Robert A. Barton
Inspector General

Office of the Inspector General

Valley State Prison
Medical Inspection Results
Cycle 5

June 2017

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

Office of the Inspector General
VALLEY STATE PRISON
Medical Inspection Results
Cycle 5

Robert A. Barton
Inspector General

Roy W. Wesley
Chief Deputy Inspector General

Shaun R. Spillane
Public Information Officer

June 2017

TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

EXECUTIVE SUMMARY

Pursuant to California Penal Code Section 6126, which assigns the Office of the Inspector General (OIG) responsibility for oversight of the California Department of Corrections and Rehabilitation (CDCR), the OIG conducts a comprehensive inspection program to evaluate the delivery of medical care at each of CDCR's 35 adult prisons. The OIG **explicitly** makes no determination regarding the constitutionality of care in the prison setting. That determination is left to the Receiver and the federal court. The assessment of care by the OIG is just one factor in the court's determination whether care in the prisons meets constitutional standards. In Cycle 5, for the first time, the OIG will be inspecting institutions that have been delegated back to CDCR from the Receivership. There will be no difference in the standards used for assessment of a delegated institution versus an institution not yet delegated.

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

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

Overall Assessment: Adequate

The OIG performed its Cycle 5 medical inspection at Valley State Prison (VSP) from January to March 2017. The inspection included in-depth reviews of 52 patient files conducted by clinicians, as well as reviews of documents from 377 patient files covering 86 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 13 health care quality indicators applicable to the institution. To conduct clinical case reviews, the OIG employs a clinician team consisting of a physician and a registered nurse consultant, while compliance testing is done by a team of registered nurses trained in monitoring medical policy compliance. Of the indicators, seven were rated by both case review clinicians and compliance inspectors, three were rated by case review clinicians only, and three were rated by compliance inspectors only. The *VSP Executive Summary Table* on the following page identifies the applicable individual indicators and scores for this institution.

VSP Executive Summary Table

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

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

Clinical Case Review and OIG Clinician Inspection Results

The clinicians' case reviews sampled patients with high medical needs and included a review of 1,416 patient care events.[1] Of the 12 primary indicators applicable to VSP, 10 were evaluated by clinician case review; two were *proficient*, and eight were *adequate.* When determining the overall adequacy of care, the OIG paid particular attention to the clinical nursing and provider quality indicators, as adequate health care staff can sometimes overcome suboptimal processes and programs. However, the opposite is not true; inadequate health care staff cannot provide adequate care, even though the established processes and programs onsite may be adequate. The OIG clinicians identify inadequate medical care based on the risk of significant harm to the patient, not the actual outcome.

Despite its designation as a basic institution, VSP had a greater number of high-risk patients than expected. This, together with overcrowding and the large number of both enhanced outpatient program (EOP) patients with mental illnesses and older patients, posed challenges to health care delivery.

Program Strengths — Clinical

- VSP's greatest strength was its executive team's commitment toward dramatically turning around the previous inadequate care identified in the OIG's Cycle 4 Medical Inspection Report, and now achieving excellence in many areas of health care delivery. The OIG clinicians learned that a correctional plan had been implemented based on deficiencies identified during the OIG's Cycle 4 inspection as well as California Correctional Health Care Services (CCHCS) initiatives to improve patient care. The providers described their chief physician and surgeon (CP&S) and their chief medical executive (CME) as being readily available for guidance and support and involved in patient care activities. A unique observation was the personal involvement of the institution's chief executive officer (CEO) in the provider meetings and the CEO's proactive approach to remedying system problems.

- Health care team members had good working relationships, and meaningful interactions occurred during the daily morning huddles and the regularly held population management meetings.

- Providers actively participated in consultation with their nursing colleagues. This initiative was reported to have significantly reduced the number of referrals for evaluation by a provider following nurse triage visits, thus improving access to health care for the patient population at large. Providers remarked that most requests for consultation were appropriate.

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

- The institution had efficient systems and committed staff members who ensured that consultation reports, discharge summaries, and diagnostic test results were expeditiously retrieved and forwarded to providers.

- Most of the providers were experienced with care of patients in a correctional setting. The CME said that VSP was a desirable institution for medical providers, that it had a high retention rate, and that a recently approved position would be quickly filled.

Program Weaknesses — Clinical

- Staff at VSP unanimously voiced concern that there was a shortage of nurses. The mandated needs to remain beyond scheduled work hours, to assist other clinic nurses, and to cover the triage and treatment area (TTA) and the outpatient housing unit (OHU) were identified as the primary reasons for low morale among the nursing staff.

- Numerous health information management deficiencies occurred, including many missing or mislabeled documents and duplicated scanned documents.

- Several medication management deficiencies were noted. These included errors in implementation of new orders, lapses in continuity of chronic medications, and missed medication doses when patients returned to the institution following discharge from a community hospital.

- The receiving and release clinic (R&R) did not have private space for examination of patients. Patients requiring more detailed evaluation had to be transferred to the TTA.

Compliance Testing Results

Of the 13 health care indicators applicable to VSP, 10 were evaluated by compliance inspectors.[2] One indicator was *proficient*, seven were *adequate*, and two were *inadequate*. There were 86 individual compliance questions within those 10 indicators, generating 1,060 data points that tested VSP's compliance with CCHCS policies and procedures.[3] Those 86 questions are detailed in *Appendix A — Compliance Test Results*.

Program Strengths — Compliance

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

- Nurses reviewed patients' requests for medical care on the same day they were received.

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

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

- Patients' radiology and laboratory services were provided within time frames specified by clinicians.

- Clinical health care areas were appropriately disinfected, cleaned, and sanitized. They contained operable sinks and sufficient quantities of hygiene supplies. Clinical staff adhered to universal hand hygiene precautions and properly controlled exposure to blood-borne pathogens and contaminated waste.

- Clinical staff followed adequate protocols for managing and storing bulk medical supplies; clinic exam rooms and common areas had environments conducive to providing medical services.

- Nursing staff employed appropriate administrative controls and followed appropriate protocols during medication preparation; staff properly stored and monitored refrigerated and frozen medications.

- The main pharmacy followed general security, organization, and cleanliness management protocols; properly stored non-refrigerated medications; and properly accounted for narcotic medications.

- The pharmacist in charge timely processed all sampled medication error reports.

- VSP offered influenza vaccinations to all patients tested during the most recent influenza season.

- Patients received their ordered specialty service appointments within required time frames.

Program Weaknesses — Compliance

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

- Patients received at VSP who were referred to a provider during the initial health screening process were not always seen within required time frames.

- Patients receiving chronic care medications did not always receive their medications as ordered.

- Clinical staff assigned to clinical areas did not employ strong security over narcotic medications and did not follow proper protocols for storing non-narcotic medications. In addition, the institution administrative controls and protocols when distributing medications to patients were poor.

Population-Based Metrics

In general, VSP performed at a high level as measured by population-based metrics, outperforming all other reporting entities in most measures with regard to comprehensive diabetes management, vaccinations, and colorectal cancer screenings.

INTRODUCTION

Pursuant 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 these ongoing inspections. The OIG conducts a clinical case review and a compliance inspection ensuring a thorough end to end assessment of medical care within CDCR.

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

ABOUT THE INSTITUTION

Valley State Prison functions as a Level II, General Population institution housing inmates requiring sensitive needs yard (SNY) 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 reentry hub for CDCR. As a reentry 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 patients needing urgent or emergency care in its triage and treatment area (TTA), treats 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 (R&R) 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 the capability to provide limited specialty medical services and consultation for a generally healthy patient population.

On August 8, 2016, the institution received national accreditation from the Commission on Accreditation for Corrections. This accreditation program is a professional peer review process based on national standards set by the American Correctional Association.

Based on staffing data the OIG obtained from the institution, VSP's vacancy rate among medical managers, primary care providers, supervisors, and non-supervisory nurses was 9 percent in January 2017, with the highest vacancy percentages among non-supervisory nurses. At the time of the OIG's inspection, the CEO reported there were ten staff members under CDCR disciplinary review.

VSP Health Care Staffing Resources as of January 2017

	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff		Totals	
Description	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Authorized Positions	5	5%	8	8%	10.5	11%	74.7	76%	98.2	100%
Filled Positions	5	100%	8	100%	10	95%	66.7	89%	89.7	91.3%
Vacancies	0	0%	0	0%	0.5	5%	8	11%	8.5	8.7%
Recent Hires (within 12 months)	2	40%	2	25%	3	30%	9	13%	16	18%
Staff Utilized from Registry	0	0%	1	13%	0	0%	13	19%	14	16%
Redirected Staff (to Non-Patient Care Areas)	0	0%	0	0%	0	0%	1	1%	1	1%
Staff on Long-term Medical Leave	0	0%	0	0%	2	20%	0	0%	2	2%

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

As of January 9, 2017, the Master Registry for VSP showed that the institution had a total population of 3,532. Within that total population, 1.8 percent were designated as high medical risk, Priority 1 (High 1), and 6.2 percent were designated as high medical risk, Priority 2 (High 2). Patients' assigned risk levels are based on the complexity of their required medical care related to their specific diagnoses, frequency of higher levels of care, age, and abnormal labs and procedures. High 1 has at least two high-risk conditions; High 2 has only one. Patients at high medical risk are more susceptible to poor health outcomes than those at medium or low medical risk. Patients at high medical risk also typically require more health care services than do patients with lower assigned risk levels. The chart below illustrates the breakdown of the institution's medical risk levels at the start of the OIG medical inspection.

VSP Master Registry Data as of January 9, 2017

Medical Risk Level	Number of Patients	Percentage
High 1	63	1.8%
High 2	220	6.2%
Medium	2,104	59.6%
Low	1,145	32.4%
Total	**3,532**	**100.0%**

OBJECTIVES, SCOPE, AND METHODOLOGY

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

To maintain a metric-oriented inspection program that evaluates medical care delivery consistently at each state prison, the OIG identified 15 indicators (14 primary (clinical) indicators and one secondary (administrative) indicator) of health care to measure. The primary quality indicators cover clinical categories directly relating to the health care provided to patients, whereas the secondary quality indicator address the administrative functions that support a health care delivery system. These 15 indicators are identified in the *VSP Executive Summary Table* on page *ii* of this report.

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

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

Patient Selection for Retrospective Case Reviews

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

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

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

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

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

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

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

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

Benefits and Limitations of Targeted Subpopulation Review

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

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

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

Case Reviews Sampled

As indicated in *Appendix B, Table B–1: Sample Sets,* the OIG clinicians evaluated medical charts for 52 unique patients. *Appendix B, Table B–4: VSP Case Review Sample Summary*, clarifies that both nurses and physicians reviewed charts for 18 of those patients, for 70 reviews in total. Physicians performed detailed reviews of 25 charts, and nurses performed detailed reviews of 15

charts, totaling 40 detailed reviews. For detailed case reviews, physicians or nurses looked at all encounters occurring in approximately six months of medical care. Nurses also performed a limited or focused review of medical records for an additional 29 patients. These generated 1,416 clinical events for review (*Appendix B, Table B–3: VSP Event–Program*). The inspection tool provides details on whether the encounter was adequate or had significant deficiencies, and identifies deficiencies by programs and processes to help the institution focus on improvement areas.

While the sample method specifically pulled only six chronic care patient records, i.e., three diabetes patients and three anticoagulation patients (*Appendix B, Table B–1: VSP Sample Sets*), the 52 unique patients sampled included patients with 185 chronic care diagnoses, including 18 additional patients with diabetes (for a total of 21) and 2 additional anticoagulation patients (for a total of 5) (*Appendix B, Table B–2: VSP Chronic Care Diagnoses*). The OIG's sample selection tool allowed evaluation of many chronic care programs because the complex and high-risk patients selected from the different categories often had multiple medical problems. While the OIG did not evaluate every chronic disease or health care staff member, the overall operation of the institution's system and staff were assessed for adequacy.

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

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

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

COMPLIANCE TESTING

Sampling Methods for Conducting Compliance Testing

From January to March 2017, registered nurse inspectors attained answers to 86 objective medical inspection test (MIT) questions designed to assess the institution's compliance with critical policies and procedures applicable to the delivery of medical care. To conduct most tests, inspectors randomly selected samples of patients for whom the testing objectives were applicable and reviewed their electronic unit health records. In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed health records for 377 individual patients and analyzed specific transactions within their records for evidence that critical events occurred. Inspectors also reviewed management reports and meeting minutes to assess certain administrative operations. In addition, during the week of January 23, 2017, registered nurse 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 1,060 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 Cycle 5 medical inspection testing, the OIG reduced the number of compliance samples tested for 18 indicator tests from a sample of 30 patients to a sample of 25 patients. The OIG also removed some inspection tests upon stakeholder agreement that either were duplicated in the case reviews or had limited value. Lastly, for Cycle 4 medical inspections, the OIG tested two secondary (administrative) indicators (*Internal Monitoring, Quality Improvement, and Administrative Operations*; and *Job Performance, Training, Licensing, and Certifications*), and have combined these tests into one *Administrative Operations* indicator for Cycle 5 inspections.

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

Scoring of Compliance Testing Results

After compiling the answers to the 86 questions for the 10 applicable indicators, the OIG derived a score for each quality indicator by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Based on those results, the OIG assigned a rating to each quality indicator of *proficient* (greater than 85 percent), *adequate* (between 75 percent and 85 percent), or *inadequate* (less than 75 percent).

OVERALL QUALITY INDICATOR RATING FOR CASE REVIEWS AND COMPLIANCE TESTING

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

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

POPULATION-BASED METRICS

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

MEDICAL INSPECTION RESULTS

The quality indicators assess the clinical aspects of health care. As shown on the *VSP Executive Summary Table* on page *ii* of this report, 13 of the OIG's indicators were applicable to VSP. Of those 13 indicators, 7 were rated by both the case review and compliance components of the inspection, 3 were rated by the case review component alone, and 3 were rated by the compliance component alone. The *Administrative Operations* indicator is a secondary indicator, and, therefore, was not relied upon for the institution's overall score.

Summary of Case Review Results: The clinical case review component assessed 10 of the 12 primary (clinical) indicators applicable to VSP. Of these ten indicators, OIG clinicians rated two *proficient*, eight *adequate*, and zero *inadequate*.

The OIG physicians rated the overall adequacy of care for each of the 25 detailed case reviews they conducted. Of these 25 cases, 3 were *proficient*, 20 were *adequate*, and 2 were *inadequate*. In the 1,416 events reviewed, there were 250 deficiencies, of which 39 were considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

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

- In case 5, a diabetic patient had a severe episode of hypoglycemia (low blood sugar) caused by a change to a much higher dose of insulin by a provider not familiar with the patient. This event is discussed in the *Quality of Provider Performance* indicator.

- In case 9, after the provider changed the dose of warfarin (blood thinner), the patient continued to receive the discontinued dose as well as the new dose. This led to the patient receiving nearly double the prescribed dose for a two-day period. This event is discussed in the *Pharmacy and Medication Management* indicator.

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

1 — *ACCESS TO CARE*

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

Case Review Rating:
Adequate
Compliance Score:
Adequate
(81.8%)

Overall Rating:
Adequate

Case Review Results

The OIG clinicians reviewed 332 provider and nurse encounters and identified 28 deficiencies related to access to care. Three of these (cases 9, 22, and 38) were significant, placing the patient at risk for harm.

RN Sick Call Access

The OIG clinicians reviewed 95 sick call nursing encounters. This included evaluation of the appropriateness and timeliness of patient triage and assessment, and the identification and prioritization of health care needs. The majority of the nurses utilized the CCHCS nursing encounter protocol forms and appropriately documented their assessment and interventions. However, when the forms were not utilized, the nurses did not document a thorough assessment, did not establish clear and attainable goals, and did not appropriately refer patients. In some instances the nurse failed to identify the urgency of the symptoms and to see the patient in a timely manner. These cases are discussed in the *Quality of Nursing Performance* indicator.

The nurses appropriately consulted with the provider or referred the patient to the provider for further evaluation. In some cases, these appointments did not occur or were late. Patient sick call requests were discussed in the morning huddles. On some occasions, the provider instructed that the patient be added to the provider schedule instead of first being evaluated by an RN.

RN-to-Provider Referrals

Nurses at VSP often sought provider consultation for assistance with problems outside their scope of practice. This greatly reduced the number of sick call visits that led to orders for provider follow-up. In most of the cases in which follow-up was ordered, patients were appropriately scheduled for the visit with the provider. Exceptions occurred in the following cases:

- In case 21, the nurse referred the post-surgery patient for a provider appointment within five days, but the patient was not seen until nine days later.

- In case 47, the RN referred the patient for a routine appointment, and the appointment did not occur.

- In case 50, the patient was referred for an urgent provider appointment to address his narcotic pain medication, and the appointment occurred five days later, instead of within 48 hours.

Provider Follow-up Appointments

Patients discharged from the outpatient housing unit (OHU) were seen by their yard providers within an appropriate time period. Among patients in the general population, appointments were not scheduled as ordered by the provider in cases 1, 9, 27, and the following:

- In case 9, a patient with a blood clot in the lung was not scheduled to follow up with a lung specialist as ordered.

- In case 38, a patient with asthma who had received treatment for increased shortness of breath was not scheduled for provider follow-up as ordered. This was a significant deficiency.

Follow-up After Specialty Services

Delays in return visits to specialty providers are discussed in the *Specialty Services* indicator.

Follow-up After Specialty Consultation

Patients were seen by their providers within an appropriate time frame following specialty consultations.

Follow-up After TTA Evaluation

Patients seen in the TTA for emergent or urgent problems were typically followed up with by their primary care providers as ordered, with the following exception:

- In case 22, the patient was evaluated in the TTA and then sent to a community hospital for a leg abscess, but he was not seen by his primary care provider on the following day as ordered. The patient was never seen, and he paroled about a month later. This was a significant deficiency.

Follow-up After Hospitalization

Patients were seen by their providers within an appropriate time frame following discharge from a higher level of care.

Specialized Medical Housing

Patients in the OHU were evaluated based on both clinical necessity and follow-up requirements. During the morning huddle, the office technician notified the provider of overnight admissions and patients who needed to be seen for monthly visits or for scheduled chronic care appointments. No deficiencies in access to care occurred in the OHU.

Transfers In

Nursing assessments of patients transferred to the institution were adequate, and provider referrals were ordered within the appropriate time frame, with the exception of the following case:

- In case 29, the nurse failed to refer this high-risk patient with chronic medical problems to the provider within the 30-day time frame required by CCHCS policy. The nurse ordered a visit with the primary care provider in 150 days. Fortunately, the patient was seen about three weeks after his arrival as a result of a separate appointment generated following evaluation by a specialty consultant.

Clinician Onsite Inspection

Health care team members at VSP had a good working relationship, and meaningful interactions occurred during both the morning huddles and the population management meetings. The executive staff reported that implementation of the Complete Care Model had improved with implementation of the daily clinic huddles. Only one of four clinics reported an appointment backlog. Nurse administrators had implemented a tracking log for all sick call requests submitted by patients. However, they expressed concern regarding implementing the Electronic Health Record System and its short-term effect on patients' access to care. Implementation of the licensed vocational nurse (LVN) care coordination program, with referrals arising from provider visits and the population management meetings, was reported to have helped with management of chronic conditions, immunizations, and cancer screening, but at least one LVN expressed feeling overwhelmed by the responsibilities arising from this initiative. However, all the care coordinators stated that they received adequate support from their supervisors. With the move to encourage provider consultation at the time of nurse triage visits, many of the sick call encounters did not lead to provider follow-up appointments. According to staff, this was one of the contributing factors preventing backlogs in the clinics despite overcrowding in the institution. There was a shortage of nurses, and those on site reported low morale due to the mandated need to stay beyond regular work hours to complete their lines and assist other nurses to ensure that all scheduled patients were seen. Nurses reported that they were often asked to work overtime to cover the TTA or the OHU.

Conclusion

With a few exceptions, patients at VSP had adequate access to address their health care needs. The OIG clinicians rated this indicator *adequate*.

Compliance Testing Results

The institution performed in the *adequate* range in the *Access to Care* indicator, with a compliance score of 81.8 percent. VSP received *proficient* scores in five tests, including two 100 percent scores, as follows:

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

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

- With 29 of the 30 patients sampled who submitted health care services request forms (97 percent), nursing staff completed a face-to-face encounter within one business day of reviewing the service request form. In one exception, the nurse conducted the visit one day late (MIT 1.004).

- The OIG examined the timeliness of specialty services provided to 13 patients who needed high-priority services and another 14 patients who required routine services. Of the 27 sampled patients who received a high-priority or routine specialty service, 25 (93 percent) received a timely follow-up appointment with a provider. One patient's high priority specialty service follow-up appointment did not occur. One patient's routine specialty service follow-up appointment did not occur either (MIT 1.008).

- Among 17 sampled patients who were discharged from a community hospital, 15 (88 percent) received a timely primary care provider follow-up appointment upon their return to VSP. One patient received his follow-up appointment 11 days late; another patient did not receive an appointment at all (MIT 1.007).

With scores lower than 75 percent, VSP scored in the *inadequate* range in three tests:

- Among 11 sampled health care services request forms on which nursing staff referred the patient for a provider appointment subsequent to a nursing encounter, only eight patients (73 percent) received a timely appointment. Three patients did not receive a provider visit at all (MIT 1.005).

- Inspectors sampled 25 patients who suffered from one or more chronic care conditions; only 17 patients timely received their provider-ordered follow-up appointments (68 percent). Eight other patients received their appointments late or not at all, including five patients whose follow-up appointments occurred between 10 and 30 days late; one patient's appointment was 83 days late; one patient's appointment was 204 days late; and another patient did not receive his follow-up appointment at all (MIT 1.001).

- Among 25 patients sampled who transferred into VSP from other institutions and were referred to a provider based on nursing staff's initial health care screening, only nine (36 percent) were seen timely. Six patients received their provider appointments from 3 to 32 days late; four patients received their appointments from 62 to 103 days late; for six other patients, there was no evidence found to indicate they were ever seen (MIT 1.002).

Recommendations

No specific recommendations.

2 — *DIAGNOSTIC SERVICES*

Case Review Rating:
Proficient
Compliance Score:
Adequate
(75.9%)

Overall Rating:
Proficient

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

For this indicator, the OIG's case review and compliance review process 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 scores and ultimately rated this indicator *proficient*. Although the compliance testing showed deficiencies in provider communication of pathology reports, the case review process found that these delays did not affect patient care.

Case Review Results

The OIG clinicians reviewed 219 diagnostic events and identified only four minor deficiencies. Of these, three were related to health information management and none was due to failure to perform ordered tests. None of the deficiencies was significant.

Health Information Management

Laboratory test results and diagnostic study reports were promptly retrieved and sent to the providers for their review and action. In all except one instance (case 10), the providers reviewed the reports within three working days. The reports were scanned to each patient's electronic medical record within a day or two following provider review.

Consistent with CCHCS policy, imaging study reports were not scanned to the patient's medical record. However, in all except one instance, documentation of notification of the result to the patient was found in the patient's electronic medical record. Deficiencies related to missing laboratory reports are discussed in the *Health Information Management* indicator.

Appointments and Scheduling

In general, diagnostic studies were performed as ordered by the providers. Requests for diagnostic studies that needed approval by the chief physician and surgeon or designate were reviewed within a day or two of receipt, and scheduled within the time frame requested by the provider. The following case displayed the only instance of a minor delay:

- In case 15, the provider reordered laboratory tests after noting that blood samples had not been drawn as ordered. The tests were performed four days late.

Clinician Onsite Inspection

VSP had an efficient system to ensure that test results were expeditiously forwarded to providers for their review and action. The providers reported excellent onsite radiology support and remarked that they were immediately contacted if X-ray abnormalities were noted.

Conclusion

VSP performed well with regard to diagnostic services; the indicator rating was *proficient*.

Compliance Testing Results

The institution received an *adequate* compliance score of 75.9 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

- Radiology services were timely performed for all ten patients sampled (MIT 2.001). Radiology reports were only found in a databank (RIS-PACS) different from the regular electronic medical record. No evidence was found in the electronic medical record for any of the ten radiology reports that the provider reviewed the radiology reports by initial and date, resulting in a score of zero on this test (MIT 2.002). However, providers did timely communicate the test results to nine of the ten patients (90 percent). In one case, the provider communicated the test result three days late (MIT 2.003).

Laboratory

- All ten of the laboratory services sampled were timely performed (MIT 2.004). For nine of those ten sampled services (90 percent), the provider timely reviewed the diagnostic report and timely communicated the result to the patient. In one case, the provider did not date the laboratory diagnostic report (MIT 2.005). Among the ten sampled laboratory services, there was no evidence found in one patient's electronic medical record that the provider ever communicated to him the laboratory results (90 percent) (MIT 2.006).

Pathology

- Clinicians at VSP timely received the final pathology report for eight of ten patients sampled (80 percent). One untimely report was received 21 days late, and another was missing from the patient's electronic medical record (MIT 2.007). Providers timely reviewed the pathology results for all nine patients (MIT 2.008). However, providers timely communicated the results to only three of those nine patients sampled (33 percent). For five

patients, the provider communicated the results from 3 to 76 days late. For one additional patient, inspectors did not find evidence in the medical record that the patient ever received notification of the test results (MIT 2.009).

Recommendations

No specific recommendations.

3 — *EMERGENCY SERVICES*

Case Review Rating:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

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

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

Case Review Results

The OIG clinicians reviewed 45 urgent or emergent events and found 33 deficiencies, with four significant deficiencies (cases 20, 25, 26, and 36). Most of the noted deficiencies were minor deficiencies in nursing care and did not significantly affect patient care. In general, VSP performed well with emergency response time, BLS, and 9-1-1 activation times. Even with the deficiencies, VSP provided patients requiring urgent or emergent services timely and adequate care in the majority of the cases reviewed.

Nursing Performance

Emergency nursing deficiencies were most often related to inadequate assessment and documentation. Some TTA nursing documentation was incomplete, disorganized, and illegible. The OIG clinicians identified 17 nursing deficiencies. All four of the significant deficiencies were in this category:

- In case 20, while managing a patient with multiple comorbidities including coronary artery disease with chest pain and shortness of breath, the nurse failed to administer nitroglycerin or aspirin, failed to administer supplemental oxygen, and failed to establish intravenous access.

- In case 25, the nurse failed to recognize the significance of the patient's abnormal heart rhythm and delayed contacting the on-call provider until 42 minutes after the patient's arrival to the TTA. The patient had an abnormally fast heart rhythm. When the provider was contacted, orders were given for the patient to be emergently transferred to a higher level of care.

- In case 26, the patient was found unresponsive. Custody staff initiated CPR and medical staff continued CPR upon their arrival. This patient, who had no prior history of health problems, was not adequately assessed for signs of drug overdose. The patient was not transferred to the TTA. Instead, paramedics were called, who administered naloxone (narcotic overdose antidote) upon their arrival 18 minutes later. The patient regained consciousness and was transferred to a higher level of care. The TTA nurse should have transferred the patient to the TTA, where naloxone could have been administered sooner.

- In case 36, the nurse failed to adequately assess a patient with acute shoulder pain. There was a delay before the on-call provider was contacted. Pain was not reassessed within an appropriate time frame and there was a delay before the patient was transferred to the community hospital.

CPR Response

The first responders to medical emergencies were the yard licensed vocational nurses and or the custody staff. They promptly initiated BLS measures, when appropriate. The TTA registered nurses, on arrival, appropriately evaluated the patients, and in most cases, promptly transferred them to the TTA for further management.

Provider Performance

Consistent with VSP's designation as a basic institution, few medical emergencies occurred during case reviews. When emergencies occurred during the work day, the dedicated outpatient housing unit and TTA provider, promptly responded to calls, adequately assessed the patient, and clearly documented the management plan. VSP transferred patients to a higher level of care appropriately. The following minor deficiencies were noted:

- In case 5, the provider incorrectly concluded that low blood sugar occurred because the patient had received a higher dose than ordered of insulin, so the provider ordered the insulin to be withheld for longer than 24 hours. The actual cause of the episode was the patient missing his lunch and exercising.

- In case 14, the provider ordered an incorrect dose of trimethoprim and sulfamethoxazole (antibiotic). This error was not identified until 12 days later.

Emergency Medical Response Review Committee

The committee generally reviewed all emergency medical response incidents and took necessary actions to improve the institution's emergency medical response. The EMRRC identified that the first medical responders needed training in documentation of medical responses, and training was provided.

Clinician Onsite Inspection

The TTA had ample space for patient evaluation and working areas for both nurses and providers. The Omnicell (electronic medication locker) located in the TTA was appropriately stocked and the treatment rooms were clean and well organized. During the OIG's inspection, one of the yard clinics was undergoing construction, so that clinic had been relocated to the TTA.

Nurses in the TTA responding to emergencies on the yards were not allowed to carry needles, intravenous supplies, or naloxone spray. The TTA was not staffed with a provider after 4:00 pm or on weekends, but an on-call provider was available for telephone consultation. A pharmacist was always available and often came into the institution after hours when necessary. A review of nursing files revealed that only two of the four TTA nurses had current ACLS certification, and that the education and training for a new policy on the administration of naloxone spray had been conducted three months prior to the OIG's onsite inspection.

Conclusion

VSP generally provided prompt and appropriate care during medical emergencies; this indicator was rated *adequate*.

Recommendations

No specific recommendations.

4 — *HEALTH INFORMATION MANAGEMENT*

Case Review Rating:
Adequate
Compliance Score:
Adequate
(81.8%)

Overall Rating:
Adequate

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

During the OIG's testing period, VSP had not converted to the new Electronic Health Record System (EHRS); therefore, all testing occurred in the electronic Unit Health Record (eUHR) system.

Case Review Results

The OIG clinicians reviewed 1,416 events and found 55 deficiencies, only four of which were significant (cases 8, 13, 20, and 21); none resulted in an adverse patient outcome.

Hospital Records

The OIG clinicians reviewed 26 encounters and found that VSP promptly retrieved and scanned hospital records, discharge summaries, and emergency room records. There were four deficiencies, one of which was significant (case 21, described below). The providers reported that the utilization management nurse ensured that records were available for their review.

Specialty Services

The specialty services nurse shared with the OIG clinicians a tracking system for receipt of consultation notes and diagnostic reports the nurse had devised. As a result of the tenacious efforts of this individual, specialty consultation reports were promptly received. There was one significant deficiency, also discussed in the *Specialty Services* indicator:

- In case 13, the patient had undergone partial colon removal surgery and was seen for his first follow-up visit after the surgery, but the telemedicine general surgery consultant's note was not found in the patient's electronic medical record.

Diagnostic Reports

One significant deficiency in retrieving a diagnostic report was noted:

- In case 8, an echocardiography report was not found in the patient's electronic medical record.

The following minor deficiencies were noted in retrieving and reviewing diagnostic reports:

- In case 6, a report of urine testing to detect increased albumin excretion was not found in the patient's electronic medical record during the OIG clinician's review. After the OIG pointed this out to the institution, the report was retrieved and reviewed by a provider on the next day.

- In case 43, results of stool testing for the presence of occult blood were missing from the patient's electronic medical record three months after they were ordered.

In almost all the reviewed cases, diagnostic reports were promptly sent to the provider and reviewed on the same day or the next business day. The one exception was case 10 in which there was an eight-day delay in reviewing and signing a laboratory report.

Urgent/Emergent Records

Nursing management of patients in the TTA was appropriately documented. One exception was case 3, in which the patient's name and CDCR number were not noted in one of the emergency response documents. In almost all instances, participation of the on-call provider was accompanied by a provider telephone note. This is also discussed in the *Emergency Services* indicator.

Scanning Performance

Documents were promptly scanned but there were numerous errors in the scanning process. The most common were missing or mislabeled documents.

Two significant deficiencies were noted:

- In case 20, nursing records for a one-week period in the OHU were not found in the patient's electronic medical record. It was not possible to determine if the patient's complaint of foot pain was a new symptom or one that had been present for a few days.

- In case 21, the hospital discharge summary included records belonging to another patient.

The following minor deficiencies were noted by the OIG clinicians:

- One or more missing documents were noted on review of records of cases 1, 12, 14, 15, 19, 22, 33, 36, and 50.

- One or more mislabeled documents were noted on review of records of cases 7, 8, 14, 15, 16, 18, 21, 22, 25, 26, 27, and 38.

- Duplication of scanned documents was noted on review of records of cases 5, 13, 14, 21, 23, 25, and 38.

Legibility

Progress notes written by a few of the providers were difficult to decipher. In some instances the signature of the nurse providing care was illegible.

Clinician Onsite Inspection

In response to a question regarding measures in place to ensure accurate scanning of documents, VSP staff told OIG clinicians that new medical records staff were paired with a mentor and started with scanning of the medication administration records (MARs), the most straightforward documents, before moving to other records. With a staff of 12, the supervisor stated that attempts to audit the performance of the staff posed a challenge.

Conclusion

VSP performed well with retrieving hospital and emergency room records, consultation notes, and diagnostic reports. Scanning performance was adequate. The OIG clinicians rated this indicator as *adequate*.

Compliance Testing Results

The institution scored an *adequate* 81.8 percent in the *Health Information Management* indicator, performing at the *proficient* level in five out of six tests, as follows:

- The OIG reviewed community hospital discharge reports and treatment records for 17 sampled patients who VSP sent to an outside hospital. For 16 of the 17 patients (94 percent), the discharge summary reports were complete and timely reviewed by VSP providers. For one patient, there was no preliminary or final discharge found in the patient's electronic health care records and also no evidence that VSP followed up with the hospital to obtain the report (MIT 4.007).

- The OIG also tested 16 applicable patients' discharge records to determine if staff timely scanned the records into the patient's electronic medical record. Fifteen of the 16 samples (94 percent) were compliant. One record was scanned one day late (MIT 4.004).

- VSP medical records staff timely scanned MARs into 15 of 16 sampled patients' electronic medical records (94 percent). One MAR was scanned three days late (MIT 4.005).

- The institution timely scanned 18 of 20 sampled non-dictated progress notes, initial health screening forms, and requests for health care services into the patients' electronic medical records (90 percent). One progress note and one health service request form were each scanned one day late (MIT 4.001).

- Institution staff timely scanned 18 of 20 specialty service consultant reports sampled into the patients' electronic health care records (90 percent). The other two specialty reports were scanned seven and ten days late (MIT 4.003).

VSP showed room for improvement with an *inadequate* score in one test:

- The institution scored 29 percent in its labeling and filing of documents scanned into patients' electronic unit health records. For this test, once the OIG identifies 24 mislabeled or misfiled documents, the maximum points are lost and the resulting score is zero. For the VSP medical inspection, inspectors identified a total of 17 documents with scanning errors. Fifteen errors included mislabeled and misfiled documents. There was also a missing MAR and one instance of a patient's record scanned into the incorrect patient's file (MIT 4.006).

Recommendations

No specific recommendations.

5 — *HEALTH CARE ENVIRONMENT*

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

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

Overall Rating:
Adequate

Compliance Testing Results

The institution received an *adequate* compliance score of 82.1 percent in the *Health Care Environment* indicator, with *proficient* scores in several areas, as follows:

- Inspectors examined VSP's eight clinics to verify that adequate hygiene supplies were available and sinks were operable; all clinics were compliant (MIT 5.103).
- Health care staff at all seven applicable clinics followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste (MIT 5.105).
- All eight applicable clinics had an environment adequately conducive to providing medical services (MIT 5.109).
- Seven of the eight clinics examined (88 percent) were appropriately disinfected, cleaned, and sanitary. In one clinic, the cleaning log was not marked as completed, and cleaning staff were not able to verify if the clinical area was appropriately disinfected, cleaned, and sanitized (MIT 5.101).
- OIG inspectors observed health care clinicians in each applicable clinic to ensure they employed proper hand hygiene protocols. In seven of eight clinics, clinicians adhered to universal hand hygiene precautions, scoring 88 percent. In one clinic, OIG inspectors observed a clinician fail to wash or sanitize hands immediately after performing a blood pressure check (MIT 5.104).
- Seven of eight clinics at VSP followed adequate protocols for managing and storing bulk medical supplies (88 percent). In one clinic, inspectors found medical supplies that were stored in the same area as disinfectant and germicidal wipes (MIT 5.107).

- Inspectors visited all eight clinics where medical services were provided to ensure that clinic common areas and exam rooms had essential core medical equipment and supplies. Of the eight clinics, seven were properly equipped and adequately stocked (88 percent). One clinic had an exam room table that was missing disposable paper (MIT 5.108).

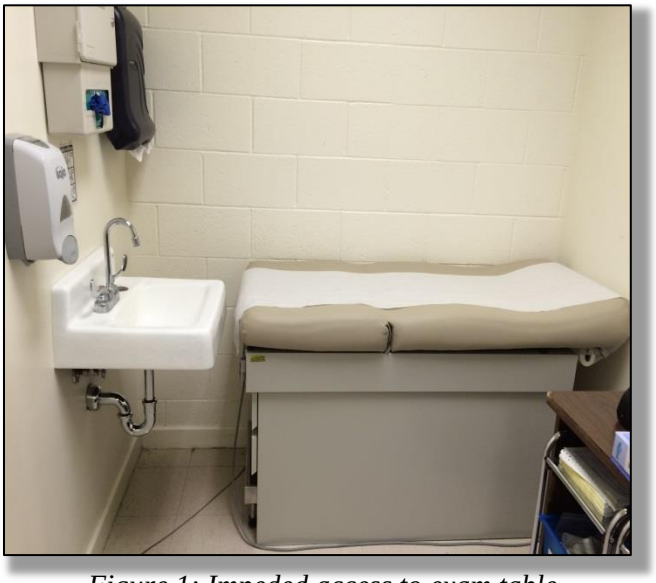

Figure 1: Impeded access to exam table

- Seven of eight clinics observed (88 percent) had appropriate space, configuration, supplies, and equipment to allow clinicians to perform a proper clinical examination. However, clinicians had impeded access to the exam table in an exam room at one clinic (*Figure 1*) (MIT 5.110).

- Clinical health care staff ensured that reusable invasive and non-invasive medical equipment was properly sterilized or disinfected at six of seven applicable clinics inspected (86 percent). At one clinic, nursing staff did not acknowledge that the exam table was disinfected as part of the daily cleaning process (MIT 5.102).

VSP scored in the adequate range for the following test:

- Inspectors examined emergency response bags to determine if they were inspected daily and inventoried monthly and whether they contained all essential items. Emergency response bags were compliant in four of the five clinical locations where they were stored (80 percent). In one clinic, the Emergency Medical Response Bag log was missing multiple entries in January 2017 (MIT 5.111).

The institution showed areas for improvement with *inadequate* scores in the following test:

- The non-clinic bulk medical supply storage areas did not met the supply management process and support needs of the medical health care program, resulting in a score of zero for this test. Inspectors found expired catheters in the temperature controlled warehouse at the time of inspection (5.106).

Non-Scored Results

- The OIG gathered information to determine if the institution's physical infrastructure was maintained in a manner that supported health care management's ability to provide timely or adequate health care. This question was not scored. When OIG inspectors interviewed health

care managers, they did not have concerns about the facility's infrastructure or its effect on the staff's ability to provide adequate health care. However, the institution had several renovation projects for clinics on four yards, and VSP was building a new pharmacy. These projects began in November 2015 and were expected to be completed by June 2018 (MIT 5.999).

Recommendations

No specific recommendations.

6 — *INTER- AND INTRA-SYSTEM TRANSFERS*

Case Review Rating:
Adequate
Compliance Score:
Proficient
(89.2%)

Overall Rating:
Adequate

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

In this indicator, the OIG's case review and compliance testing yielded different results, with the case review earning an *adequate* rating, and the compliance testing resulting in a *proficient* score. Due to the few but significant deficiencies revealed by case review, the OIG's determined the overall rating of *adequate* was appropriate for this indicator.

Case Review Results

The OIG clinicians reviewed 45 encounters relating to *Inter- and Intra-System Transfers*, including information from both the sending and receiving institutions. These included 26 hospitalization events, each of which resulted in a transfer back to the institution. In general, the transfer processes at VSP were adequate. The OIG identified 12 deficiencies, four of which were significant (cases 14, 21, 26, and 29). The majority of the transferred patients were scheduled appropriately and received timely continuity of health care services.

Transfers In

The OIG clinicians reviewed 15 patient transfer events into VSP and noted two deficiencies. The following cases displayed the only significant deficiencies in this category:

- In case 3, there was a ten-day delay in scheduling the patient for a chronic care appointment.
- In case 29, the RN did not accurately complete the Initial Health Care Screening form (CDCR Form 7277). The nurse erroneously documented a diagnosis of diabetes. In addition,

the patient had asthma, but the nurse failed to obtain any health history or assess the patient's respiratory status. The nurse documented that the patient was not at high risk for the coccidioidomycosis fungal infection (valley fever). However, the Health Care Transfer form (CDCR Form 7371) from the sending institution's indicated that the patient was at high risk. The nurse did not refer the patient to the provider within the 30-day time frame, as required per CCHCS policy for high-risk patients. The documentation showed a referral date of 150 days. Fortunately, the patient was seen 19 days later by the provider following an offsite specialty service visit.

Transfers Out

There were four transfer-out events reviewed, which were adequate except for one case in which the nurse failed to complete significant information on the transfer form:

- In case 31, the RN failed to note several pertinent issues about the patient: his follow-up oncology appointment, the diagnosis of kidney cancer, the low salt diet, his TABE (Test of Adult Basic Education) score, the fact that he was Spanish speaking, and the administration of chronic care medications prior to his transfer to another institution.

Hospitalizations

Patients returning from hospital admissions 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. Of the 26 hospitalization events, there were eight deficiencies. These occurred in the areas of medication management, appointments and scheduling, and health information management. The majority of hospital return patients were processed appropriately by the TTA RN. However, the following cases showed significant deficiencies:

- In case 14, the patient was hospitalized for an abscess in his genital area. The nurse did not document the provider's order for continued antibiotics, which caused a lapse of several days in medication therapy.

- In case 26, the patient was hospitalized after being resuscitated from a cardiac arrest complicated by pneumonia. The hospital recommended continued use of antibiotics and a medication to reduce stomach acid. The nurse did not inform the provider of the hospital recommendations. As a result, the antibiotic was never ordered, and the acid reflux medication was ordered a week later. The lapse in receiving the medications placed the patient at risk of increased harm.

Health Information Management

The OIG identified one significant deficiency in this area, also described in the *Health Information Management* indicator:

- In case 21, the hospital discharge summary included records that belonged to another patient. The discharge summary was also scanned with an incorrect encounter date.

Clinician Onsite Inspection

The VSP receiving and release clinic (R&R) had adequate space for initial screening, but did not provide private space for examination of patients transferred in. If a patient presented with any urgent situation, he was sent to the TTA for treatment. The nurse assigned to the area was knowledgeable about the process and procedures of transferring patients in and out of the institution. The nurse described the medical hold process well. This was a process to avoid transferring a patient when a medical condition placed him at risk. The R&R nurses utilized the transfer checklist to ensure all requirements of the transfer were completed, and filed the copy for one month. The primary care team discussed each new patient transfer and made decisions about needed referrals and plans of care.

Compliance Testing Results

The institution obtained a *proficient* score of 89.2 percent in the *Inter- and Intra-System Transfers* indicator, with two of the five applicable tests receiving 100 percent scores, as described below:

- Nursing staff timely completed the assessment and disposition sections of the screening form for all 25 patients (MIT 6.002).

- The OIG inspected the transfer packages of ten patients who were transferring out of the facility to determine whether the packages included required medications and support documentation. All ten transfer packages were compliant (MIT 6.101).

- Inspectors sampled 20 patients who transferred out of VSP to other CDCR institutions to determine whether the institution listed their scheduled specialty service appointments on the Health Care Transfer Information form (CDCR form 7371). VSP nursing staff documented the previously approved and still pending specialty service appointments for 18 patients, but failed to do so for two others (90 percent) (MIT 6.004).

One test earned VSP an *adequate* score:

- The OIG tested 25 patients who transferred into VSP from other CDCR institutions to determine whether they received a complete initial health screening assessment from nursing staff on their day of arrival. Although nursing staff timely prepared the screening forms,

they neglected to answer all applicable questions for four patients, resulting in a score of 84 percent (MIT 6.001).

The institution showed room for improvement in one test area that received an *inadequate* score:

- Of 25 sampled patients who transferred into VSP, 18 had an existing medication order upon arrival; only 13 of the 18 patients (72 percent) received their medications without interruption. Five patients incurred medication interruptions of one or more dosing periods upon arrival (MIT 6.003).

Recommendations

No specific recommendations.

7 — *PHARMACY AND MEDICATION MANAGEMENT*

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(69.5%)

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 prescriber, staff, and patient.

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

Case Review Results

The OIG clinicians evaluate the *Pharmacy and Medication Management* indicator as secondary processes as they relate to the quality of clinical care provided. The OIG clinicians reviewed 51 events related to pharmacy and medication management and found 15 deficiencies, four of which were significant (cases 9, 19, 28, and 37).

New Prescriptions

In the majority of cases, patients received newly prescribed medications on time. Delays were noted in the following cases:

- In case 3, the nursing staff failed to reconcile an order for a cholesterol lowering medication. This led to a six-day delay in initiation of treatment.
- In case 28, prednisone (steroid) was not tapered as ordered by the provider. The MAR did not document the administered doses. This was a significant deficiency.

- In case 37, the nurse failed to reconcile a provider's order for a new medication for management of chronic pain. This led to a 14-day delay before the patient received the medication. This was a significant deficiency.

Continuity of Chronic Care Medications

Most of the patients received their keep-on-person (KOP) or nurse-administered chronic care medications without interruption. Lapses in continuity of medication therapy were noted in the following cases:

- In case 1, there was a 38-day delay in the patient receiving a refill of his cholesterol medication and a 9-day delay in dispensing his stool softener.

- In cases 2 and 24, delays of 29 and 7 days, respectively, occurred in the patients' receipt of refills of KOP supplies of blood pressure medication.

- In case 9, after the provider modified the dose of a blood thinner, the patient continued to receive the discontinued dose. This led to the patient receiving nearly double the prescribed dose on two days. This was a significant deficiency.

- In case 19, administration of a seizure medication was not documented over a 12-day period, placing the patient at risk of harm. This was a significant deficiency.

- In case 23, record of administration of a seizure medication was missing for a two-day period.

Intra-System and Intra-Facility Transfers and Medication Continuity

Medication continuity was maintained in all but one of the reviewed cases:

- In case 31, the patient, upon departure from the institution, did not receive his morning doses of chronic care medications.

Post Hospitalization or Offsite Specialty Service Medication Continuity

The institution generally maintained medication continuity for patients returning from a hospitalization, but errors occurred in the following cases:

- In case 14, administration of an antibiotic was missed on two days in a ten-day course. This deficiency is also discussed in the *Quality of Nursing Performance* indicator.

- In case 15, the patient did not receive one dose of a steroid upon returning from an offsite treatment.

- In case 22, the patient did not receive the antibiotic course prescribed by the on-call provider following his return from the community hospital. This deficiency is also discussed in the *Quality of Provider Performance* indicator.

Specialized Medical Housing

The majority of patients in the OHU received their medications without interruption. Cases with medication deficiencies are described in the *Specialized Medical Housing* indicator.

Clinician Onsite Inspection

During the onsite inspection, the OIG clinicians met with provider, nursing, and pharmacy representatives to discuss their case review findings. VSP staff were able to provide documentation that answered the OIG's questions about medication delays or missing information.

The OIG also interviewed medication nurses in the medication clinics. During these interviews, staff revealed that the institution's policy and procedure of renewing soon-to-expire medications was not a standard process, and staff were inconsistent in their response to questions regarding the process. The staff stated that patients were allowed to come to the medication window at any time of day to refill KOP medications, and that health care staff did not, as policy requires, notify custody if patients did not pick up their medications.

The OIG clinicians also noted a problem in the medication management of patients returning from the hospital or an offsite specialty procedure. Although the TTA staff stated that they retrieved medications from the Omnicell or contacted the on-call pharmacist to obtain medications not stocked in the Omnicell, there were cases in which either maintenance medications were not ordered or the patient did not receive the medications on time.

Conclusion

The OIG clinicians noted several errors in continuity of medication administration and in dispensing prescribed medications. However, the majority of these did not pose a danger to the wellbeing of the patients. The OIG clinicians rated the *Pharmacy and Medication Management* indicator *adequate.*

Compliance Testing Results

The institution received an *inadequate* compliance score of 69.5 percent in the *Pharmacy and Medication Management* indicator. For discussion purposes, this indicator is divided into three sub-indicators: medication administration, observed medication practices and storage controls, and pharmacy protocols.

Medication Administration

In this sub-indicator, the institution received an *inadequate* average score of 67 percent, showing room for improvement in the following areas:

- Among 16 sampled patients, only nine (56 percent) timely received chronic care medications. Two patients missed one or more doses of their directly observed therapy (DOT) medications and did not receive provider counseling. One patient missed one dose of DOT medication and also received his two KOP medications four and ten days late. One patient received his KOP medication ten days late; another patient received an insufficient supply of his KOP monthly medication (only 20 days' worth); two other patients did not receive their KOP medications at all (MIT 7.001).

- VSP ensured that 15 of 25 patients sampled (60 percent) received their medications without interruption when they transferred from one housing unit to another; the remaining ten patients did not receive their medication at the proper dosing interval (MIT 7.005).

- When the OIG sampled ten patients who were in transit to another institution and were temporarily laid over at VSP, only six (60 percent) received their medications without interruption. Four patients each missed at least one dose of their required medications (MIT 7.006).

- Clinical staff timely provided new and previously prescribed medications to 12 of 17 patients sampled who had been discharged from a community hospital and returned to the institution (71 percent). Three patients received ordered DOT or KOP medications one to 19 days late. For another two patients, there was no evidence found in the medical record that the patients received their ordered KOP medications (MIT 7.003).

The institution received a *proficient* score on the following test:

- VSP timely administered or delivered new medication orders to 22 of the 25 patients sampled (88 percent). For the three patients who did not receive their medication timely, the delays were from one to 11 days (MIT 7.002).

Observed Medication Practices and Storage Controls

In this sub-indicator, the institution received an *inadequate* average score of 63 percent, showing areas needing improvement in the following tests:

- The OIG interviewed nursing staff and inspected storage areas specifically for the storage of narcotics at seven applicable locations to assess whether strong narcotics security controls existed. Only one of the seven areas (14 percent) was adequately controlled. All six exceptions related to missing signatures in the narcotics logbook, indicating habitual lack of physical shift inventories performed by nursing staff to safeguard narcotics (MIT 7.101).

- VSP properly stored non-narcotic medications not requiring refrigeration in three of the seven applicable clinic and medication line storage locations (43 percent). In four locations, one or more of the following deficiencies were observed: the medication area lacked a designated area for return to pharmacy medications; internal and external medications were not properly separated when stored; and a multiuse medication was not labeled with the date it was opened (MIT 7.102).

- Inspectors observed the medication preparation and administration processes at five applicable medication line locations. Nursing staff were compliant regarding proper hand hygiene and contamination control protocols at three locations (60 percent). At two locations, not all nursing staff washed or sanitized their hands when required, such as prior to putting on gloves or before re-gloving (MIT 7.104).

- Only three of the five inspected medication preparation and administration areas demonstrated appropriate administrative controls and protocols (60 percent). In two locations, one or more of the following deficiencies were observed: the medication nurse did not ensure if the patient swallowed DOT medication; the medication nurse signed the MAR prior to administering medications; and the medication nurse did not properly administer medication by crushing and floating it as ordered by the provider (MIT 7.106).

The following two tests received *proficient* scores:

- The institution properly stored non-narcotic medications that required refrigeration at all nine applicable clinics and medication line locations (MIT 7.103).

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

Pharmacy Protocols

In this sub-indicator, VSP received an *adequate* average score of 80 percent, comprised of scores received at the institution's main pharmacy. The institution received *proficient* scores of 100 percent in the following four tests:

- The institution followed general security, organization, and cleanliness management protocols in its main pharmacy (MIT 7.107).

- The institution properly stored and monitored non-narcotic medications that did not require refrigeration (MIT 7.108).

- The institution's pharmacist in charge (PIC) properly accounted for narcotic medications stored in VSP's pharmacy and reviewed monthly inventories of controlled substances in the institution's clinical and medication line storage locations (MIT 7.110).

- VSP's PIC timely processed all 20 sampled medication error reports (MIT 7.111).

The institution received an *inadequate* score of zero on one test in the Pharmacy Protocols sub-indicator:

- The main pharmacy did not properly store refrigerated or frozen medications. The refrigerator log showed temperatures that exceeded the acceptable range on several days during the prior 30-day period (MIT 7.109).

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 found no applicable medication errors (MIT 7.998).

Recommendations

No specific recommendations.

8 — *PRENATAL AND POST-DELIVERY SERVICES*

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

Because VSP is a male-only institution, this indicator did not apply.

Case Review Rating:
Not Applicable
Compliance Score:
Not Applicable

Overall Rating:
Not Applicable

9 — *PREVENTIVE SERVICES*

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

Case Review Rating:
Not Applicable
Compliance Score:
Adequate
(76.0%)

Overall Rating:
Adequate

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

Compliance Testing Results

The institution performed in the *adequate* range in the *Preventive Services* indicator, with a compliance score of 76.0 percent, with three of the six tests receiving *proficient* scores, as follows:

- All 25 patients sampled timely received or were offered influenza vaccinations during the most recent influenza season (MIT 9.004).

- The OIG tested whether patients who suffered from a chronic care condition were offered vaccinations for influenza, pneumonia, and hepatitis. Among the 16 sampled patients with applicable chronic conditions, 15 patients (94 percent) were timely offered the vaccinations. For one patient, there was no record that the patient received or refused the pneumococcal immunization (MIT 9.008).

- VSP offered colorectal cancer screenings to 23 of 25 sampled patients subject to the annual screening requirement (92 percent). For two patients, there was no medical record evidence either that health care staff offered a colorectal cancer screening within the previous 12 months or that the patient had a normal colonoscopy within the last ten years (MIT 9.005).

The institution showed room for improvement with *inadequate* scores in three areas:

- VSP scored poorly for the timely administration of tuberculosis (TB) medications. The OIG examined the health care records of all 15 patients who were on TB medications during the inspection period, and only eight patients received all of their required medications (53 percent). More specifically, 7 of the 15 examined patients did not receive their medications at the provider scheduled interval dates. Each of the seven patients missed one or more scheduled dates, and none of them received provider counseling regarding the missed doses. One of the seven patients missed three scheduled days of his medication; one patient received extra doses on two other unscheduled days; two patients received two doses

of the TB medications on the same day. Finally, according to the MARs, one of the seven patients also missed one scheduled dose but received extra doses on three unscheduled days (MIT 9.001).

- The institution scored poorly for monitoring of patients on TB medications. For 7 of 15 patients sampled, the institution either failed to complete monitoring at all required intervals or failed to scan the monitoring form into the patient's medical record in a timely manner (53 percent) (MIT 9.002).

- OIG inspectors sampled 30 patients to determine whether they received a TB screening within the last year. Fifteen of the sampled patients were classified as Code 22 (requiring a TB skin test in addition to a signs and symptoms check), and 15 sampled patients were classified as Code 34 (subject only to an annual signs and symptoms check). Of the 30 sample patients, nursing staff timely and appropriately conducted those screenings for only 19 of them (63 percent). More specifically, nurses properly screened 7 of the 15 Code 22 patients and 12 of the 15 Code 34 patients. Inspectors identified the following deficiencies (MIT 9.003):

    - For eight Code 22 patient screenings, the 48-to-72-hour compliance window to read the test results was not determinable because nursing staff did not document either the administered (start) or read (end) time on the Tuberculin Testing/Evaluation Report (CDCR Form 7331). In addition, for three of the Code 22 patients, an LVN or psychiatric technician read the test results rather than an RN, public health nurse, or primary care provider as required by the CCHCS policy in place at the time of the OIG's review.

    - Two Code 34 patients were not screened for TB in the last year; for one of the Code 34 patients, the nursing staff did not document the screening date on the TB form.

Recommendations

No specific recommendations.

10 — *QUALITY OF NURSING PERFORMANCE*

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

Overall Rating:
Adequate

The *Quality of Nursing Performance* indicator is a qualitative evaluation of the institution's nursing services. The evaluation is completed entirely by OIG nursing clinicians within the case review process, and, 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, 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 sick call 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 *adequate*. The OIG clinicians reviewed 394 nursing encounters, of which 184 were in the outpatient setting. Most outpatient nursing encounters were for sick call requests, walk-in visits, and RN follow-up visits. In all, there were 68 deficiencies identified related to nursing care performance, 11 of which were significant.

Nursing Assessment

Case review revealed nursing assessments were appropriate and thorough. The majority of the sick call nurses utilized the CCHCS nursing encounter protocol forms which likely contributed to appropriate documentation and interventions.

Nursing Intervention

In general, nursing interventions were appropriate and based on subjective and objective nursing assessments (observation and patient interviews). Referrals to the provider for follow-up were timely. Outpatient medication administration was accurate and timely provided. However,

deficiencies were found in the implementation and documentation of wound care, including missed measurements and descriptions of wounds and healing status:

- In case 14, the patient had wound care orders for an abscess in his genital area. The initial wound care order was for dressing changes twice a day. On three different days, the wound care was provided once daily.

- In case 39, the patient had a blister on the side of an ingrown toenail for ten days. The provider evaluated the patient and ordered wound care for seven days. Although the wound care order was discontinued three days later, the dressing changes did not occur at all prior to the order for discontinuation.

Nursing Documentation

Nursing documentation was generally adequate. The majority of nurses appropriately documented nursing assessments and interventions. One nurse in the OHU demonstrated exemplary documentation.

Nursing Sick Call

Nurses used the institution's local operational procedures and the CCHCS Complete Care Model, and usually had providers available for consult at the time of the sick call visit. Nursing staff generally collected and reviewed health care services request forms timely, and most patients with non-urgent medical conditions were appropriately scheduled for nurse clinic visits on the next business day. However, the following deficiencies were identified in sick call nursing encounters:

- In case 17, the diabetic patient had severe pain in toes in both feet. The nurse did not thoroughly assess the lower extremities or document that the patient was dependent on insulin. The nurse referred the patient to the provider for a routine (14-day) follow-up for his pain. The patient was seen 15 days later, had developed an infected lesion on his lower leg, and required treatment with antibiotics. The nurse saw the patient again two months later for pain in his toes, failed to assess the patient's lower extremities, and did not document the patient's recent history of toe infections and daily wound care.

- In case 25, the patient had undergone recent back surgery and requested a refill for pain medication for continuing pain. The nurse referred the patient to a provider without assessing the patient's complaint of continued pain.

- In case 28, the patient with history of asthma submitted a sick call request for pain all over his body, trouble breathing at night, and need for his breathing machine. The sick call nurse did not assess the patient on the same day for a potentially urgent condition. However, the patient was seen two days later and informed the nurse that his asthma attack had resolved with his inhalers.

- In case 33, on two separate occasions, the sick call nurse failed to assess the patient. The patient had tardive dyskinesia (movement disorder causing involuntary painful muscle spasms) and requested a walker after experiencing a recent fall. In the second request, the patient had neck pain and difficulty swallowing. The nurse did not evaluate the patient.

- In case 51, the patient submitted two sick call requests for medical symptoms, but the nurse did not conduct a face-to-face assessment. The patient complained of right arm and shoulder pain, and the nurse documented the provider had seen the patient for these complaints although the appointment with the provider had been 20 days previously. In the second request, the patient had the same complaint of pain and the case was discussed in the morning primary care team huddle. The patient was referred to the provider, but the appointment did not occur.

Urgent/Emergent Care

Emergency nursing services were adequate. Nurses in the TTA and emergency responders were knowledgeable in providing emergency care. Some clinic nurses had been relocated to the TTA because one of the clinic yards was undergoing construction. Deficiencies in emergency care are further described in the *Emergency Services* indicator.

Care Management

The CCHCS Complete Care Model was clearly evident at VSP. Providers were usually available to nurses for consultation at the time of sick call visits. These consultation encounters, interventions, and decisions were appropriately documented in the patients' health care records.

Post-Hospital Returns

The TTA nurses appropriately assessed the majority of patients returning to VSP after hospital discharge. This is further discussed in the *Inter- and Intra-System Transfers* indicator.

Specialized Medical Housing

Nursing care in the OHU was adequate, and identified deficiencies were determined to be minor. The *Specialized Medical Housing* indicator includes additional information on these encounters.

Intra-System Transfers

Intra-system transfer nursing services were adequate. The majority of patients who transferred into VSP were scheduled appropriately and received timely continuity of health care services. The *Inter- and Intra-System Transfer* indicator includes more details.

Offsite Specialty Services Returns

Patients returning from offsite specialty appointments were assessed by a nurse following their return to VSP, and the follow-up recommendations from the specialty consultant were

communicated to the provider without delay. This is further discussed in the *Specialty Services* indicator.

Clinician Onsite Inspection

The OIG clinicians visited various clinical areas and interviewed 22 nurses, including those in specialty services, R&R, OHU, TTA, facilities A, B, C, D, and the administrative segregation unit. All nurses in the clinics were familiar with their work responsibilities and duties and the patient population within their assigned clinical areas. Care coordinators spoke freely of current practices and the challenges they faced. Clinic nurses were active participants in the morning huddles and care management. The morning huddles had good attendance and active communication.

The OIG clinicians reviewed 16 employee files and 12 training and supervisory files. The training files were well organized and included RN and LVN current licensure, current BLS (basic life support) certifications, annual mandatory training and competency training related to administration of clozapine (psychosis medication) and naloxone (opioid antidote). Nursing licenses and annual mandatory training documentation were current in all files. However, review of supervisory files showed that sick call audits had not been completed within the past eight months.

Clinician Summary

Nursing staff in all clinics voiced concerns about the current nursing shortage, pressures to ensure all scheduled patients were seen, and mandated overtime to complete tasks. Several nurses felt nursing morale was low. Nursing shortages at VSP were primarily due to recent staff resignations, retirements, and medical leaves. However, nursing services at VSP were adequate, and nursing staff across the institution exemplified a high standard of care.

Recommendations

No specific recommendations.

11 — *QUALITY OF PROVIDER PERFORMANCE*

In this indicator, the OIG physicians provide a qualitative evaluation of the adequacy of provider care at the institution. Appropriate evaluation, diagnosis, and management plans are reviewed for programs including, but not limited to, nursing sick call, chronic care programs, 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 394 medical provider encounters and identified 52 deficiencies related to provider performance, of which 8 were significant (two in cases 8, 19, and 22, and one each in cases 5 and 15). Of the 25 cases reviewed, three received *proficient* care and 20 patients received *adequate* care. Care of two patients was rated *inadequate*. Provider performance was rated *adequate* overall.

Assessment and Decision-Making

Errors in assessment and decision-making by providers were found in the records of six patients. This was the main reason that the OIG clinicians rated one detailed case review (case 19) as *inadequate*, and contributed to the *inadequate* rating of another (case 22).

- In case 5, the patient experienced an episode of severe low blood sugar after the provider increased insulin to a much higher dose.
- In case 8, on several occasions, the provider did not ask the patient about bleeding side effects while taking warfarin (blood thinner).
- In case 19, there were repeated failures by the provider to correlate abnormal laboratory results with the doses of both seizure and thyroid medications. The patient had two seizures during the course of this review, and in both instances, the seizure medication management response was inadequate.
- In case 22, on an earlier occasion, a provider, after making a diagnosis of a skin infection and prescribing an antibiotic, failed to order a follow-up appointment for reevaluation.
- Also in case 22, the OHU provider, during the hospital discharge summary review, failed to recognize that the on-call provider prescribed a shorter-than-recommended course of an antibiotic.

Review of Records

Adequate review of records is essential, especially when the provider is not familiar with the patient's history, after investigations have been performed, following evaluation by a specialist, or when the patient has returned from a higher level of care. Inadequate review of records led to failure to act (cases 19 and 22, already described) and to documentation of erroneous information, as follows:

- In case 5, the provider erroneously attributed an episode of low blood sugar to the patient receiving a higher-than-ordered dose of insulin. The low blood sugar level was most likely caused by the patient missing his lunch along with greater exercise than usual.

Chronic Care

Identification and appropriate management of chronic health problems, such as diabetes mellitus, hypertension, and hyperlipidemia, are important in reducing the risk for both acute and long-term complications. In most instances, providers at VSP appropriately managed their patients' chronic health conditions, with a few exceptions:

- In case 17, on more than one occasion, the provider incorrectly concluded that the patient's diabetes was improving, when the lab tests showed rising blood glucose.

Specialty Services

Providers at VSP appropriately referred patients for specialty consultation. Appointments were scheduled within appropriate time frames; reports were almost always promptly reviewed by the providers. This is further discussed in the *Specialty Services* indicator.

Emergency Care

The providers at VSP appropriately managed patients presenting to the TTA. These cases are further discussed in the *Emergency Services* indicator.

Specialized Medical Housing

A dedicated provider managed patients in the OHU. This is further discussed in the *Specialized Medical Housing* indicator.

Clinician Onsite Inspection

VSP, classified as a basic institution, had eight medical providers (five physicians and three mid-level providers (nurse practitioners or physician assistants)). An additional position had recently been approved. Two providers (a physician and a mid-level provider) were assigned to three of the four yard clinics, one physician in the fourth clinic, and one provider was responsible for care of patients in the 23-active-medical-bed OHU and in the TTA. The TTA was described as quiet, with an average of four to five patients being seen per day. Six of the providers had been at

the institution for several years. Staff at one of the yard clinics reported multiple provider changes over the past year as a result of reassignments.

The providers started their day by participating in a meeting to review the previous day's events, which was followed by individual clinic team huddles. These huddles were described as having greatly facilitated implementation of the Complete Care Model. A typical workday included evaluating 12 to 14 scheduled patients and three to four walk-ins or returns from a higher level of care. In addition, providers participated in nurse consultation visits. Consultation visits were encouraged to reduce the need for provider visits following RN triage encounters. Providers reported that requests for consultation were mostly appropriate.

Each clinic had an LVN designated as the "care coordinator." Responsibilities of this LVN included scheduling health screening tests, including following up with patients who had not returned fecal occult blood test cards, scheduling testing for patients receiving warfarin, reviewing educational materials with patients, and coordinating the clinic huddle together with the RN.

With a policy that all scheduled patients should be seen, only one clinic reported a backlog. However, with the imminent deployment of the Electronic Health Record System, staff voiced their concern regarding the potential short-term effect on patients' access to care.

The executive leadership actively participated in the regularly held multidisciplinary population management meetings. The chief executive officer's active involvement was described as being instrumental in prompt resolution of identified system problems. Overall, the morale among the providers was high. The providers described VSP as a good institution to work in, attributing this to the stability of the group, the collegial atmosphere, and excellent support from the chief physician and surgeon and the chief medical executive. Helpful clinic staff, responsive schedulers, and a good working relationship with the custody staff were also described as positives.

The CME stated that the strengths of the institution were providers who were experienced in care of patients in the correctional environment, a high provider retention rate, and good relationships with custody. Reported challenges were overcrowding, higher than the allocated number of enhanced outpatient program (EOP), high-risk, and older patients, and the shortage of nursing staff.

Recommendations

No specific recommendations.

12 — *RECEPTION CENTER ARRIVALS*

Case Review Rating:
Not Applicable
Compliance Score:
Not Applicable

Overall Rating:
Not Applicable

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

For VSP, this indicator did not apply because the institution had no reception center.

13 — *SPECIALIZED MEDICAL HOUSING*

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

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(63.3%)

Overall Rating:
Adequate

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

Case Review Results

The institution had 23 active OHU medical beds, 13 of which were capable of providing respiratory isolation. The OIG clinicians reviewed 14 admissions, including 171 provider and 111 nursing encounters, and identified 71 deficiencies, of which six were significant. The case review clinicians rated this indicator *adequate*.

Provider Performance

Patients in the OHU had straightforward medical problems and generally received adequate care. However, two significant deficiencies occurred:

- In case 8, during a follow-up encounter with the patient for elevated blood pressure and rapid heart rate, the provider did not document the patient's blood pressure, heart rate, or pertinent physical examination findings. On another occasion, the management of diabetes and anticoagulation were not appropriately addressed.

- In case 22, the provider reviewed the hospital discharge summary but failed to recognize that the on-call provider had prescribed a shorter course of antibiotics than recommended.

These cases are also discussed in the *Quality of Provider Performance* indicator.

Nursing Performance

Nursing performance in the OHU was adequate. Documentation by one registered nurse was particularly good. There were two significant deficiencies:

- In case 7, nurses administered twice the prescribed dose of warfarin (blood thinner). This temporarily led to a dangerously high level, placing the patient at increased risk for bleeding. Fortunately, the dose was adjusted before the patient was harmed.

- In case 14, the patient had been hospitalized for a genital abscess requiring surgical drainage. During the OHU admission, the patient did not receive the full antibiotics course as prescribed, placing him at risk for continued infection. At the second OHU admission, a different abscess developed in the same area upon return from the hospital, and the nurse failed to document the provider's antibiotics order. This resulted in two missed doses of antibiotics.

The wound care administration in the OHU was adequate. However, there were minor deficiencies in wound care and medication therapy and failures to notify the provider:

- In case 14, the patient had an abscess and required daily wound care. On several occasions, the nurse failed to measure the wound to note if the wound was healing. On one occasion, the nurse failed to inform the provider of the patient's refusal to allow wound treatment. During both outpatient housing admissions, the staff did not document a nursing multidisciplinary treatment plan and note if the wound was healing.

- In case 15, the patient had lung cancer. On several occasions, the nurse failed to assess whether the pain medication was effective after being given to the patient. Another time, the nurse did not assess the patient with a new rash on his hand. There was also a lapse in medication therapy when the patient did not receive his prescribed dose of a steroid upon returning from his radiation treatment.

- In case 16, the patient had diabetes and peripheral vascular disease. He received wound care for a slow-healing foot ulcer. On another occasion, the nurse did not apply the prescribed ointment because it was not available, but the nurse did not try to obtain the ointment, which caused a lapse in therapy.

Health Information Management

These deficiencies, which included one significant deficiency, are discussed in the *Health Information Management* indicator.

Clinician Onsite inspection

The OHU had a designated medical provider to ensure continuity of care. A registry provider who had long served as OHU provider had recently left the institution, and another provider from a yard clinic had been assigned to manage patients in the OHU and the TTA. Following the morning huddle, the provider made rounds accompanied by a certified nursing assistant and a custody officer. The CP&S or CME participated in rounds once a week and were available for guidance to address challenging clinical problems.

The OIG found an inconsistent pattern of documenting the size and appearance of wounds during the period reviewed. However, in December 2016, VSP provided training to improve the documentation of wound care and implemented a wound care medical record form for nursing documentation.

Conclusion

With mostly low-acuity patients, the provider and nursing performance in the OHU was good. The OIG clinicians rated the *Specialized Medical Housing* indicator *adequate*.

Compliance Testing Results

VSP scored an *inadequate* 63.3 percent in compliance testing in this indicator. In two of the three tests, the institution scored in the *proficient* range, but the extremely low score in one test significantly affected the average score:

- Although the institution's OHU utilized a call-button system, OHU staff did not properly documented on the daily log if the call-button tests showed they were in proper working condition, scoring zero on this test. However, knowledgeable staff stated that urgent or emergent access to cells was timely at less than a minute, and management did not identify any concerns related to this reported response time (MIT 13.101).

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

- For nine of the ten sampled patients (90 percent), providers completed their Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes at required 14-day intervals. One patient's provider visits occurred one and three days late (MIT 13.003).

Recommendations

No specific recommendations.

14 — *SPECIALTY SERVICES*

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

Case Review Rating:
Proficient
Compliance Score:
Adequate
(83.8%)

Overall Rating:
Proficient

For this indicator, the OIG's case review and compliance review process 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 scores and ultimately rated this indicator proficient. The key factors were that most of the compliance tests yielded scores in the *proficient* range, and the final compliance score of 83.8 percent was very close to *proficient*.

Case Review Results

The OIG clinicians reviewed 158 events related to specialty services, the majority of which were specialty consultations and procedures. Ten deficiencies were noted in this category, of which only two were significant (cases 9 and 13).

Access to Specialty Services

Specialty services were promptly provided for the patients at VSP. The only exception was as follows:

- In case 9, the patient had recently had pulmonary emboli (blood clots in the lungs) but was not scheduled for a follow-up with pulmonary medicine, as intended by the R&R clinic nurse.

On the occasions when a specialty services request was denied, the patient was scheduled for a follow-up appointment with a provider.

Nursing Performance

All the patients were seen by a nurse following specialty appointments, and follow-up recommendations were communicated to the provider without delay.

Provider Performance

Overall, providers at VSP made appropriate requests for specialty services, and these were promptly reviewed by the CP&S or CME.

Health Information Management

Diagnostic reports were promptly retrieved and reviewed. The only two exceptions were as follows:

- In case 8, an echocardiography report was not found in the patient's electronic medical record. This is also noted in the *Health Information Management* indicator.

- In case 13, a general surgery consultant's note was not found in the patient's electronic medical record. This deficiency is also noted in the *Health Information Management* indicator.

Clinician Onsite Inspection

The providers reported that following the implementation of a tracking system, consultation notes and diagnostic reports were promptly received. This system, devised by the specialty services nurse, was a simple one that involved handwritten entries on the Physician Request for Services (CDCR Form 7243).

Clinician Summary

Patients at VSP were appropriately referred without delay to specialty services. Nursing performance was adequate. Overall, the OIG clinicians rated the *Specialty Services* indicator *proficient.*

Compliance Testing Results

The institution received an *adequate* compliance score of 83.8 percent in the *Specialty Services* indicator, with four of the seven applicable tests yielding *proficient* scores, as follows:

- For all 15 patients sampled, routine specialty service appointments occurred within 90 calendar days of the provider's order (MIT 14.003).

- VSP's health care management timely denied providers' specialty services requests for 19 of 20 sampled patients (95 percent). Management denied one specialty service request 54 days late (MIT 14.006).

- Providers timely received and reviewed the specialists' reports for 14 of the 15 sampled patients with high-priority services (93 percent). For one patient, no specialty report was found in the electronic medical record (MIT 14.002).

- Specialists' reports were timely reviewed by a provider following routine specialty service appointments in 14 of the 15 cases reviewed (93 percent). One report was reviewed three days late (MIT 14.004).

Two tests resulted in *adequate* scores:

- Of the 15 patients sampled, 12 (80 percent) received their high-priority specialty service appointments or services within 14 calendar days of the provider's order. Three patients received their specialty services one day late (MIT 14.001).

- Among 20 patients sampled who had a specialty service denied by VSP's health care management, 16 (80 percent) received timely notification of the denied service, including the provider meeting with the patient within 30 days to discuss alternate treatment strategies. For four patients, there was no provider follow-up to discuss the denial at all (MIT 14.007).

VSP showed room for improvement in one test area:

- When patients are approved or scheduled for specialty services at one institution and then transfer to another institution, policy requires that the receiving institution reschedule and provide the patient's appointment within the required time frame. At VSP, only nine of the 20 sampled transfer-in patients (45 percent) received their specialty services appointment within the required time frame. Nine patients received their appointments between 8 and 66 days late. One patient had two approved services, of which VSP provided one service 50 days late but the other service not at all; another patient never received his service (MIT 14.005).

Recommendations

No specific recommendations.

15 — *ADMINISTRATIVE OPERATIONS (SECONDARY)*

Case Review Rating:
Not Applicable
Compliance Score:
Adequate
(83.4%)

Overall Rating:
Adequate

This indicator focuses on the institution's administrative health care oversight functions. The OIG evaluates whether the institution promptly processes patient medical appeals and addresses all appealed issues. Inspectors also verify that the institution follows reporting requirements for adverse/sentinel events and patient deaths. 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. In addition, OIG examines whether the institution adequately manages its health care staffing resources by evaluating whether job performance reviews are completed as required; specified staff possess current, valid credentials and professional licenses or certifications; nursing staff receive new employee orientation training and annual competency testing; and clinical and custody staff have current medical emergency response certifications. The *Administrative Operations* indicator is a secondary indicator, and, therefore, was not relied on for the overall score for the institution.

Compliance Testing Results

The institution scored an *adequate* 83.4 percent in the *Administrative Operations* indicator, with several tests yielding *proficient* scores, as follows:

- The institution promptly processed all inmate medical appeals in each of the most recent 12 months (MIT 15.001).
- VSP's QMC met monthly, evaluated program performance, and took action when management identified areas for improvement opportunities (MIT 15.003).
- VSP took adequate steps to ensure the accuracy of its Dashboard data reporting (MIT 15.004).
- Based on a sample of ten second-level medical appeals, the institution's responses addressed all of the patients' appealed issues (MIT 15.102).
- Medical staff promptly submitted the initial Inmate Death Report (CDCR Form 7229A) to CCHCS's Death Review Unit for all three applicable deaths that occurred at VSP in the prior 12-month period (MIT 15.103).
- All ten nurses sampled were current with their clinical competency validations (MIT 15.105).

- All providers at the institution were current with their professional licenses (MIT 15.107).

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

- All nurses and the pharmacist in charge were current with their professional licenses and certification requirements (MIT 15.109).

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

One test scored in the *adequate* range:

- Of the 12 sampled incident packages for emergency medical responses reviewed by the institution's Emergency Medical Response Review Committee (EMRRC) during the prior 12 month period, nine (75 percent) complied with policy. Three of the incident review packages did not provide the required EMRRC review forms (MIT 15.005).

The institution showed room for improvement with four tests earning *inadequate* scores:

- The OIG reviewed the only reported adverse/sentinel event (ASE) that occurred at VSP during the prior six-month period. The event was reported to CCHCS's ASE Committee 30 days late. As a result, VSP received a score of zero on this test (MIT 15.002).

- Four of eight providers had a proper clinical performance appraisal completed (50 percent). For the other four providers, the required 360 Degree Evaluation was not completed (MIT 15.106).

- OIG inspectors examined records to determine if nursing supervisors completed the required number of monthly performance reviews for subordinate nurses and discussed the results of those reviews with staff. Inspectors sampled five reviews for subordinate nurses; all five had the required number of reviews completed by their supervisors; however, for two nurses, the nursing supervisor did not address the positive, well-performed aspects of their performance; for one of those two, the supervisor also failed to address the aspects needing improvement in the employee's performance, as CCHCS policy requires. As a result, VSP scored 60 percent on this test (MIT 15.104).

- The institution did not meet the emergency response drill requirements for the most recent quarter for one of its three watches, resulting in a score of 67 percent. More specifically, the institution's second watch drill package did not contain a Triage and Treatment Services Flow Sheet (CDCR Form 7464) as required by CCHCS policy (MIT 15.101).

Non-Scored Results

- The OIG gathered data regarding the completion of death review reports. CCHCS' Death Review Committee (DRC) did not timely complete its death review summary for any of the three deaths that occurred at VSP during the OIG's inspection period. The DRC is generally required to complete a death review summary within either 30 or 60 days of death (depending on whether the death was expected or unexpected) and then expeditiously notify the institution's CEO of the review results, so that any needed corrective action may be promptly pursued. For one patient death, the committee completed its summary 36 days late (96 days after death) and the institution's CEO was notified of the results 48 days late (115 days after death). For two other patients, the DRC completed the death review summaries 23 days late (53 days after death) and 20 days late (80 days after death), but the CEO did not receive notification of those deaths at all (MIT 15.998).

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

Recommendations

No specific recommendations.

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 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 electronic medical records, 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 outperformed Medi-Cal in all five measures, and outperformed Kaiser Permanente (both North and South regions) in four of five diabetic measures selected. Kaiser, South, scored 2 percentage points higher than VSP for eye exams. When compared nationally, VSP outperformed Medicaid, Medicare, and commercial health plans in all five diabetic measures. VSP outscored the United States Department of Veterans Affairs (VA) in three of the applicable measures, but scored 10 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, commercial plans, Medicaid, and Medicare. With respect to administering influenza vaccinations to both older and younger adults, VSP outperformed all statewide and national plans. With regard to administering pneumococcal vaccines to older adults, VSP scored higher than both Medicare and the VA.

Cancer Screening

With respect to colorectal cancer screening, VSP scored higher than all health care plans, statewide and nationally, by more than 9 percentage points.

Summary

VSP's population-based metrics performance reflected a high-quality chronic care program that compares positively to other statewide and national health care plans.

VSP Results Compared to State and National HEDIS Scores

Clinical Measures	California				National			
	VSP Cycle 5 Results[1]	HEDIS Medi-Cal 2015[2]	HEDIS Kaiser (No. CA) 2016[3]	HEDIS Kaiser (So.CA) 2016[3]	HEDIS Medicaid 2016[4]	HEDIS Com-mercial 2016[4]	HEDIS Medicare 2016[4]	VA Average 2015[5]
Comprehensive Diabetes Care								
HbA1c Testing (Monitoring)	**100%**	86%	94%	94%	86%	90%	93%	98%
Poor HbA1c Control (>9.0%)[6, 7]	**3%**	39%	20%	23%	45%	34%	27%	19%
HbA1c Control (<8.0%)[6]	**86%**	49%	70%	63%	46%	55%	63%	-
Blood Pressure Control (<140/90)[6]	**90%**	63%	83%	83%	59%	60%	62%	74%
Eye Exams	**79%**	53%	68%	81%	53%	54%	69%	89%
Immunizations								
Influenza Shots - Adults (18–64)	**63%**	-	56%	57%	39%	48%	-	55%
Influenza Shots - Adults (65+)	**90%**	-	-	-	-	-	72%	76%
Immunizations: Pneumococcal	**100%**	-	-	-	-	-	71%	93%
Cancer Screening								
Colorectal Cancer Screening	**91%**	-	79%	82%	-	63%	67%	82%

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

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

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

4. National HEDIS data for Medicaid, commercial plans, and Medicare was obtained from the 2016 *State of Health Care Quality Report*, available on the NCQA website: www.ncqa.org. The results for commercial plans were based on data received from various health maintenance organizations.

5. The Department of Veterans Affairs (VA) data was obtained from the VA's website, www.va.gov.
For the Immunizations: Pneumococcal measure only, the data was obtained from the *VHA Facility Quality and Safety Report - Fiscal Year 2012 Data*.

6. For this indicator, the entire applicable 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.

APPENDIX A — COMPLIANCE TEST RESULTS

Valley State Prison **Range of Summary Scores: 63.33% - 89.24%**	
Indicator	**Compliance Score (Yes %)**
1 – ***Access to Care***	81.78%
2 – ***Diagnostic Services***	75.93%
3 – ***Emergency Services***	Not Applicable
4 – ***Health Information Management (Medical Records)***	81.80%
5 – ***Health Care Environment***	82.11%
6 – ***Inter- and Intra-System Transfers***	89.24%
7 – ***Pharmacy and Medication Management***	69.50%
8 – ***Prenatal and Post-Delivery Services***	Not Applicable
9 – ***Preventive Services***	75.96%
10 – ***Quality of Nursing Performance***	Not Applicable
11 – ***Quality of Provider Performance***	Not Applicable
12 – ***Reception Center Arrivals***	Not Applicable
13 – ***Specialized Medical Housing (OHU, CTC, SNF, Hospice)***	63.33%
14 – ***Specialty Services***	83.81%
15 – ***Administrative Operations***	83.44%

Reference Number	1 – *Access to Care*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
1.001	Chronic care follow-up appointments: Was the patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter?	17	8	25	68.00%	0
1.002	For endorsed patients received from another CDCR institution: If the nurse referred the patient to a provider during the initial health screening, was the patient seen within the required time frame?	9	16	25	36.00%	0
1.003	Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received?	30	0	30	100.00%	0
1.004	Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed?	29	1	30	96.67%	0
1.005	Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter?	8	3	11	72.73%	19
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?	0	0	0	N/A	30
1.007	Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame?	15	2	17	88.24%	0
1.008	Specialty service follow-up appointments: Do specialty service primary care physician follow-up visits occur within required time frames?	25	2	27	92.59%	3
1.101	Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms?	6	0	6	100.00%	0
Overall percentage:					**81.78%**	

Reference Number	2 – *Diagnostic Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
2.001	Radiology: Was the radiology service provided within the time frame specified in the provider's order?	10	0	10	100.00%	0
2.002	Radiology: Did the primary care provider review and initial the diagnostic report within specified time frames?	0	10	10	0.00%	0
2.003	Radiology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	9	1	10	90.00%	0
2.004	Laboratory: Was the laboratory service provided within the time frame specified in the provider's order?	10	0	10	100.00%	0
2.005	Laboratory: Did the primary care provider review and initial the diagnostic report within specified time frames?	9	1	10	90.00%	0
2.006	Laboratory: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	9	1	10	90.00%	0
2.007	Pathology: Did the institution receive the final diagnostic report within the required time frames?	8	2	10	80.00%	0
2.008	Pathology: Did the primary care provider review and initial the diagnostic report within specified time frames?	9	0	9	100.00%	1
2.009	Pathology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	3	6	9	33.33%	1
Overall percentage:					**75.93%**	

3 – *Emergency Services*

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

Reference Number	4 – *Health Information Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated healthcare documents (provider progress notes) scanned within 3 calendar days of the patient encounter date?	18	2	20	90.00%	0
4.002	Are dictated/transcribed documents scanned into the patient's electronic health record within five calendar days of the encounter date?	0	0	0	N/A	0
4.003	Are High-Priority specialty notes (either a Form 7243 or other scanned consulting report) scanned within the required time frame?	18	2	20	90.00%	0
4.004	Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge?	15	1	16	93.75%	0
4.005	Are medication administration records (MARs) scanned into the patient's electronic health record within the required time frames?	15	1	16	93.75%	0
4.006	During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files?	7	17	24	29.17%	0
4.007	For patients discharged from a community hospital: Did the preliminary hospital discharge report include key elements and did a primary care provider review the report within three calendar days of discharge?	16	1	17	94.12%	0
Overall percentage:					**81.80%**	

Reference Number	5 – *Health Care Environment*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
5.101	Are clinical health care areas appropriately disinfected, cleaned and sanitary?	7	1	8	87.50%	0
5.102	Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	6	1	7	85.71%	1
5.103	Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	8	0	8	100.00%	0
5.104	Does clinical health care staff adhere to universal hand hygiene precautions?	7	1	8	87.50%	0
5.105	Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	7	0	7	100.0%	1
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%	1
5.107	Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	7	1	8	87.50%	0
5.108	Do clinic common areas and exam rooms have essential core medical equipment and supplies?	7	1	8	87.50%	0
5.109	Do clinic common areas have an adequate environment conducive to providing medical services?	8	0	8	100.00%	0
5.110	Do clinic exam rooms have an adequate environment conducive to providing medical services?	7	1	8	87.50%	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	1	5	80.00%	3
Overall percentage:					**82.11%**	

Reference Number	6 – *Inter- and Intra-System Transfers*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
6.001	For endorsed patients received from another CDCR institution or COCF: Did nursing staff complete the initial health screening and answer all screening questions on the same day the patient arrived at the institution?	21	4	25	84.00%	0
6.002	For endorsed patients received from another CDCR institution or COCF: When required, did the RN complete the assessment and disposition section of the health screening form; refer the patient to the TTA, if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening?	25	0	25	100.00%	0
6.003	For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption?	13	5	18	72.22%	7
6.004	For patients transferred out of the facility: Were scheduled specialty service appointments identified on the patient's health care transfer information form?	18	2	20	90.00%	0
6.101	For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents?	10	0	10	100.00%	0
Overall percentage:					**89.24%**	

Reference Number	*7 – Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.001	Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows?	9	7	16	56.25%	9
7.002	Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames?	22	3	25	88.00%	0
7.003	Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames?	12	5	17	70.59%	0
7.004	For patients received from a county jail: Were all medications ordered by the institution's reception center provider administered, made available, or delivered to the patient within the required time frames?	0	0	0	N/A	0
7.005	Upon the patient's transfer from one housing unit to another: Were medications continued without interruption?	15	10	25	60.00%	0
7.006	For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption?	6	4	10	60.00%	0
7.101	All clinical and medication line storage areas for narcotic medications: Does the Institution employ strong medication security over narcotic medications assigned to its clinical areas?	1	6	7	14.29%	6
7.102	All clinical and medication line storage areas for non-narcotic medications: Does the Institution properly store non-narcotic medications that do not require refrigeration in assigned clinical areas?	3	4	7	42.86%	2
7.103	All clinical and medication line storage areas for non-narcotic medications: Does the institution properly store non-narcotic medications that require refrigeration in assigned clinical areas?	9	0	9	100.00%	4
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	2	5	60.00%	0
7.105	Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients?	5	0	5	100.00%	0
7.106	Medication preparation and administration areas: Does the Institution employ appropriate administrative controls and protocols when distributing medications to patients?	3	2	5	60.00%	0
7.107	Pharmacy: Does the institution employ and follow general	1	0	1	100.00%	0

Reference Number	7 – *Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
	security, organization, and cleanliness management protocols in its main and satellite pharmacies?					
7.108	Pharmacy: Does the institution's pharmacy properly store non-refrigerated medications?	1	0	1	100.00%	0
7.109	Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications?	0	1	1	0.00%	0
7.110	Pharmacy: Does the institution's pharmacy properly account for narcotic medications?	1	0	1	100.00%	0
7.111	Does the institution follow key medication error reporting protocols?	20	0	20	100.00%	10
Overall percentage:					**69.50%**	

8 – *Prenatal and Post-Delivery Services*

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

Reference Number	9 – *Preventive Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
9.001	Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed?	8	7	15	53.33%	0
9.002	Patients prescribed TB medication: Did the institution monitor the patient monthly for the most recent three months he or she was on the medication?	8	7	15	53.33%	0
9.003	Annual TB Screening: Was the patient screened for TB within the last year?	19	11	30	63.33%	0
9.004	Were all patients offered an influenza vaccination for the most recent influenza season?	25	0	25	100.00%	0
9.005	All patients from the age of 50 - 75: Was the patient offered colorectal cancer screening?	23	2	25	92.00%	0
9.006	Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy?	0	0	0	N/A	0
9.007	Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy?	0	0	0	N/A	0
9.008	Are required immunizations being offered for chronic care patients?	15	1	16	93.75%	9
9.009	Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	0	0	0	N/A	0
Overall percentage:					**75.96%**	

10 – *Quality of Nursing Performance*

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

11 – *Quality of Provider Performance*

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

12 – *Reception Center Arrivals*

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

Reference Number	13 – *Specialized Medical Housing*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient on the day of admission, or within eight hours of admission to CMF's Hospice?	10	0	10	100.00%	0
13.002	For CTC and SNF only: Was a written history and physical examination completed within the required time frame?	0	0	0	N/A	0
13.003	For OHU, CTC, SNF, and Hospice: Did the primary care provider complete the Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes on the patient at the minimum intervals required for the type of facility where the patient was treated?	9	1	10	90.00%	0
13.101	For OHU and CTC Only: Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter patient's cells?	0	1	1	0.00%	0
Overall percentage:					**63.33%**	

Reference Number	14 – *Specialty Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	Did the patient receive the high priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service?	12	3	15	80.00%	0
14.002	Did the primary care provider review the high priority specialty service consultant report within the required time frame?	14	1	15	93.33%	0
14.003	Did the patient receive the routine specialty service within 90 calendar days of the primary care provider order or Physician Request for Service?	15	0	15	100.00%	0
14.004	Did the primary care provider review the routine specialty service consultant report within the required time frame?	14	1	15	93.33%	0
14.005	For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames?	9	11	20	45.00%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	19	1	20	95.00%	0
14.007	Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame?	16	4	20	80.00%	0
Overall percentage:					**83.81%**	

Reference Number	15 – *Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.001	Did the institution promptly process inmate medical appeals during the most recent 12 months?	12	0	12	100.00%	0
15.002	Does the institution follow adverse / sentinel event reporting requirements?	0	1	1	0.00%	0
15.003	Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified?	6	0	6	100.00%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	1	0	1	100.00%	0
15.005	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	9	3	12	75.00%	0
15.006	For institutions with licensed care facilities: Does the Local Governing Body (LGB), or its equivalent, meet quarterly and exercise its overall responsibilities for the quality management of patient health care?	0	0	0	N/A	0
15.101	Did the institution complete a medical emergency response drill for each watch and include participation of health care and custody staff during the most recent full quarter?	2	1	3	66.67%	0
15.102	Did the institution's second level medical appeal response address all of the patient's appealed issues?	10	0	10	100.00%	0
15.103	Did the institution's medical staff review and submit the initial inmate death report to the Death Review Unit in a timely manner?	3	0	3	100.00%	0
15.104	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	3	2	5	60.00%	0
15.105	Are nursing staff who administer medications current on their clinical competency validation?	10	0	10	100.00%	10
15.106	Are structured clinical performance appraisals completed timely?	4	4	8	50.00%	4
15.107	Do all providers maintain a current medical license?	11	0	11	100.00%	4
15.108	Are staff current with required medical emergency response certifications?	3	0	3	100.00%	0
15.109	Are nursing staff and the Pharmacist-in-Charge current with their professional licenses and certifications, and is the pharmacy licensed as a correctional pharmacy by the California State Board of Pharmacy?	6	0	6	100.00%	1

Reference Number	15 – *Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.110	Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	0	0	0	N/A	0
15.111	Are nursing staff current with required new employee orientation?	1	0	1	100.00%	0
Overall percentage:					**83.44%**	

APPENDIX B — CLINICAL DATA

Table B-1: VSP Sample Sets

Sample Set	Total
Anticoagulation	3
Death Review/Sentinel Events	3
Diabetes	3
Emergency Services – CPR	1
Emergency Services – Non-CPR	3
High Risk	5
Hospitalization	4
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	20
Specialty Services	4
	52

Table B-2: VSP Chronic Care Diagnoses

Diagnosis	Total
Anemia	2
Anticoagulation	5
Arthritis/Degenerative Joint Disease	7
Asthma	8
COPD	13
Cancer	5
Cardiovascular Disease	7
Chronic Kidney Disease	3
Chronic Pain	14
Coccidioidomycosis	1
Deep Venous Thrombosis/Pulmonary Embolism	4
Diabetes	21
Gastroesophageal Reflux Disease	6
Hepatitis C	12
Hyperlipidemia	21
Hypertension	31
Mental Health	9
Migraine Headaches	2
Rheumatological Disease	1
Seizure Disorder	5
Sleep Apnea	5
Thyroid Disease	3
	185

Table B-3: VSP Event – Program

Program	Total
Diagnostic Services	219
Emergency Care	59
Hospitalization	47
Intra-System Transfers In	14
Intra-System Transfers Out	4
Not Specified	4
Outpatient Care	552
Specialized Medical Housing	358
Specialty Services	159
	1,416

Table B-4: VSP Review Sample Summary

	Total
MD Reviews Detailed	25
MD Reviews Focused	1
RN Reviews Detailed	15
RN Reviews Focused	29
Total Reviews	70
Total Unique Cases	52
Overlapping Reviews (MD & RN)	18

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

Valley State Prison			
Quality Indicator	**Sample Category (number of samples)**	**Data Source**	**Filters**
Access to Care			
MIT 1.001	Chronic Care Patients (25)	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • **Randomize**
MIT 1.002	Nursing Referrals (25)	OIG Q: 6.001	• See ***Inter- and Intra-System Transfers***
MITs 1.003–006	Nursing Sick Call (5 per clinic) (30)	MedSATS	• Clinic (each clinic tested) • Appointment date (2–9 months) • **Randomize**
MIT 1.007	Returns from Community Hospital (17)	OIG Q: 4.007	• See ***Health Information Management*** (returns from community hospital)
MIT 1.008	Specialty Services Follow-up (30)	OIG Q: 14.001 & 14.003	• See ***Specialty Services***
MIT 1.101	Availability of Health Care Services Request Forms (6)	OIG onsite review	• Randomly select one housing unit from each yard
Diagnostic Services			
MITs 2.001–003	Radiology (10)	Radiology Logs	• Appointment date (90 days–9 months) • **Randomize** • Abnormal
MITs 2.004–006	Laboratory (10)	Quest	• Appointment date (90 days–9 months) • Order name (CBC or CMPs only) • **Randomize** • Abnormal
MITs 2.007–009	Pathology (10)	InterQual	• Appointment date (90 days–9 months) • Service (pathology related) • **Randomize**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Health Information Management (Medical Records)			
MIT 4.001	Timely Scanning (20)	OIG Qs: 1.001, 1.002, & 1.004	• Non-dictated documents • 1st 10 IPs MIT 1.001, 1st 5 IPs MITs 1.002, 1.004
MIT 4.002	(0)	OIG Q: 1.001	• Dictated documents • First 20 IPs selected
MIT 4.003	(20)	OIG Qs: 14.002 & 14.004	• Specialty documents • First 10 IPs for each question
MIT 4.004	(17)	OIG Q: 4.007	• Community hospital discharge documents • First 20 IPs selected
MIT 4.005	(16)	OIG Q: 7.001	• MARs • First 20 IPs selected
MIT 4.006	(24)	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.007	Returns From Community Hospital (17)	Inpatient claims data	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • **Randomize** (each month individually) • First 5 patients from each of the 6 months (if not 5 in a month, supplement from another, as needed)
Health Care Environment			
MIT 5.101-105 MIT 5.107–111	Clinical Areas (9)	OIG inspector onsite review	• Identify and inspect all onsite clinical areas.
Inter- and Intra-System Transfers			
MIT 6.001-003	Intra-System Transfers (25)	SOMS	• Arrival date (3–9 months) • Arrived from (another CDCR facility) • Rx count • **Randomize**
MIT 6.004	Specialty Services Send-Outs (20)	MedSATS	• Date of transfer (3–9 months) • **Randomize**
MIT 6.101	Transfers Out (10)	OIG inspector onsite review	• R&R IP transfers with medication

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Pharmacy and Medication Management			
MIT 7.001	Chronic Care Medication (25)	OIG Q: 1.001	*See* ***Access to Care*** • At least one condition per patient—any risk level • **Randomize**
MIT 7.002	New Medication Orders (25)	Master Registry	• Rx count • **Randomize** • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns from Community Hospital (17)	OIG Q: 4.007	• See ***Health Information Management (Medical Records)*** *(returns from community hospital)*
MIT 7.004	RC Arrivals – Medication Orders *N/A at this institution*	OIG Q: 12.001	• See ***Reception Center Arrivals***
MIT 7.005	Intra-Facility Moves (25)	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • **Randomize**
MIT 7.006	En Route (10)	SOMS	• Date of transfer (2–8 months) • Sending institution (another CDCR facility) • **Randomize** • NA/DOT meds
MITs 7.101-103	Medication Storage Areas (varies by test)	OIG inspector onsite review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–106	Medication Preparation and Administration Areas (varies by test)	OIG inspector onsite review	• Identify and inspect onsite clinical areas that prepare and administer medications
MITs 7.107-110	Pharmacy (1)	OIG inspector onsite review	• Identify & inspect all onsite pharmacies
MIT 7.111	Medication Error Reporting (20)	Monthly medication error reports	• All monthly statistic reports with Level 4 or higher • Select a total of 5 months
MIT 7.999	Isolation Unit KOP Medications (0)	Onsite active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in isolation units
Prenatal and Post-Delivery Services			
MIT 8.001-007	Recent Deliveries *N/A at this institution*	OB Roster	• Delivery date (2–12 months) • **Most recent** deliveries (within date range)
	Pregnant Arrivals *N/A at this institution*	OB Roster	• Arrival date (2–12 months) • **Earliest** arrivals (within date range)

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

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Reception Center Arrivals			
MITs 12.001–008	RC *N/A at this institution*	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • **Randomize**
Specialized Medical Housing			
MITs 13.001–003	OHU (10)	CADDIS	• Admit date (1–6 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • **Randomize**
MIT 13.101	Call Buttons OHU (all)	OIG inspector onsite review	• Review by location
Specialty Services			
MITs 14.001–002	High-Priority (15)	MedSATS	• Approval date (3–9 months) • **Randomize**
MITs 14.003–004	Routine (15)	MedSATS	• Approval date (3–9 months) • Remove optometry, physical therapy or podiatry • **Randomize**
MIT 14.005	Specialty Services Arrivals (20)	MedSATS	• Arrived from (other CDCR institution) • Date of transfer (3–9 months) • **Randomize**
MIT 14.006-007	Denials (20)	InterQual	• Review date (3–9 months) • **Randomize**
	(0)	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • **Randomize**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Administrative Operations			
MIT 15.001	Medical Appeals (all)	Monthly medical appeals reports	• Medical appeals (12 months)
MIT 15.002	Adverse/Sentinel Events (1)	Adverse/sentinel events report	• Adverse/sentinel events (2–8 months)
MITs 15.003–004	QMC Meetings (6)	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.005	EMRRC (12)	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.006	LGB *N/A at this institution*	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills (3)	Onsite summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	2nd Level Medical Appeals (10)	Onsite list of appeals/closed appeals files	• Medical appeals denied (6 months)
MIT 15.103	Death Reports (3)	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.104	RN Review Evaluations (5)	Onsite supervisor periodic RN reviews	• RNs who worked in clinic or emergency setting six or more days in sampled month • **Randomize**
MIT 15.105	Nursing Staff Validations (10)	Onsite nursing education files	• On duty one or more years • Nurse administers medications • **Randomize**
MIT 15.106	Provider Annual Evaluation Packets (8)	OIG Q:16.001	• All required performance evaluation documents
MIT 15.107	Provider licenses (11)	Current provider listing (at start of inspection)	• Review all

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

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

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

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

June 14, 2017

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) Cycle 5 Medical Inspection Results for Valley State Prison (VSP) conducted from January 2017 to March 2017. California Correctional Health Care Services (CCHCS) acknowledges all OIG findings.

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

Sincerely,

Janet Lewis

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

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