

- The TTA had adequate space for patient evaluation, with working areas for both nurses and providers. The TTA had ample lighting and was well stocked with medications and medical equipment, such as an automated external defibrillator (AED) and an emergency crash cart.

- Providers, nurses (including medication nurses) and custody staff attended morning huddles. These meetings were productive, as pertinent matters of the nurse and provider lines, as well as any custody issues related to access to care, were discussed.

Compliance Testing Results

The institution received an *inadequate* compliance score of 59.4 percent in the *Health Care Environment* indicator; 7 of the 11 test areas scored in the *inadequate* range, as described below:

Figure 1: Heat sensitive medical supplies stored on the ground in Conex box floor.

- The institution's medical supply management process did not adequately support the needs of the medical health care program. The institution used multiple storage rooms and Conex boxes for stock piling medical equipment and supplies in a manner that was often unorganized, subjected supplies to heat exposure, or that included storage of items directly on the ground, which could lead to deterioration (Figures 1 and 2). More specifically, inspectors found five Conex boxes loaded with medical supplies and equipment, and recorded temperatures ranging from 113 to 120 degrees. One Conex box with a measured temperature of 120 degrees contained latex exam gloves that the manufacturer required to be stored in a cool, dry, and well-ventilated storage area of no more than 86 degrees. In another Conex box, inspectors found expired personal protective equipment stored. In addition, two other centralized bulk supply storage rooms were found to be disorganized with such items as medical supply test strips, lancets, and catheters stored on the floor. As a result, the institution scored zero for this test (MIT 5.106).

Figure 2: Unorganized central storage location with medical supplies stored on the ground.

- Clinic common areas and exam rooms were often missing essential supplies and core equipment necessary to conduct a comprehensive exam. As a result, only two of the nine clinics (22 percent) were fully stocked with essential supplies and equipment. The remaining seven clinics' common areas or exam rooms had one or more missing pieces of core equipment or medical supply items. Those items included: bio-hazard waste receptacles or bags, hemoccult cards with developer (in the PCP room), lubricating jelly (in the PCP room), tongue depressors, a nebulization unit, an oto-ophthalmoscope, and a permanently affixed Snellen chart with an established distance marker on the floor. Also, two clinics had expired calibration stickers on an oto-ophthalmoscope and an automated vital signs machine; one clinic's RN exam room lacked an exam table. OIG inspectors were told that clinical staff were unable to maintain appropriate medical supply levels because former clinical space had been turned over to the dental program (MIT 5.108).

- Only three of nine clinics' common areas (33 percent) had an environment conducive to providing medical services. Five clinics did not provide adequate auditory privacy in their triage areas and vital sign check stations (Figure 3). A sixth clinic's associated blood draw station did not ensure auditory privacy when more than one patient received a blood draw at the same time (MIT 5.109).

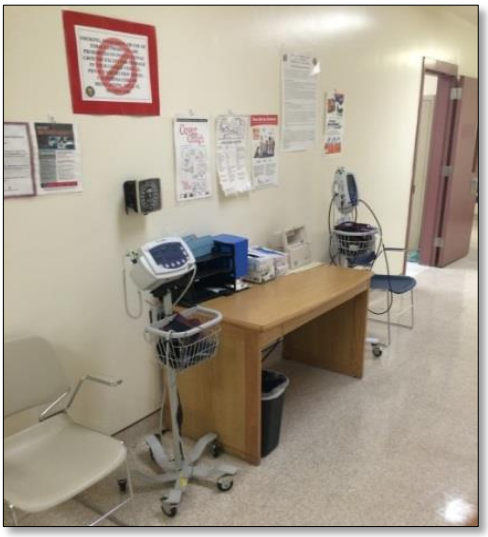

Figure 3: Triage areas that do not ensure auditory privacy.

- Only four of the nine clinics observed (44 percent) had appropriate space, configuration, supplies, and equipment to allow clinicians to perform a proper clinical exam. Five clinics had exam rooms with one or more deficiencies, including exam tables with torn or worn vinyl areas that could not be adequately disinfected and could harbor infectious agents, an exam table that could not be extended to allow a patient to lie in a full and unhindered supine position (Figure 4), unlabeled supply cabinets or drawers, and personal food items stored with medical supplies. Four clinics had locations where confidential medical records designated for shredding were either easily accessible to be viewed by other inmates or not discarded daily. Also, OIG inspectors were told by a clinician in one clinic that dressing changes were performed in the common area hall ways due to space limitations (MIT 5.110).

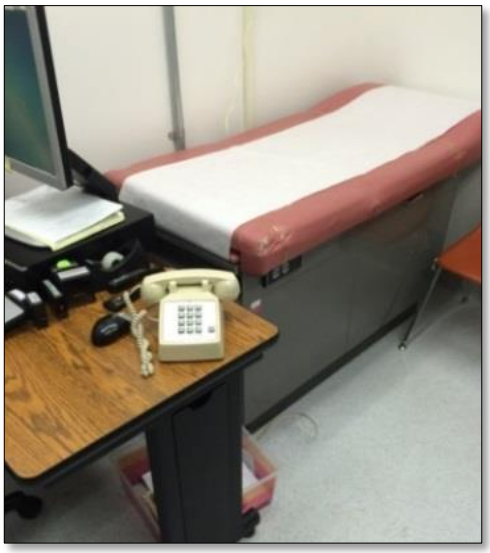

Figure 4: Poor table placement for exam table and worn vinyl corner.

- Only five of nine clinics (56 percent) followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste. The four remaining clinics had exam rooms that did not have a sharps container (MIT 5.105).

- Inspectors examined emergency response bags to verify staff inspected them daily and inventoried them monthly, and whether they contained all essential items. Emergency response bags were compliant in only four of the seven clinical locations where bags were stored (57 percent). In one clinic, staff had not inventoried the emergency response bag contents within the prior 30 days; in another clinic, the bag's oxygen tank was not fully charged; and in a third clinic, the bag did not have an access control seal on all bag compartments and one of two required glucose sticks was missing (MIT 5.111).

- OIG inspectors observed clinicians' encounters with inmate-patients in eight of the institution's applicable clinics and concluded that clinicians followed good hand hygiene practices in five of the clinics (63 percent). In three clinics, inspectors observed that clinicians did not always properly sanitize their hands prior to putting on gloves, before patient contact, and after removing gloves (MIT 5.104).

The institution performed well in the four areas below:

- All nine clinical areas examined possessed operable sinks with adequate hygiene supplies, including both hand soap and disposable hand towels (MIT 5.103).

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

- Clinical health care staff at eight of nine clinics (89 percent) ensured that reusable invasive and non-invasive medical equipment was properly sterilized or disinfected. The only exception was one clinic that utilized an alternate chemical sterilization cleaning process for invasive medical equipment that did not include the use of an autoclave, cleaning log, or post sterilization protective packaging. Specifically, the clinic simply cleaned its reusable invasive equipment with a solution and then stored the equipment in an unpackaged and unlabeled storage tray with other similar equipment (MIT 5.102).

- Eight of the nine clinics examined (89 percent) were appropriately disinfected, cleaned, and sanitary. However, inspectors observed one clinic that was extremely dusty, dirty, and without evidence of recent cleaning logs. Inspectors learned that, due to the primary clinic's construction renovation, health care management had redirected most patients to another clinic for health care services; however, inspectors found that nurses still triaged some patients in the clinic's temporary common areas for such services as bandage changes, foot soakings, and blood pressure checks (MIT 5.101).

Other Information Obtained from Non-Scored Results

The OIG gathered information to determine if the institution's physical infrastructure is maintained in a manner that supports health care management's ability to provide timely or adequate health care. The OIG does not score this question. When OIG inspectors interviewed health care management, the staff did not indicate they had any significant concerns. Management indicated that the current infrastructure does present some limitations and that health care staff perform the best they can with the resources currently available, but that new construction projects underway will alleviate those concerns. VSP has three infrastructure projects underway, including a pharmacy renovation, Facility A renovation, and a third project to renovate and add space to Facilities B, C, and D primary clinic areas. Construction started in fall 2015, with the expected completion for all projects by late 2016 (MIT 5.999).

Recommendations

The OIG recommends that VSP:

- Monitor areas where medical supplies are stored to ensure the supplies are unexpired; not stored directly on the ground; adequately organized and labeled, when needed; and temperature controlled based on manufacturer guidelines, as applicable.

- Properly maintain and stock clinic areas with a full complement of core medical equipment and supplies. Require staff to monitor calibration expiration dates for applicable medical equipment.

- Ensure that clinic common areas and exam areas maintain auditory privacy for patients being examined or triaged in those areas.

- Position exam tables in exam rooms so that patients can lie fully extended on the exam table and clinicians can have unimpeded access to the patient. Repair or replace exam table covers that have worn spots or tears.

INTER- AND INTRA-SYSTEM TRANSFERS

Case Review Rating:
Adequate
Compliance Score:
Adequate
(80.1%)

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 VSP to another CDCR facility. The OIG review includes evaluation of the institution's ability to provide and document health screening assessments, initiation of relevant referrals based on patient needs, and the continuity of medication delivery to patients arriving from another institution. For those patients, the OIG clinicians also review the timely completion of pending health appointments, tests, and requests for specialty services. For inmate-patients who transfer out of the facility, the OIG evaluates the ability of the institution to document transfer information that includes pre-existing health conditions, pending appointments, tests and requests for specialty services, medication transfer packages, and medication administration prior to transfer. The OIG clinicians also evaluate the care provided to patients returning to the institution from an outside hospital and check to ensure appropriate implementation of the hospital assessment and treatment plans.

Case Review Results

The OIG clinicians reviewed 37 encounters relating to *Inter- and Intra-System Transfers*, including information from both the sending and receiving institutions. In addition, the OIG clinicians also reviewed 45 hospitalization events, each of which resulted in a transfer back to the institution. In general, the inter- and intra-system transfer processes at VSP were adequate, with the majority of the transferring patients receiving timely continuity of health care services. There were 39 minor deficiencies related to health information management, delay in receiving medications, and incomplete nursing documentation. Specific examples of case review findings are listed below.

Transfers In

The following nursing deficiencies were identified:

- In case 17, the RN did not indicate the primary language of the patient or if he had any disability (per the eUHR, the patient had significant foot deformity). Also, the RN did not explain why the patient appeared to have difficulty understanding or making appropriate responses.

- In case 24, the outpatient housing unit (OHU) RN who completed the initial health screening form did not perform an assessment of the patient's complaint of pain. While the MAR showed the patient was given pain medication, the nurse failed to record the time given or the effectiveness. In addition, the nurse incorrectly documented that the patient did not have

elevated risk for coccidioidomycosis exposure, when he actually was at medical risk level 2 due to continuous oxygen. The nurse did not review and sign the transfer form until nine days after the patient arrived at the institution.

- In case 61, the RN failed to make a referral for chronic care provider follow-up for a patient with hypertension and diabetes who required several medications. In addition, the nurse failed to accurately document the patient's time of arrival. An accurate arrival time is crucial for determining medication continuation from the sending institution.

- In case 64, the Health Care Screening form (CDCR Form 7277) was not completed upon the patient's arrival at the institution, and direct admission to the OHU.

Transfers Out

The deficiencies found for patients transferring out of VSP were mainly due to incomplete nursing documentation of significant medical information on the Health Care Transfer Information Form (CDCR Form 7371). The following deficiencies were found:

- In case 28, the nurse did not accurately complete the transfer form. The nurse did not document the date of the last provider visit, did not list the pending specialty appointments, and did not complete the disability and developmental status of the patient.

- In case 29, the nurse failed to list the patient's pending appointments. In addition, the nurse failed to document that the patient wore a disability vest and a back brace.

Hospitalizations

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

The majority of hospital return patients were processed appropriately by the TTA RN. The following deficiencies were identified after hospital return:

- In case 21, there was no hospital discharge summary for the provider to review.

- In case 22, the progress notes were incomplete.

- Hospital discharge summaries were scanned into the eUHR without a provider signature in cases 2, 3, 13, 19, 20, 23, 31, 32, 33, and 34.

- Medication lapses occurred after returning from hospitalization in cases 32, 33, and 34.

- In case 31, there was no nursing documentation upon the patient's return from hospitalization.

Clinician Onsite Inspection

At the time of the OIG clinician's inspection, VSP's receiving and release (R&R) clinic provided ample space for examination and auditory privacy for the patients during initial screening. The nursing staff assigned to the area were knowledgeable about the procedures and processes of transferring patients in and out of the institution.

Compliance Testing Results

Valley State Prison obtained an *adequate* compliance score of 80.1 percent in the *Inter- and Intra-System Transfers* indicator and scored in either the *proficient* or *adequate* range in the four test areas discussed below:

- The transfer packages for all three inmate-patients who transferred out of the institution during the OIG's onsite inspection included the patients' required medications, medication administration records, and medication reconciliation documents (MIT 6.101).

- For all 30 of the patients sampled, VSP's registered nurses completed the assessment and disposition sections of the Initial Health Screening form (CDCR Form 7277) on the same day staff completed an initial screening of the patient (MIT 6.002).

- Of nineteen sampled inmate-patients who transferred into VSP with an existing medication order, only 15 of the patients (79 percent) continued to receive their medications without interruption or by the next dosing interval after arrival. Four inmate-patients did not receive scheduled doses of one or more medications (MIT 6.003).

- The institution received a score of 77 percent when the OIG tested 30 patients who transferred into VSP from another CDCR institution to determine whether they received a complete initial health screening assessment from nursing staff on their day of arrival. Nursing staff timely completed the Initial Health Screening (CDCR Form 7277) for 23 of the patients sampled, but neglected to answer all screening questions for seven others (MIT 6.001).

The institution scored poorly in the one area described below:

- The institution scored 45 percent when the OIG tested 20 inmate-patients who transferred out of VSP to another CDCR institution to determine whether VSP listed the patients' pending specialty service appointments on their Health Care Transfer Information form (CDCR Form 7371). The institution failed to include specialty service appointments approved at VSP on the transfer forms for 11 patients. In 8 of the 11 noted deviations, the transfer form indicated that detailed information regarding the specialty service was on an attached form; however, that document was not scanned into the eUHR (MIT 6.004).

Recommendation

The OIG recommends that VSP consider improving the hospital return process by developing a process that ensures providers timely review hospital and emergency room discharge reports prior to records management staff scanning the documents into the eUHR.

PHARMACY AND MEDICATION MANAGEMENT

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(72.5%)

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 PCP prescriber, staff, and patient.

Case Review Results

The OIG clinicians evaluated the *Pharmacy and Medication Management* indicator as secondary processes as they relate to the quality of clinical care provided. Compliance testing was a more targeted approach and was heavily relied on for the overall rating for this indicator. For case reviews, the clinicians reviewed 31 events related to pharmacy and medication management. Within the 28 deficiencies seen, there were 15 delays in patients' receiving keep-on-person (KOP) medications.

New Prescriptions

In the majority of cases, patients received their medications timely and as prescribed. However, there was one case in which prescriptions were not processed timely:

- In case 22, the new KOP prescription tamsulosin (prostate medication) was delivered to the patient four days late. In addition, a new prescription of magnesium hydroxide (antacid) was delivered to the patient three days late. In the same case, a new prescription of antibiotic cream was delivered to the patient four days late.

Chronic Care Medication Continuity

The majority of patients received their chronic care medications without interruption. However, five cases had either significant delays in receiving chronic care medications or unexplained missed doses of chronic care medications:

- In case 1, a KOP asthma inhaler was refilled but delivered 18 days later. In the same case, a KOP cholesterol medication was refilled, but delivered to the patient 14 days later, and a KOP eye drops prescription was refilled but delivered to the patient 20 days later.

- In case 2, fluorouracil (anti-cancer skin cream) was ordered as a nurse-administered medication. There was no indication that nighttime doses for May 12 and May 22, 2015, were administered.

- In case 4, the pharmacist refilled triamcinolone (nasal allergy spray), but the medication was delivered to the patient 22 days later.

- In case 14, the medication administration record indicated that the patient's chronic care hydrochlorothiazide (diuretic) and glipizide (diabetes) medications expired on April 20, 2015, but were not reordered until June 2015. The delay may have contributed to the patient's uncontrolled hypertension and diabetes found at his following provider visit.

- In case 34, there was a nine day delay in delivering a KOP atorvastatin (cholesterol lowering) medication to the patient.

Intra-System and Intra-Facility Transfers and Medication Continuity

Medication continuity was maintained in the majority of the reviewed transfer cases. However, there was one deficiency:

- In case 32, the patient did not receive his triamcinolone nasal spray until two days after his arrival.

Post Hospitalization Medication Continuity

Medication continuity for patients returning from a hospitalization was generally maintained for the reviewed cases. However, there were two cases with minor medication lapses after the patient's return after hospitalization:

- In case 32, the patient returned from the hospital and was not given his evening DOT doses of phenytoin (anticonvulsant) and rifaximin (antibiotic).

- In case 33, there was a three-day delay in delivering the patient's KOP furosemide (diuretic), clonidine (blood pressure medication), and carvedilol (heart medication).

Medication Administration

Case review found the following deficiencies in medication administration. These are also addressed in the *Quality of Nursing Performance* indicator.

- In cases 3, 20, 31, 32, 35, and 63, the nurses failed to initial the MARs to show that medications were administered or that the patient otherwise failed to present to the medication line.

Clinician Onsite Inspection

During the onsite inspection, OIG clinicians met with medical, nursing, and pharmacy representatives regarding case review findings. VSP nursing and pharmacy management was aware of these specific cases, and had conducted interdisciplinary discussions and root cause analysis exercises regarding the issues. The pharmacy staff demonstrated medication-logging procedures and ensured that medications were well stocked in the TTA Omni-cell. The pharmacists were very knowledgeable about tracking and reporting institutional medication errors. The medication error log showed a total of 67 medication errors reported for the month of August 2015. For the 67 reported errors identified by the institution's medical staff, none were high level errors, i.e. level 4 or higher (high level errors are those requiring a change in medical treatment, hospitalization, or death).

Conclusion

The OIG case review rated *Pharmacy and Medication Administration* performance *inadequate*, with specific concerns regarding the continuity of KOP medications, timeliness of receiving new prescriptions, and continuity of medications for patients returning from outside hospitalization.

Compliance Testing Results

The institution received an *inadequate* compliance score of 72.5 percent for the *Pharmacy and Medication Management* indicator. For discussion purposes below, this indicator is divided into three sub-indicators that consist of Medication Administration, Observed Medication Practices and Storage Controls, and Pharmacy Protocols.

Medication Administration

This sub-indicator, in which the institution received an average score of 57 percent, consists of four applicable questions. The institution has an opportunity to improve in the following medication administration areas:

- Chronic care medications were provided timely to only 12 of the 30 inmate-patients sampled (40 percent). Eighteen patients received their medications late, received the wrong medication dosage, or did not receive required PCP counseling when they missed doses of their medication (MIT 7.001).

- Clinical staff timely provided new and previously prescribed medications to only 9 of 20 patients sampled who had been recently discharged from a community hospital and returned to VSP (45 percent). Ten patients received their medications from one to three days late; two of those ten patients also had provider orders for an additional medication that they never received. Another patient continued to receive two medications for several days, even

though the VSP provider had discontinued the medications upon the patient's return from the hospital (MIT 7.003).

- Inspectors evaluated 30 inmate-patients who transferred from one housing unit to another to verify they received their medications without interruption. Only 19 patients (63 percent) received all required doses of their DOT medications following a housing unit move. For eight patients, although nursing staff documented that the patient was either a "no show" or had refused to come to medication, they failed to document their follow-up efforts to deliver the medication to the patient or bring the patient to the medication line location. For three other patients who missed doses of their medications, there was no documentation at all (MIT 7.005).

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

- Twenty-four of the 30 patients sampled (80 percent) timely received their new medication orders. Five inmate-patients received their medication from one to 17 days late, and one additional inmate-patient's MAR did not have the printed date he received his medication (MIT 7.002).

Observed Medication Practices and Storage Controls

This sub-indicator, in which the institution received an average score of 65 percent, consists of six applicable questions. The institution has an opportunity to improve in the following three test areas:

- Valley State Prison demonstrated strong medication security controls over narcotic medications in only one of the nine applicable clinics and medication line storage locations sampled, scoring 11 percent for this test. The other eight clinics and medication line storage locations had weak medication security controls because more than one nurse had a key to each location's narcotics locker during the same shift (MIT 7.101).

- At only three out of seven sampled medication lines (43 percent) were nursing staff generally compliant with proper hand hygiene contamination control protocols. For four of the medication lines, nurses failed to sanitize their hands prior to initially putting on gloves and between subsequent glove changes (MIT 7.104).

- The institution properly stored non-narcotic medications that required refrigeration at 6 of the 11 applicable clinics and medication line storage locations inspected (55 percent). For five of the other areas inspected, refrigerated medication awaiting return back to the pharmacy was not clearly identified or stored separately from other medications. In one of the same locations, inspectors also found a medication refrigerator that was operating at a temperature above the allowable upper temperature range limit (MIT 7.103).

The institution received *proficient* scores in the following three pharmacy and medication management areas:

- Nursing staff followed appropriate administrative controls and protocols during the medication distribution process at all seven pill line locations the OIG inspectors observed (MIT 7.106).

- The institution properly stored non-narcotic medications that did not require refrigeration at 14 of the 15 applicable clinics and medication line storage locations sampled (93 percent). In one clinic's exam room, the medication cabinet was left unlocked while not in active use (MIT 7.102).

- Nursing staff at six of the seven sampled medication and preparation administration locations (86 percent) followed appropriate administrative controls and protocols during medication preparation. At one location, the medication line nurse had no system in place to reconcile patients' newly received medications back to the physician's order to validate receipt of the correct medication (MIT 7.105).

Pharmacy Protocols

This sub-indicator category consists of five questions, in which the institution received an average score of 94 percent, which falls in the *proficient* range.

The institution scored 100 percent in the following four tests:

- In its main pharmacy, the institution followed general security, organization, and cleanliness management protocols; properly stored and monitored non-narcotic medications that required refrigeration and those that did not; and maintained adequate controls and properly accounted for narcotic medications (MIT 7.107, 7.108, 7.109, 7.110).

The institution has an opportunity to improve in the following pharmacy operational area:

- VSP followed key medication error reporting protocols for only 18 of 25 samples tested (72 percent). In the other 7 samples, the pharmacist-in-charge (PIC) did not follow proper protocols. Specifically, for five samples the PIC did not complete a medication error follow-up report and in two other instances the PIC either did not identify their follow-up review date or did not assign a severity level to the medication error (MIT 7.111).

Non-Scored Tests

In addition to testing reported medication errors, OIG inspectors follow up on any significant medication errors found during the case reviews or compliance testing to determine whether the errors were properly identified and reported. The OIG provides those results for information

purposes only; however, at VSP, the OIG did not find any applicable medication errors (MIT 7.998).

In another non-scored test area, inspectors verified that inmate-patients in isolation units had their prescribed rescue medications such as KOP asthma inhalers and nitroglycerin medications. At VSP, three of the four applicable inmate-patients housed in isolation units had immediate access to their prescribed KOP rescue medications. One patient reported that custody staff had confiscated his rescue inhaler when he was placed on contraband watch, and that he had not informed medical staff of the confiscation. Inspectors immediately notified the institution's CEO who took timely action to ensure that an inhaler was issued to the patient (MIT 7.999).

Recommendation

To help ensure adequate medication control, the OIG recommends the institution ensure that only one shift nurse maintains control of a particular narcotics storage area and that each location requires a different access key.

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:
Inadequate
(66.1%)

Overall Rating:
Inadequate

Compliance Testing Results

The institution performed in the *inadequate* range in the *Preventive Services* indicator with a compliance score of 66.1 percent. The institution received *inadequate* scores in three of six test areas, as discussed below:

- The institution scored 33 percent for timely administration of anti-tuberculosis (INH) medications. Of 18 patients sampled, only six received all required doses of INH for the most recent three-month period. Seven of the patients missed one or more medication doses, and none of them received provider counseling about the missed medication. Four other patients, according to their medical administration records (MAR), received one or more extra doses of INH. Finally, one additional patient's MAR erroneously indicated that the patient received a medication dose one day after he paroled (MIT 9.001).

- The institution scored 43 percent for conducting annual tuberculosis screenings. Although all 30 inmate-patients sampled were screened for tuberculosis within the prior year, zero of the 15 inmate-patients classified as Code 22 (requiring a tuberculosis skin test in addition to screening of signs and symptoms) were properly tested. For each of the 15 sampled Code 22 patient screenings, there was one or more of the following deficiencies: the 48-to-72-hour window to read test results was not determinable because nursing staff did not document either the administered (start) or read (end) date and time of the skin test; an LVN read and interpreted the test results rather than an RN, public health nurse, or primary care provider; or nursing staff did not complete all required sections of the Tuberculin Testing/Evaluation Report (CDCR Form 7331) including the history section. In addition to the sampled Code 22 patients, inspectors also sampled 15 inmate-patients classified as Code 34 (those who have previously tested positive for tuberculosis and do not receive a skin test). Inspectors found that nursing staff did not complete the CDCR Form 7331 history section for two of them (MIT 9.003).

- The OIG tested whether the institution offered vaccinations for influenza, pneumonia, and hepatitis to inmate-patients who suffered from a chronic care condition; 13 of the 21 sampled patients (62 percent) received all recommended vaccinations at the required

interval. However, the institution did not offer or document evidence of either a pneumonia vaccine or a hepatitis vaccine, or both, in eight of the sampled patients (MIT 9.008).

The institution scored at either the *proficient* or *adequate* levels in the following three areas:

- The institution was 93 percent compliant in offering annual influenza vaccinations to 28 of 30 inmate-patients sampled. Two inmate-patients did not either receive or refuse an influenza vaccination during the most recent influenza season (MIT 9.004).

- The institution provided colorectal cancer screenings to 26 of 30 sampled inmate-patients subject to the annual screening requirement (87 percent). For three patients, there was no evidence of a fecal occult blood test (FOBT) within the previous 12 months, even though a provider ordered one. For another patient, there was no evidence that the patient was offered or refused a fecal occult blood test within the previous 12 months or received a normal colonoscopy within the previous ten years (MIT 9.005).

- Fourteen of 18 inmate-patients sampled (78 percent) were properly monitored while taking INH anti-tuberculosis medications. Four patients did not receive all monthly monitoring during the three-month test period (MIT 9.002).

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 Quality of Nursing Performance at VSP was *inadequate*. The OIG RN clinicians evaluated 339 nursing encounters with 182 deficiencies, 15 of which were significant.

Failure to Perform Provider's Orders

On two occasions, VSP nurses failed to perform provider's orders:

- In case 11, a provider ordered blood pressure checks twice weekly for 30 days; however, the checks were not done.

- In case 34, a provider ordered a repeat blood pressure check later in the evening, which was not done.

Nursing Sick Call Triage Deficiencies

Nursing sick call triage was inadequate. CCHCS policy requires the nurse to review every sick call request on the same day it is received. The purpose of this review is to identify patients requiring same-day nurse assessment for serious complaints and symptoms, or to schedule the nurse assessment for the next business day. The following are examples of deficiencies:

- In case 23, the patient submitted a request, which was reviewed timely, due to chest pain; however, the nurse who triaged the request did not see the urgency of the request and waited two more days to examine the patient. The nursing assessment was inadequate. The patient was eventually seen by the primary care provider (PCP) the following day.

- In case 32, the patient was experiencing a possible medication side effect. He was not seen by the nurse until three days later. The nurse did not review the request on the date it was received.

- In case 40, the patient submitted a request related to knee pain. He was seen by the nurse one day late.

- In case 45, the patient submitted a request for upper respiratory symptoms. He was not seen by the nurse until two days after the request was received.

- In case 47, the patient submitted a request for having a foreign object stuck in the back of his tongue. The nurse failed to see the urgency of the complaint. The patient was not scheduled to see the nurse until two days later. The nurse should have taken the patient to the TTA for urgent evaluation. By the time he was scheduled for evaluation, he refused to see the nurse, stating that the issue was resolved.

Nursing Assessment and Documentation Deficiencies

The majority of nursing encounters demonstrated inadequate assessment. Some of these significant deficiencies could potentially have contributed to patient harm. In many of these cases, the encounter form was partially completed. The OIG clinicians could not determine if the nurse asked important questions, performed necessary measurements, or examined pertinent areas of the body. Nurses failed to routinely document the presence or absence of common accompanying signs and symptoms. Nurses also made direct referrals to providers without assessing the patient's physical complaint. Although some of the nursing assessments were generally rated adequate, the following cases demonstrate areas for nursing improvement:

Referrals without nursing assessments:

- In case 1, the patient submitted a request to see medical staff for medication side effects possibly affecting his stomach and esophagus. The nurse reviewed and processed the request

and made a referral to the PCP. The nurse failed to assess the patient's physical complaint before making a PCP referral. The patient had a PCP visit on that same day.

- In case 21, the patient submitted a request to see medical staff due to medication side effects. The nurse reviewed and processed the request and made a referral to the PCP. The nurse failed to assess the patient's physical complaint before making a PCP referral.

- In case 32, the patient submitted a request to see medical staff due to medication side effects of shaking. The nurse reviewed, processed the request, and made a referral to the PCP. The nurse failed to assess the patient's physical complaint before making a PCP referral.

- In case 41, the patient submitted a request to see medical staff due to soreness to his hip and ankle. The nurse reviewed and processed the request and made a referral to the PCP. The nurse failed to assess the patient's physical complaint before making a PCP referral.

- In case 50, the patient submitted a request to see medical staff due to foot pain. The nurse reviewed and processed the request and made a referral to the PCP. The nurse failed to assess the patient's physical complaint before making a PCP referral. This routine referral did not occur. Therefore, the patient submitted another request for the same problem two days later. Once again, the nurse did not assess the patient's physical complaint and made another referral to the PCP. The patient was eventually seen by a specialist 12 days later.

- In case 63, the patient submitted a request to see medical staff due to right arm weakness. The nurse reviewed and processed the request and made a referral to the PCP. The nurse failed to assess the patient's physical complaint. While there was a scheduled PCP encounter later that day, the eUHR lacked progress notes to indicate that the visit with the PCP occurred.

Inadequate or incomplete assessments or interventions:

- In case 1, the patient was seen in the clinic for several issues, including dry skin, an eyelashes procedure, and a need for medical boots. The nurse did not perform an assessment of the patient's skin, eyes, or vision. The patient also had musculoskeletal problems. The nursing assessment was incomplete and was improperly formatted.

- In case 2, the patient was seen in the clinic for a follow-up nursing review for all of his chronic conditions. The nurse failed to provide appropriate education on the patient's request for information on the salt content in his food. In addition, this patient was seen for swelling of the hands, knees, and legs. The nurse assessed the patient, checked his vital signs, and examined the affected areas, but the nursing assessment was inadequate; the nurse did not check circulation in the patient's legs, knees, hands, or feet, nor comment if his skin was dry or cracked. The nurse did not compare the patient's current weight with his previous

weight. The nurse failed to follow standard nursing protocols for formulating a nursing diagnosis, as required by NANDA[4] guidelines, which CCHCS requires nurses to adhere to.

- In case 3, the patient was seen in the clinic due to the complaint of pain and vision problems. The nurse failed to obtain a past medical history of diabetes, and to perform a visual acuity test. The nurse should have referred the patient to the provider on that same day. Other deficiencies related to this case are the following:

    - The nurse saw the patient for incontinence for the past four days. The nurse did not perform an adequate objective assessment. The nurse did not provide protocol medication for diarrhea. Further, the nurse should have scheduled a follow-up nurse visit the next day to check on the patient's condition.

    - The nurse saw the patient in the clinic for severe pain and burning sensation of his shoulder and hand and a bump on his inner forearm for the past ten days. The nursing assessment did not address the complaints.

    - The LVN referred the patient to the after-hours TTA RN to assess the patient's weakness, dizziness, headaches and body aches, and sweating. The TTA RN failed to follow up on the LVN referral and did not assess the patient. Instead, the TTA RN advised the LVN to add the patient to the next day's normal RN's morning sick call line. The morning visit did not occur.

- In case 11, the nurse saw the patient in the clinic for leg swelling. The nursing assessment was inadequate. The nurse failed to assess the leg for warmth and tenderness. Based on the patient's past history of deep vein thrombosis (blood clots), the nurse failed to make an urgent referral to the PCP for further diagnostic testing. The nurse did not document that the patient was wearing support hose to prevent his legs from swelling. The nurse did not compare pulses of both legs, and did not notify the PCP of the elevated blood pressures. The nurse documented that the patient was at risk for deep vein thrombosis on his left leg instead of consulting with a provider. The nurse did not tell the patient to notify staff if his leg developed pain, redness, warmth, or if he had chest pain, shortness of breath, or increased leg swelling.

- In case 20, the patient had urinary problems. The nursing subjective and objective assessments were inadequate. The nurse did not ask about any accompanying symptoms such as burning sensation, itching, or blood in the urine, nor any history of chronic diseases, and the nurse failed to examine or feel the abdomen over the patient's bladder. The nurse did not perform a urinalysis. In addition, the patient was seen for the same urinary problem two months earlier. The nurse did not see the urgency of the fact that the patient could not

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

urinate. The patient was at high risk for urinary retention, a life-threatening situation. The nurse made a routine PCP referral instead of an urgent referral.

- In case 23, the patient was seen in the clinic for chest pain. The nursing subjective and objective assessments were inadequate. The nurse did not detail the patient's complaint of pain for onset, severity, or quality. The nurse also failed to obtain the history of illicit drugs use. The nurse did not assess the patient for neck vein distention, tracheal deviation, or any signs of difficulty breathing, and did not listen to his heart or lung sounds. The triage nurse failed to recognize the urgency of the request. This patient was not seen in the clinic for evaluation until two days after the request was received.

- In case 35, the patient was seen for abdominal pain. The nurse assessed the patient, checked his vital signs, and sent the patient to the TTA for further evaluation. Multiple deficiencies were identified: illegible handwriting and signature, failure to listen to bowel sounds, failure to feel the abdomen, failure to ask about accompanying symptoms, and failure to document if patient education was provided.

- In case 41, the patient was seen for soreness in his hip and ankle. The nurse failed to assess the patient's physical complaint.

- In case 43, the patient was seen for foot pain and wanted a soft shoe chrono. The nurse did not take the patient's vital signs and did not document the physical condition of the patient.

- In case 49, the patient was seen for eye and ear pain after he sustained an injury to his face. The nursing assessment of the patient's eyes and ears was inadequate. The nurse did not examine the inner part of the patient's ear, did not test the patient's visual acuity, and did not assess the pupils for roundness, reactivity to light, or symmetry. The nurse did not document what patient education was provided. The nurse's pain assessment was inadequate.

- In case 65, the patient submitted a request to see medical staff due to pain and weakness. The nurse reviewed and processed the request and made a referral to the PCP. However, the PCP saw the patient that same day, but failed to address the patient's chief complaint.

Nursing Documentation Deficiencies

Illegible handwriting for notes and signatures was found in the majority of the records reviewed. The following cases demonstrate deficiencies in documentation, the requirements of which are clearly established by CCHCS nursing policy and protocols. They are part of the institutional nursing education and training orientation.

- Cases 1, 3, 31, and 33 were examples wherein nursing progress notes had illegible signatures and handwriting.

- In cases 1, 5, and 45, the nurse failed to accurately complete the refusal forms, encounter forms, or progress notes.

Medication Management and Administration

Outpatient medication administration was generally timely and reliable. During the onsite inspection visit, all the clinic and medication LVNs participated in the primary care morning huddles to ensure they shared medication issues and received pertinent information affecting their delivery of care. See the *Pharmacy and Medication Management* and *Emergency Services* indicators for specific findings.

Emergency Care

Nurses working in the TTA and emergency responders at VSP were knowledgeable and skillful in providing emergency nursing care. Documentation demonstrated adequate nursing decision-making and good performance during challenging cases. A few deficiencies were found, namely inconsistent documentation, illegible documentation, and inadequate assessments; however, all were minor and unlikely to contribute to patient harm. Nursing emergency care was adequate. The deficiencies are further described in the *Emergency Services* indicator.

Clinician Onsite Inspection

Nurses in all the clinics were active participants in morning huddles, coordinating and communicating care management needs of patients. The clinic RNs effectively facilitated the morning huddle, covering such topics as recent TTA patients, transfers out and in, patients who were noncompliant with medications, patients who returned from outside hospitals, significant labs or diagnostic reports, PCP or RN line backlogs, and add-ons and referrals from the previous day. The morning huddle started on time with good attendance, including clinic providers, RNs, clinic LVNs, and the medication LVNs. Custody's participation was on an as-needed basis only. The primary care team had a huddle script, and the participants maintained a sign-in sheet to ensure tracking of the daily morning huddle.

The OIG clinicians visited various clinical areas and spoke freely with nursing staff during walking rounds, including nurses in specialty services, preventive services, OHU, TTA, facilities A, B, C, and D, and the administrative segregation unit. Nursing and support staff were knowledgeable about their duties and responsibilities and the patient populations within their assigned clinical areas. Nursing had specific communication channels for making requests and reporting issues, as well as improvement strategies for nursing performance. Nursing staff at all levels stated there were no major barriers to communication with providers, nursing supervisors, or custody staff.

The OIG clinicians reviewed 14 supervisory files and 18 training files for one or more RNs assigned to each clinic, the TTA, and the OHU. The training files for the public health nurse and the nursing instructor were also reviewed. Twelve of the 14 supervisory files lacked a current annual performance evaluation and duty statement. In addition, all 18 sampled training files lacked proof of

orientation training and evidence of recently completed RN competency validation testing. File folder records were often disorganized, outdated, and some competency validation tests found were never graded or evaluated. However, it should be noted that, during the OIG's on-site compliance testing, inspectors found that eight of ten sampled LVN's had properly completed nurse competency tests on file; however, the compliance test only focused on LVNs and not the RNs as discussed above.

Recommendations

The OIG recommends that:

- The chief nurse executive and the supervising registered nurses review and improve the current process of evaluating nursing competency to reflect an accurate assessment of a nurse's knowledge and performance.

- Nurses are provided additional training to ensure that they understand how to recognize cases requiring same-day assessment and how to appropriately prioritize sick call requests to help reduce the current back log of patient appointments.

- Nursing supervisors ensure that subordinate nurses develop and document nursing diagnoses and conclusions in accordance with NANDA taxonomy.

- Nurses utilize dictation and signature stamps to improve legible writing.

- VSP management seek input from nursing staff at all levels for quality improvement projects and monitoring strategies with the goal of improving operations, such as nursing documentation.

QUALITY OF PROVIDER PERFORMANCE

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

Case Review Rating:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

Case Review Results

The OIG clinicians reviewed 309 medical provider encounters and identified 41 deficiencies related to provider performance. Most deficiencies were minor and unlikely to contribute to patient harm. There were eight significant deficiencies. As a whole, VSP provider performance was rated *adequate*.

Assessment and Decision-Making

In general, the providers at VSP made appropriate assessments and sound medical plans. There were two significant deficiencies identified:

- In case 9, the patient had impaired kidney function (creatinine level of 1.67). The provider should have discontinued metformin (diabetes medication) since it was contraindicated for a creatinine at or above 1.5.

- In case 14, the provider failed to address a significant laboratory finding that showed impaired kidney function (creatinine of 1.67), and an acid buildup in the blood (metabolic acidosis with bicarbonate of 17 with an anion gap of 16). The patient was taking metformin, contraindicated as described above. The metformin could have further elevated the acidosis. The provider should have ordered a repeat basic metabolic panel sooner than three months.

Anticoagulation Management

VSP providers generally managed anticoagulation appropriately. There was one minor deficiency:

- In case 11, the provider prescribed an inappropriately low dose of enoxaparin (blood thinner). This placed the patient at risk for blood clot enlargement and for serious embolism (movement of the clot) to the heart and lungs.

Emergency Care

Providers generally made appropriate triage decisions when patients presented emergently to the TTA, and providers were available for consultation with the TTA nursing staff. Overall, care provided was adequate; however, there was one minor deficiency:

- In case 18, the patient refused transfer to a community hospital for chest pain. The provider should have made sure that the patient followed up with his primary care provider the next day.

Chronic Care and Sick Call

Chronic care performance was generally adequate, as most providers demonstrated good care in regard to hypertension, asthma, hepatitis C, and cardiovascular disease. There were two significant deficiencies:

- In case 14, the provider evaluated the patient during a chronic care visit and failed to address chronic medical conditions of hypertension, kidney disease, and dyslipidemia (high cholesterol).

- Also, in case 14, the provider failed to start a cholesterol-lowering medication (a statin) to a patient at high risk for heart disease or stroke (the patient had a calculated 10 year risk of 29.4 percent). According to the guidelines, the patient should have been on a high-intensity statin.

There were two minor deficiencies in provider management of acute and chronic conditions:

- In case 1, the patient was a 67-year-old male with history of smoking. The provider failed to screen this patient who was at risk for an abdominal aortic aneurysm.

- In case 3, the provider failed to address a nursing sick call referral of "right eye pain causing throbbing headache."

The management of diabetes was adequate, with appropriate adjustments of insulin and medications to assure glucose control. Most diabetic patients had preventative pneumonia immunizations and yearly retina exams. Their blood pressure and cholesterol levels were at goal. However, there were two significant deficiencies:

- In case 3, the patient had a recent adjustment of basal insulin, but the provider failed to check the patient's daily fasting finger-stick blood glucose, and failed to follow up in three to seven days for further adjustment of basal insulin until the patient's average fasting glucose reached the target range.

Specialty Services

VSP providers generally referred appropriately and reviewed specialty reports timely; however, not all the reports were properly signed by the providers to evidence their review of the findings and recommendations. In most cases, the providers appropriately implemented the consultant's recommendations; however, there was one significant deficiency:

- As mentioned above, in case 9, the provider failed to address the endocrinology recommendation to discontinue metformin if repeat creatinine levels are more than 1.5. The patient had a subsequent creatinine level of 1.67.

There was also one minor deficiency with regard to provider performance in specialty services:

- In case 8, the provider failed to address the specialist's recommendation to start nortriptyline for the treatment of neuralgia pain.

Hospital Return

Although providers failed to properly sign several hospital discharge summaries, providers generally implemented the hospitals' recommendations. However, there was one significant deficiency:

- In case 3, the provider failed to review a hospital report and to address the CT scan finding of a pulmonary nodule. The patient had history of smoking and was at an increased risk for lung cancer.

Pain Management

VSP providers appropriately managed acute pain, chronic arthritic pain, neuropathic pain, and cancer pain. VSP had a Pain Management Committee, which assisted providers in managing chronic pain. There were no significant deficiencies identified in pain management.

Health Information Management

Providers generally documented outpatient, TTA, and OHU encounters on the same day the provider saw the patient, and most progress notes were legible. However, in cases 18, 28, and 63, provider progress notes were not found in the eUHR.

Clinician Onsite Inspection

At the time of the OIG clinician's inspection, VSP had recently filled its one previously vacant provider position. The chief medical executive (CME) was transferred from another institution only about two weeks prior to the OIG clinical inspection. Each provider was mainly assigned to one clinic to assure continuity of care. The chief physician and surgeon provided clinical support in difficult cases, supervised the four mid-level providers, and performed all annual evaluations for all

the providers. The providers were supportive of the chief physician and surgeon and expressed satisfaction with ancillary services such as specialty and diagnostic services. All providers attended the daily provider meeting and morning huddles. Most providers expressed general job satisfaction with their positions, and the overall morale was good.

Conclusion

Overall, the VSP providers delivered good care in the majority of the physician-reviewed cases. The OIG rated VSP's *Quality of Provider Performance* as *adequate.*

Recommendations

Providers at VSP have an opportunity to improve their patient care with continuing medical education for the management of diabetes and anticoagulation. As a result, the OIG recommends the following:

- All VSP providers should familiarize themselves with contraindications for medications such as metformin, and dosing recommendations of enoxaparin for specific indications.

- VSP health care management should implement a process to ensure that providers properly sign all hospital discharge summaries and specialty reports and address their recommendations.

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. VSP's only specialized medical housing unit is the outpatient housing unit (OHU).

Case Review Rating:
Inadequate
Compliance Score:
Proficient
(94.0%)

Overall Rating:
Inadequate

For this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *inadequate* rating and the compliance testing resulting in a *proficient* score. The OIG's internal review process considered those factors that led to both scores and ultimately rated this indicator *inadequate.* The key factors were that the case review had a larger sample size, and the case review focused on the quality of care provided. As a result, the case review testing results were deemed a more accurate reflection of the appropriate overall indicator rating.

Case Review Results

VSP had 23 OHU beds at the time of the OIG's onsite inspection. All rooms were designated as medical beds with ten negative pressure rooms (rooms designed to minimalize spread of airborne infections). At the time of the OIG clinicians' visit, all medical beds were occupied. There were 108 provider encounters reviewed and eight deficiencies identified. There were 81 nursing events reviewed in the OHU and 38 deficiencies identified. Because of the numerous and significant nursing deficiencies, the case review rating for the *Specialized Medical Housing* indicator was *inadequate.*

Provider Performance

Provider performance in *Specialized Medical Housing* was adequate. The providers performed admission exams on all patients admitted to the OHU and addressed all active medical conditions. Most of the eight provider deficiencies were minor and unlikely to contribute to patient harm. There was one significant deficiency:

- In case 9, the patient had impaired kidney function (creatinine of 1.67). The provider failed to discontinue metformin (a diabetes medication) which is contraindicated for a creatinine equal to or greater than 1.5 (also discussed in the *Quality of Provider Performance* indicator).

For patients returning from outside hospital care or specialty services, providers were generally aware of the pertinent diagnoses and recommendations and appropriately addressed them. However, in one case, the provider failed to address a specialist's recommendation:

- In case 8, a provider failed to address a specialist's recommendation to start nortriptyline medication for the treatment of neuralgia pain (also discussed in the *Quality of Provider Performance* indicator).

Providers regularly evaluated patients in the OHU every 14 days, per policy, or sooner as indicated. There was one deficiency identified in provider follow-up:

- In case 6, the provider did not evaluate the patient for 18 days after admission to the OHU (also discussed in the *Access to Care* indicator).

Nursing Performance

Nursing performance in *Specialized Medical Housing* was *inadequate*. There were failures to communicate a patient's abnormal vital signs (elevated temperature) to a provider, inadequate or missing nursing assessments, and incomplete or illegible documentation. Of the 38 deficiencies, 29 involved the quality of nursing care, one involved appointments and scheduling, and eight involved health information management.

- In case 17, the following deficiencies were identified:
    - The patient had a temperature of 100.2 and tachycardia (rapid heart rate) of 120 beats per minute; nursing staff failed to perform a thorough evaluation or to alert a provider of the findings.
    - The temperature on the graphic record was 100.3; however, the nurse documented in the progress notes that the vital signs were stable.
    - On a different occasion, the patient had a temperature of 101.5 and nursing staff failed to perform a thorough evaluation and to alert a provider of the finding.
    - The patient had a heart rate of 119 beats per minute; nursing staff failed to perform a thorough evaluation or to alert a provider of the findings.
    - A nurse failed to reassess the patient's pain after administering pain medication.
    - The nurse delayed reporting the patient's fall to the provider for nine hours. Also, nurses should have performed head injury checks at least every shift until the patient was seen by a provider.
    - A nurse did not obtain a peak flow reading before and after a nebulizer breathing treatment, and there was no order for a nebulizer treatment.
    - A nurse noted swelling on both feet but did not document if the patient was wearing, or should be wearing, leg support hose in accordance with his approved medical needs form.

- The patient was taking furosemide (diuretic) for edema, which required that nursing staff weigh the patient at least monthly, but this was not done.

- The patient had a history of seizures, but the nurse failed to document fall precautions. The last fall risk assessment was done at another institution and rated the patient at moderate fall risk.

- In case 19, the nurse failed to explore the patient's complaint of low back pain after an un-witnessed fall two days prior to the encounter. The following deficiencies were also identified in this case:

    - Documentation of nursing rounds and assessments were missing for two days in the month of March 2015 and six days in the month of May 2015.

    - A nurse failed to adequately assess the patient's complaint of a rash and pruritus (itch).

- In case 61, the patient's height and weight were never measured for the duration of the patient's OHU stay. The following deficiencies were also identified:

    - A nurse failed to adequately assess swelling of the patient's lower extremities.

    - A nurse failed to adequately assess, treat, and document the patient's skin abrasions and did not make a referral to the provider for follow-up evaluation.

- In case 62, multiple deficiencies were identified:

    - A nurse failed to assess the patient's psychosocial status upon admission.

    - A nurse failed to obtain an actual weight of the patient who was receiving cancer treatment and could therefore have experienced weight loss.

    - A nurse failed to educate the patient about the medication delivery in the OHU setting, as the patient's pain medications were converted from keep-on-person to direct-observe therapy.

    - A nurse failed to adequately assess the patient's complaint of abdominal pain.

- In case 63, a nurse did not entirely complete the assessment form nor document the admitting diagnosis. A nurse documented the skin was intact, when, in fact, the patient had 33 sutures to his head. It was not clear if the nurse's documented patient-weight was an actual weight or a stated weight.

- In case 64, a nurse did not document if an elevated blood pressure (157/95) was communicated to the on-call provider and the nurse did not recheck blood pressure before the change of shift. Also, when this patient transferred out of the OHU, a nurse failed to indicate on the assessment placement tool that the patient had bladder incontinence, used adult diapers, and performed self-catheterization three times a day. In addition, there was no documentation of nursing rounds and assessments for all three shifts on one day.

Health Information Management

The OIG identified the following missing or misfiled documents.

- In case 24, the only nursing progress notes found in the eUHR from the second and third watch was a note stating an EKG was done.

- In case 61, there was no physician's order sheet on file for OHU placement. The institution did not follow the CCHCS guidelines, which require a Physician's Order Form 7221 for each OHU placement.

    - In this same case, there was no nursing documentation on file for an entire day, and there was no nursing documentation for the second watch on another day.

- In case 62, there was no nursing documentation of a patient discharge from the OHU on a day prior to hospitalization. It was unclear if this patient was appropriately processed as a discharged patient.

    - In this same case, there was no provider order for the patient's placement upon return to the OHU.

Clinician Onsite Inspection

During the onsite visit, the OHU had adequate medical supplies, clinical space, and nurse staffing levels. The OHU staff stated that they maintained their daily huddle to review cases with significant issues. However, the nursing rounds were not done consistently. Six nursing rounds for the month of March 2015 and four for May 2015 were not documented on the logbook. The OIG clinicians reviewed supervisory files and training files for nurses assigned to the OHU; training files lacked documentation of orientation and performance evaluations. Further, training records were disorganized and outdated. For the sampled RN files reviewed, none included evidence of a currently completed and graded nursing competency test.

Compliance Testing Results

The institution received a *proficient* score of 94 percent for the *Specialized Medical Housing* indicator, which focused on the institution's outpatient housing unit. As indicated below, VSP scored 100 percent in all but one of the following compliance test areas:

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

- Providers evaluated all ten sampled patients within 24 hours of admission (MIT 13.002). However, providers completed a history and physical within 72 hours of admission for only seven of the ten sampled patients, resulting in a score of 70 percent. For three sampled patients, there was no evidence that providers completed history and physical examinations (MIT 13.003).

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

- When the OIG observed the working order of sampled call buttons in OHU patient rooms, inspectors found them all working properly. According to staff the OIG interviewed, custody officers and clinicians were able to expeditiously access and enter inmate-patients' locked rooms when emergent events occurred (MIT 13.101).

Recommendations

The OIG recommends that:

- The institution reevaluate its current OHU process for monitoring nursing performance. A sufficient process includes ensuring that nursing staff complete legible documentation, conducting accurate patient assessments whenever there is a change in a medical condition, and timely communicating abnormal findings to providers.

- The chief nursing executive and supervising registered nurses review and improve the current process for evaluating nursing competency and conduct tests at least annually, and ensure that the tests reflect an accurate assessment of a nurse's knowledge and performance.

SPECIALTY SERVICES

_Case Review Rating__:_
Proficient
_Compliance Score__:_
Adequate
(83.8%)

Overall Rating:
Proficient

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

For this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving a *proficient* rating and the compliance review resulting in an *adequate* score. The OIG's internal review process considered those factors that led to both results and ultimately rated this indicator *proficient.* The key factors were that most of the compliance tests fell into the *proficient* range, and the final compliance score of 83.8 percent was very close to the *proficient* range.

Case Review Results

The OIG clinicians reviewed 160 events related to *Specialty Services*, and there were 71 deficiencies. All of the deficiencies were related to the health information management process. VSP effectively utilized telemedicine and onsite and offsite specialty services. In general, staff assigned to specialty services were very knowledgeable about their roles and responsibilities, and there was a tracking process to ensure specialty appointments were completed. Even though the providers did not properly sign many specialty reports, the providers were aware of the specialist reports and appropriately addressed their recommendations. The case review rating for *Specialty Services* was *proficient*.

Provider Performance

Case review showed that providers generally referred patients to specialists appropriately. The providers addressed specialist recommendations except on two occasions. These occasions are discussed further in the *Quality of Provider Performance* indicator.

Specialty Access

Specialty services were provided within excellent time frames for both routine and urgent services. Recommendations were generally addressed timely.

Health Information Management

Specialty reports were generally retrieved and scanned into the eUHR in a timely manner. However, the OIG identified the following deficiencies:

- In cases 2 and 7, specialty reports were not scanned into the eUHR for the provider to review.

- In case 34, a specialty report was scanned into the eUHR, but labeled as a health care services request form.

- In cases 1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 15, 18, 19, 21, 23, 28, 30, and 33, specialty reports were not properly signed by providers to evidence their review prior to being scanned by health records management staff.

Compliance Testing Results

The institution performed in the *adequate* range in the *Specialty Services* indicator, with a compliance score of 83.8 percent. However, five of the seven compliance tests scored in the *proficient* range, including the following:

- Fourteen of the 15 patients sampled (93 percent) received their high-priority specialty services appointments or services within 14 calendar days of the provider's order; one patient received his specialty service 12 days late (MIT 14.001). Providers reviewed high-priority specialists' reports within three business days of when the service was provided for 13 of the 14 patients sampled (93 percent). For one patient, there was no evidence of provider review of the consultant's report (MIT 14.002).

- For 14 of the 15 inmate-patients sampled (93 percent), a routine specialty service appointment or service occurred within 90 calendar days of the provider's order; one inmate-patient received his specialty service three days late (MIT 14.003). Providers reviewed routine specialists' reports within three business days of when the service was provided for 14 of 15 patients sampled (93 percent). For one patient, there was no evidence of provider review of the consultant's report (MIT 14.004).

- The institution received a score of 90 percent when the OIG tested the timeliness of VSP's denials of providers' specialty services requests for 20 inmate-patients; 18 denials were timely. The institution denied one service three days late and another, 25 days late (MIT 14.006).

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

- When inmate-patients are approved or scheduled for specialty services appointments at one institution and then transfer to another institution, policy requires that the receiving

institution ensure that the patient's appointment is timely rescheduled or scheduled, and held. Only 11 of the 20 patients sampled (55 percent) received their specialty services appointment within the required time frame. Seven patients received their specialty appointment between 2 and 85 days late, and two other patients did not receive an appointment at all (MIT 14.005).

- For 19 sampled patients who were denied a specialty service, only 13 (68 percent) received a timely notification of the denied service. California Correctional Health Care Services policy requires that when a specialty service is deferred or denied, the provider must communicate the decision to the patient and provide the patient with alternate treatment strategies during a follow-up visit within 30 days. For one patient, this requirement was not met at all; five other patients received a provider follow-up visit between 5 and 29 days late (MIT 14.007).

Recommendations

No specific recommendations.

SECONDARY (ADMINISTRATIVE) QUALITY INDICATORS OF HEALTH CARE

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

To test both the scored and non-scored areas within these two secondary quality indicators, OIG inspectors interviewed key institutional employees and reviewed documents during their onsite visit to VSP in August 2015. They also reviewed documents obtained from the institution and from CCHCS prior to the start of the inspection. The test questions used to assess compliance for each indicator are detailed in *Appendix A*.

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

INTERNAL MONITORING, QUALITY IMPROVEMENT, AND ADMINISTRATIVE OPERATIONS

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(45.6%)

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

Overall, VSP scored in the *inadequate* range for the *Internal Monitoring, Quality Improvement, and Administrative Operations* indicator, receiving a compliance score of 45.6 percent. The following five individual test areas scored in the *inadequate* range:

- When reviewing VSP's 2014 Performance Improvement Work Plan, inspectors found that the institution did not adequately document evidence of improvement in achieving targeted performance objectives for any of its four main quality improvement initiatives, scoring zero for this test. In general, the work plan included insufficient progress information to demonstrate that each of its performance objectives either improved or reached the targeted level (MIT 15.005).

- Inspectors reviewed drill packages for three medical emergency response drills conducted in the prior quarter. None of the drills included actual participation by custody staff, as CCHCS policy requires. In addition, one of the drill packages inspectors reviewed also did not include a required CDCR Form 7464 Triage and Treatment Services Flowsheet. As a result, VSP scored zero on this test (MIT 15.101).

- Based on information obtained from the institution's CEO, the institution's QMC meeting minutes or other subcommittee meeting minutes do not include discussions related to VSP's methodologies used to train staff who collect Dashboard data. As a result, the institution received a zero on this test (MIT 15.004).

- VSP timely processed inmate medical appeals during only four of the most recent 12 months (33 percent). Based on data received from the institution, there were extremely high levels

of overdue medical appeals for the eight-month period from August 2014 to March 2015. More specifically, during this time period the institution reported having more than 1,137 overdue medical appeals. However, the institution reported only three overdue medical appeals during April 2015, meaning VSP timely processed 99 percent of the appeals received that month, and reported no overdue medical appeals for the months of May through July 2015. The institution attributed the high number of overdue appeals from August to March 2015 to the absence of a key health care appeals coordinator who was out on a long term leave; sufficient staff were not reassigned to keep up with the case load during the coordinator's absence (MIT 15.001).

- The OIG inspected incident review packages for 12 emergency medical response incidents reviewed by the institution's EMRRC during the prior six-month period; only five of the packages (42 percent) complied with policy. For four of the reviewed incidents, the corresponding EMRRC meeting minutes were approved by a CEO designee instead of the CEO, as required by CCHCS policy. For three other reviewed incident packages, the findings section of the case review form was not complete (MIT 15.007).

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

- Medical staff promptly submitted the CDCR Form 7229A Initial Inmate Death Report to CCHCS's Death Review Unit for all three deaths that occurred at VSP during the OIG review period (MIT 15.103).

- Inspectors reviewed six recent months of QMC meeting minutes and confirmed that the QMC met monthly, evaluated program performance, and took action when improvement opportunities were identified, receiving a score of 100 percent (MIT 15.003).

- The institution's response addressed all of the patients' appealed issues for nine of ten second-level medical appeals reviewed (90 percent) (MIT 15.102).

Other Information Obtained from Non-Scored Areas

The OIG gathered non-scored data regarding death review reports and found that CCHCS's Death Review Committee did not timely complete its death review summary for the three deaths that occurred during the OIG's sample test period. The CCHCS Death Review Committee is required to complete a death review summary within 30 business days of the death and submit it to the institution's CEO. However, the committee completed its three summary reports between 17 and 149 days late (between 59 and 193 days after the death). As a result, CCHCS did not timely submit any of its reports to the institution (MIT 15.996).

Inspectors met with the institution's CEO to inquire about VSP's protocols for tracking appeals. The institution's health care appeals coordinator provides management with a monthly appeals tracking log to monitor the aging of appeals, as well as other weekly reports that the CEO regularly

discusses with the appeals coordinator. The reports break down appeals received, completed, open, and overdue. The reports also identify appeals processed and their disposition, and the appealed issues listed by category. For VSP, most health care appeals fell into the categories of medication or access to care. The CEO periodically tracks specific appeal complaints and, at the time of the OIG inspection, inmates were frequently appealing issues related to requests for low bunk assignments and the elimination or reduction of prescribed narcotics. According to the CEO, many patients arrive at VSP with narcotic addictions. When VSP eliminates or reduces those patients' narcotics prescriptions, patients often file an appeal. For these and other appeal problem areas, the CEO works closely with relative program staff to understand why the appeals are occurring and resolve related issues (MIT 15.997).

Non-scored data gathered regarding the institution's practices for implementing local operating procedures (LOPs) indicates that the institution had an effective process in place for developing LOPs. If existing LOPs needed revision due to local changes, the end user of the impacted area notified the Health Program Specialist (HPS) or the Chief Support Executive (CSE) to initiate a revised LOP. When a new or revised policy and procedure was received from CCHCS headquarters, both the HPS and the CSE reviewed it. If changes to existing LOPs were needed, the HPS brought the LOP to the medical subcommittee to discuss it, and the HPS prepared a draft LOP for the medical subcommittee and Quality Management Committee to review. If a new LOP was needed, the Executive team developed one. Once revised or new LOPs were approved, the final LOP was routed again through various committees, and to the CEO and warden for their signatures. If appropriate, the nurse instructor provided instruction and on-the-job training to applicable health care staff. At the time of the inspection, the institution had implemented 44 of the 48 applicable stakeholder-recommended LOPs (92 percent) (MIT 15.998).

The OIG discusses the institution's health care staffing resources in the *About the Institution* section on page 1 of this report (MIT 15.999).

Recommendation

The OIG recommends that VSP's health care management cross train staff or develop other protocols to help ensure that the institution timely processes inmate medical appeals when key staff are unexpectedly absent for long periods of time.

JOB PERFORMANCE, TRAINING, LICENSING, AND CERTIFICATIONS

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

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(71.1%)

Overall Rating:
Inadequate

Compliance Testing Results

The institution received an *inadequate* compliance score of 71.1 percent in the *Job Performance Training, Licensing, and Certifications* indicator. The following three areas display opportunities for improvement:

- Three nursing staff hired within the last year did not timely receive new employee orientation training. As a result, VSP received a zero for this test (MIT 16.107).
- Only two of seven providers (29 percent) received timely and complete performance appraisals. The 360 Degree Evaluation was not completed for five providers (MIT 16.103).
- Nursing supervisors properly completed monthly nursing reviews for only three of five nurses sampled (60 percent). For one nurse, the supervisor did not complete any of the required monthly reviews; for another nurse, their supervisor did not document evidence that the evaluation results were discussed with the nurse under review (MIT 16.101).

The institution scored at the *adequate* level in the following area:

- Eight of the ten LVN nurses sampled (80 percent) were current on their clinical competency validations. Two nurses did not receive a clinical competency within the required time frame (MIT 16.102).

VSP received *proficient* scores of 100 percent in all three of the following administrative areas:

- All providers, nursing staff, and the pharmacist-in-charge were current with their professional licenses and certification requirements (MIT 16.001, 16.105).
- All provider, nursing, and custody staff had current emergency response certifications (MIT 16.104).
- The institution's pharmacy and providers who prescribed controlled substances were 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 Valley State Prison, nine HEDIS measures were selected and are listed in the following *VSP Results Compared to State and National HEDIS Scores* table. Multiple health plans publish their HEDIS performance measures at the State and national levels. The OIG has provided selected results for several health plans in both categories for comparative purposes.

Results of Population-Based Metric Comparison

Comprehensive Diabetes Care

For chronic care management, the OIG chose measures related to the management of diabetes. Diabetes is the most complex common chronic disease requiring a high level of intervention on the part of the health care system in order to produce optimal results. VSP performed very well with its management of diabetes.

When compared statewide, VSP significantly outperformed Medi-Cal scores in all five diabetic measures selected and also outperformed or matched Kaiser in all five measures. When compared nationally, VSP outperformed the averages for Medicaid, Medicare, and commercial health plans (based on data obtained from health maintenance organizations) in each of the selected five diabetic measures. When compared to the U.S. Department of Veterans Affairs (VA), VSP's performance outscored the VA's performance in three of four applicable measures, and scored 5 percentage points lower than the VA in diabetic eye exams.

Immunizations

Comparative data for immunizations was only fully available for the VA and partially available for Kaiser Permanente, commercial plans, and Medicare. With respect to administering influenza shots to adults aged 18 to 64, VSP's rate was higher than the average rates for Kaiser Permanente and commercial plans, but 5 percentage points lower than the VA's rate. For administering influenza shots to adults aged 65 and older, the institution scored higher than Medicare and matched the VA. In addition, with regard to administering pneumococcal vaccines, VSP scored higher than Medicare but significantly lower than the VA.

The OIG found that patient refusals negatively affected VSP's immunization scores. Specifically, for influenza shots to younger adults, an additional 30 percent of the patients were offered the shot but refused it; for patients aged 65 and older, an additional 15 percent of the patients were offered the shot but refused it; and with respect to pneumonia vaccinations, an additional 6 percent of the sampled patients were offered but refused the immunization.

Cancer Screening

With respect to colorectal cancer screening, VSP scored 8 percentage points lower than Kaiser's southern region average. Nationally, VSP performed better than both commercial plans and Medicare, but performed 8 percentage points lower than the VA. However, similar to other comparable measures, patient refusals directly impacted the institution's performance for this measure; an additional 12 percent of the patients who did not receive the screening were timely offered the screening but refused it.

Summary

Overall, VSP's performance reflects an adequate chronic care program, corroborated by the institution's *adequate* score in the *Quality of Provider Performance*. With regard to VSP's performance in the immunization and colorectal cancer screening measures, the institution should make interventions to lower the rate of patient refusals.

VSP Results Compared to State and National HEDIS Scores

Clinical Measures	California				National			
	VSP Cycle 4 Results [1]	HEDIS Medi-Cal 2014 [2]	Kaiser (No.CA) HEDIS Scores 2015 [3]	Kaiser (So.CA) HEDIS Scores 2015 [3]	HEDIS Medicaid 2015 [4]	HEDIS Com-mercial 2015 [4]	HEDIS Medicare 2015 [4]	VA Average 2012 [5]
Comprehensive Diabetes Care								
HbA1c Testing (Monitoring)	**100%**	83%	95%	94%	86%	91%	93%	99%
Poor HbA1c Control (>9.0%) [6,7]	**6%**	44%	18%	24%	44%	31%	25%	19%
HbA1c Control (<8.0%) [6]	**85%**	47%	70%	62%	47%	58%	65%	-
Blood Pressure Control (<140/90)	**85%**	60%	84%	85%	62%	65%	65%	80%
Eye Exams	**85%**	51%	69%	81%	54%	56%	69%	90%
Immunizations								
Influenza Shots - Adults (18–64) [8]	**60%**	-	54%	55%	-	50%	-	65%
Influenza Shots - Adults (65+)	**76%**	-	-	-	-	-	72%	76%
Immunizations: Pneumococcal	**74%**	-	-	-	-	-	70%	93%
Cancer Screening								
Colorectal Cancer Screening	**74%**	-	80%	82%	-	64%	67%	82%

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

APPENDIX A — COMPLIANCE TEST RESULTS

Valley State Prison Range of Summary Scores: 45.63% - 94.00%	
Indicator	**Compliance Score (Yes %)**
Access to Care	66.27%
Diagnostic Services	81.11%
Emergency Services	Not Applicable
Health Information Management (Medical Records)	56.56%
Health Care Environment	59.36%
Inter- and Intra-System Transfers	80.12%
Pharmacy and Medication Management	72.53%
Prenatal and Post-Delivery Services	Not Applicable
Preventive Services	66.06%
Quality of Nursing Performance	Not Applicable
Quality of Provider Performance	Not Applicable
Reception Center Arrivals	Not Applicable
Specialized Medical Housing (OHU, CTC, SNF, Hospice)	94.00%
Specialty Services	83.75%
Internal Monitoring, Quality Improvement, and Administrative Operations	45.63%
Job Performance, Training, Licensing, and Certifications	71.07%

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?	13	17	30	43.33%	0
1.002	**For endorsed inmate-patients received from another CDCR institution:** If the nurse referred the inmate-patient to a provider during the initial health screening, was the inmate-patient seen within the required time frame?	10	16	26	38.46%	4
1.003	**Clinical appointments:** Did a registered nurse review the inmate-patient's request for service the same day it was received?	28	2	30	93.33%	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?	6	12	18	33.33%	12
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?	1	3	4	25.00%	26
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?	16	4	20	80.00%	0
1.008	**Specialty service follow-up appointments:** Do specialty service primary care physician follow-up visits occur within required time frames?	26	3	29	89.66%	1
1.101	**Clinical appointments:** Do inmate-patients have a standardized process to obtain and submit health care services request forms?	6	0	6	100.00%	0
Overall percentage:					**66.27%**	

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?	9	1	10	90.00%	0
2.002	**Radiology:** Did the primary care provider review and initial the diagnostic report within specified time frames?	6	4	10	60.00%	0
2.003	**Radiology:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	9	1	10	90.00%	0
2.004	**Laboratory:** Was the laboratory service provided within the time frame specified in the provider's order?	10	0	10	100.00%	0
2.005	**Laboratory:** Did the primary care provider review and initial the diagnostic report within specified time frames?	10	0	10	100.00%	0
2.006	**Laboratory:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	10	0	10	100.00%	0
2.007	**Pathology:** Did the institution receive the final diagnostic report within the required time frames?	10	0	10	100.00%	0
2.008	**Pathology:** Did the primary care provider review and initial the diagnostic report within specified time frames?	4	6	10	40.00%	0
2.009	**Pathology:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	5	5	10	50.00%	0
Overall percentage:					**81.11%**	

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?	16	4	20	80.00%	0
4.002	Are dictated / transcribed documents scanned into the eUHR within five calendar days of the inmate-patient encounter date?	1	3	4	25.00%	0
4.003	Are specialty documents scanned into the eUHR within five calendar days of the inmate-patient encounter date?	13	7	20	65.00%	0
4.004	Are community hospital discharge documents scanned into the eUHR within three calendar days of the inmate-patient date of hospital discharge?	15	5	20	75.00%	0
4.005	Are medication administration records (MARs) scanned into the eUHR within the required time frames?	14	6	20	70.00%	0
4.006	During the eUHR review, did the OIG find that documents were correctly labeled and included in the correct inmate-patient's file?	0	12	12	0.00%	0
4.007	Did clinical staff legibly sign health care records, when required?	20	12	32	62.50%	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?	15	5	20	75.00%	0
Overall percentage:					**56.56%**	

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	1	9	88.89%	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?	8	1	9	88.89%	0
5.103	**Infection Control:** Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	9	0	9	100.00%	0
5.104	**Infection control:** Does clinical health care staff adhere to universal hand hygiene precautions?	5	3	8	62.50%	1
5.105	**Infection control:** Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	5	4	9	55.56%	0
5.106	**Warehouse, Conex and other non-clinic storage areas:** Does the medical supply management process adequately support the needs of the medical health care program?	0	1	1	0.00%	0
5.107	**Clinical areas:** Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	7	0	7	100.00%	2
5.108	**Clinical areas:** Do clinic common areas and exam rooms have essential core medical equipment and supplies?	2	7	9	22.22%	0
5.109	**Clinical areas:** Do clinic common areas have an adequate environment conducive to providing medical services?	3	6	9	33.33%	0
5.110	**Clinical areas:** Do clinic exam rooms have an adequate environment conducive to providing medical services?	4	5	9	44.44%	0
5.111	**Emergency response bags:** Are TTA and clinic emergency medical response bags inspected daily and inventoried monthly, and do they contain essential items?	4	3	7	57.14%	2
5.999	**For Information Purposes Only:** Does the institution's health care management believe that all clinical areas have physical plant infrastructures sufficient to provide adequate health care services?	Information Only				
Overall percentage:					**59.36%**	

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?	23	7	30	76.67%	0
6.002	**For endorsed inmate-patients received from another CDCR institution or COCF:** When required, did the RN complete the assessment and disposition section of the health screening form; refer the inmate-patient to the TTA, if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening?	30	0	30	100.00%	0
6.003	**For endorsed inmate-patients received from another CDCR institution or COCF:** If the inmate-patient had an existing medication order upon arrival, were medications administered or delivered without interruption?	15	4	19	78.95%	11
6.004	**For inmate-patients transferred out of the facility:** Were scheduled specialty service appointments identified on the Health Care Transfer Information Form 7371?	9	11	20	45.00%	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?	3	0	3	100.00%	2
Overall percentage:					**80.12%**	

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?	12	18	30	40.00%	0
7.002	Did health care staff administer or deliver new order prescription medications to the inmate-patient within the required time frames?	24	6	30	80.00%	0
7.003	**Upon the inmate-patient's discharge from a community hospital:** Were all medications ordered by the institution's primary care provider administered or delivered to the inmate-patient within one calendar day of return?	9	11	20	45.00%	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?	19	11	30	63.33%	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?	1	8	9	11.11%	7
7.102	**All clinical and medication line storage areas for non-narcotic medications:** Does the institution properly store non-narcotic medications that do not require refrigeration in assigned clinical areas?	14	1	15	93.33%	1
7.103	**All clinical and medication line storage areas for non-narcotic medications:** Does the institution properly store non-narcotic medications that require refrigeration in assigned clinical areas?	6	5	11	54.55%	5
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?	3	4	7	42.86%	9
7.105	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when preparing medications for inmate-patients?	6	1	7	85.71%	9
7.106	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when distributing medications to inmate-patients?	7	0	7	100.00%	9
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	1	0	1	100.00%	0

Reference Number	*Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
	non-refrigerated medications?					
7.109	**Pharmacy:** Does the institution's pharmacy properly store refrigerated or frozen medications?	1	0	1	100.00%	0
7.110	**Pharmacy:** Does the institution's pharmacy properly account for narcotic medications?	1	0	1	100.00%	0
7.111	**Pharmacy:** Does the institution follow key medication error reporting protocols?	18	7	25	72.00%	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:					**72.53%**	

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

Reference Number	*Preventive Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
9.001	**Inmate-patients prescribed INH:** Did the institution administer the medication to the inmate-patient as prescribed?	6	12	18	33.33%	0
9.002	**Inmate-patients prescribed INH:** Did the institution monitor the inmate-patient monthly for the most recent three months he or she was on the medication?	14	4	18	77.78%	0
9.003	**Annual TB Screening:** Was the inmate-patient screened for TB within the last year?	13	17	30	43.33%	0
9.004	Were all inmate-patients offered an influenza vaccination for the most recent influenza season?	28	2	30	93.33%	0
9.005	**All inmate-patients from the age 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?	13	8	21	61.90%	9
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:					**66.06%**	

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

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

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

Reference Number	*Specialized Medical Housing (OHU, CTC, SNF, Hospice)*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	**For all higher level care facilities:** Did the registered nurse complete an initial assessment of the inmate-patient on the day of admission, or within eight hours of admission to CMF's Hospice?	10	0	10	100.00%	0
13.002	**For OHU, CTC, & SNF only:** Did the primary care provider for OHU or attending physician for a CTC & SNF evaluate the inmate-patient within 24 hours of admission?	10	0	10	100.00%	0
13.003	**For OHU, CTC, & SNF only:** Was a written history and physical examination completed within 72 hours of admission?	7	3	10	70.00%	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?	8	0	8	100.00%	2
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:					**94.00%**	

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?	14	1	15	93.33%	0
14.002	Did the PCP review the high-priority specialty service consultant report within the required time frame?	13	1	14	92.86%	1
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?	14	1	15	93.33%	0
14.005	**For endorsed inmate-patients received from another CDCR institution:** If the inmate-patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames?	11	9	20	55.00%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	18	2	20	90.00%	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?	13	6	19	68.42%	1
Overall percentage:					**83.75%**	

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?	4	8	12	33.33%	0
15.002	Does the institution follow adverse/sentinel event reporting requirements?	Not Applicable				
15.003	Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified?	6	0	6	100.00%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	0	1	1	0.00%	0
15.005	For each initiative in the Performance Improvement Work Plan (PIWP), has the institution performance improved or reached the targeted performance objective(s)?	0	4	4	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?	Not Applicable				
15.007	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	5	7	12	41.67%	0
15.101	Did the institution complete a medical emergency response drill for each watch and include participation of health care and custody staff during the most recent full quarter?	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?	9	1	10	90.00%	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	0	3	100.00%	0
15.996	**For Information Purposes Only:** Did the CCHCS Death Review Committee submit its inmate death review summary to the institution timely?	Information Only				
15.997	**For Information Purposes Only:** Identify the institution's protocols for tracking medical appeals.	Information Only				
15.998	**For Information Purposes Only:** Identify the institution's protocols for implementing health care local operating procedures.	Information Only				
15.999	**For Information Purposes Only:** Identify the institution's health care staffing resources.	Information Only				
Overall percentage:					**45.63%**	

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?	13	0	13	100.00%	0
16.101	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	3	2	5	60.00%	0
16.102	Are nursing staff who administer medications current on their clinical competency validation?	8	2	10	80.00%	0
16.103	Are structured clinical performance appraisals completed timely?	2	5	7	28.57%	0
16.104	Are staff current with required medical emergency response certifications?	3	0	3	100.00%	0
16.105	Are nursing staff and the Pharmacist-in-Charge current with their professional licenses and certifications?	5	0	5	100.00%	1
16.106	Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	1	0	1	100.00%	0
16.107	Are nursing staff current with required new employee orientation?	0	1	1	0.00%	0
Overall percentage:					**71.07%**	

APPENDIX B — CLINICAL DATA

Table B-1 VSP Sample Sets	
Sample Set	**Total**
Anticoagulation	3
CTC/OHU	5
Death Review/Sentinel Events	2
Diabetes	3
Emergency Services - CPR	1
Emergency Services - Non-CPR	5
High Risk	5
Hospitalization	5
Intra-System Transfers-in	3
Intra-System Transfers-out	3
RN Sick Call	25
Specialty Services	5
	65

Table B-2 VSP Chronic Care Diagnoses	
Diagnosis	**Total**
Anemia	6
Anticoagulation	4
Arthritis/Degenerative Joint Disease	5
Asthma	11
COPD	14
Cancer	4
Cardiovascular Disease	9
Chronic Kidney Disease	3
Chronic Pain	9
Cirrhosis/End Stage Liver Disease	3
Coccidioidomycosis	1
DVT/PE	2
Deep Venous Thrombosis/Pulmonary Embolism	2
Diabetes	16
Gastroesophageal Reflux Disease	15
Gastrointestinal Bleed	1
Hepatitis C	20
Hyperlipidemia	21
Hypertension	40
Mental Health	11
Migraine Headaches	1
Seizure Disorder	8
Sleep Apnea	1
Thyroid Disease	4
	211

Table B-3 VSP Event - Program	
Program	**Total**
Diagnostic Services	165
Emergency Care	55
Hospitalization	45
Intra-System Transfers-in	20
Intra-System Transfers-out	16
Not Specified	1
Outpatient Care	394
Specialized Medical Housing	218
Specialty Services	158
	1,072

Table B-4 VSP Case Review Sample Summary	
	Total
MD Reviews Detailed	30
MD Reviews Focused	0
RN Reviews Detailed	23
RN Reviews Focused	29
Total Reviews	82
Total Unique Cases	65
Overlapping Reviews (MD & RN)	17

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

Valley State Prison			
Quality Indicator	**Sample Category (number of patients/samples)**	**Data Source**	**Filters**
Access to Care	Chronic Care (30)	Master Registry	• Chronic care conditions (at least one condition per inmate-patient—any risk level) • **Randomize**
	Nursing Sick Call (5 per clinic) (30)	MedSATS	• Clinic (each clinic tested) • Appt. date (2–9 months) • **Randomize**
	Returns from Community Hospital (20)	Inpatient Claims Data	• See ***Health Information Management (Medical Records)*** (returns from community hospital)
Diagnostic Services	Radiology (10)	Radiology Logs	• Appt. Date (90 days–9 months) • **Randomize** • Abnormal
	Laboratory (10)	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • **Randomize** • Abnormal
	Pathology (10)	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • **Randomize**
Health Information Management (Medical Records)	Timely Scanning (20)	OIG Qs: 1.001, 1.002, 1.006, & 9.004	• Non-dictated documents • First 5 inmate-patients selected for each question
	 (4)	OIG Q: 1.001	• Dictated documents • First 20 inmate-patients selected
	 (20)	OIG Qs: 14.002 & 14.004	• Specialty documents • First 10 inmate-patients selected for each question
	 (20)	OIG Q: 4.008	• Community hospital discharge documents • First 20 inmate-patients selected for the question
	 (20)	OIG Q: 7.001	• MARs • First 20 inmate-patients selected
	Legible Signatures and Review (32)	OIG Qs: 4.008, 6.001/6.002, 7.001, 12.001/12.002, & 14.002	• First 8 inmates sampled • One source document per inmate-patient
	Complete and Accurate Scanning (all)	Documents for any tested inmate	• Any incorrectly scanned eUHR document identified during OIG eUHR file review, e.g., mislabeled, misfiled, illegibly scanned, or missing
	Returns from Community Hospital (20)	Inpatient Claims Data	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • **Randomize** (each month individually) • First 5 inmate-patients from each of the 6 months (if not 5 in a month, supplement from another, as needed)

Quality Indicator	Sample Category (number of patients/samples)	Data Source	Filters
Health Care Environment	Clinical Areas (9)	OIG Inspector Onsite Review	• Identify and inspect all onsite clinical areas.
Inter- and Intra-System Transfers	Intra-System transfers (30)	SOMS	• Arrival date (3–9 months) • Arrived from (another CDCR facility) • Rx count • **Randomize**
	Specialty Service Send-outs (20)	MedSATS	• Date of Transfer (3–9 months) • **Randomize**
Pharmacy and Medication Management	Chronic Care Medication (30)	OIG Q: 1.001	See ***Access to Care*** • (At least one condition per inmate-patient—any risk level) • **Randomize**
	New Medication Orders (30)	Master Registry	• Rx Count • **Randomize** • Ensure no duplication of inmate-patients tested in chronic care medications
	Intra-Facility moves (30)	MAPIP Transfer Data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (high–low)–*inmate-patient must have NA/DOT meds to qualify for testing* • **Randomize**
	En Route *N/A at this institution*	SOMS	• Date of transfer (2–8 months) • Sending institution (another CDCR facility) • **Randomize** • Length of stay (minimum of 2 days) • NA/DOT meds
	Returns from Community Hospital (20)	Inpatient Claims Data	• See ***Health Information Management (Medical Records)*** (returns from community hospital)
	Medication Preparation and Administration Areas (7)	OIG Inspector Onsite Review	• Identify and inspect onsite clinical areas that prepare and administer medications
	Pharmacy (1)	OIG Inspector Onsite Review	• Identify and inspect onsite pharmacies
	Medication Error Reporting (25)	OIG Inspector Review	• Five reports from 5 months with highest-severity errors
Prenatal and Post-delivery Services	Recent Deliveries *N/A at this institution*	OB Roster	• Delivery date (2–12 months) • **Most recent** deliveries (within date range)
	Pregnant Arrivals *N/A at this institution*	OB Roster	• Arrival date (2–12 months) • **Earliest** arrivals (within date range)

Quality Indicator	Sample Category (number of patients/samples)	Data Source	Filters
Preventive Services	Chronic Care Vaccinations (21)	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per inmate-patient—any risk level) • **Randomize** • Condition must require vaccination(s)
	INH (18)	Maxor	• Dispense date (past 9 months) • Time period on INH (at least a full 3 months) • **Randomize**
	Colorectal Screening (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • **Randomize**
	Influenza Vaccinations (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • **Randomize** • Filter out inmate-patients tested in chronic care vaccination sample
	TB Code 22, annual TST (15)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (22) • **Randomize**
	TB Code 34, annual screening (15)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (34) • **Randomize**
	Mammogram *N/A at this institution*	SOMS	• Arrival date (at least 2 years prior to inspection) • Date of birth (age 52–74) • **Randomize**
	Pap Smear *N/A at this institution*	SOMS	• Arrival date (at least three years prior to inspection) • Date of birth (age 24–53) • **Randomize**
	Valley Fever *N/A at this institution*	Cocci Transfer Status Report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • **All**
Reception Center Arrivals	RC *N/A at this institution*	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • **Randomize**
Specialized Medical Housing	OHU (10)	CADDIS	• Admit date (1–6 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • **Randomize**

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

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

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

February 18, 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 Valley State Prison (VSP) conducted from August 2015 to October 2015. California Correctional Health Care Services (CCHCS) acknowledges all OIG findings.

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

Sincerely,

Janet Lewis

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

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