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Office of the Inspector General

Avenal State Prison
Medical Inspection Results
Cycle 4

August 2016

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

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AVENAL STATE PRISON
Medical Inspection Results
Cycle 4

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TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

EXECUTIVE SUMMARY

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

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

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

The OIG performed its Cycle 4 medical inspection at ASP from January to March 2016. The inspection included in-depth reviews of 76 inmate-patient files conducted by clinicians, as well as reviews of documents from 427 inmate-patient files, covering 92 objectively scored tests of compliance with policies and procedures applicable to the delivery of medical care. The OIG assessed the case review and compliance results at ASP using 14 health care quality indicators applicable to the institution, made up of 12 primary clinical indicators and two secondary administrative indicators. To conduct clinical case reviews, the OIG employs a clinician team consisting of a physician and a registered nurse consultant, while compliance testing is done by a team of deputy inspectors general and registered nurses trained in monitoring medical compliance. Of the 12 primary indicators, seven were rated by both case review clinicians and compliance inspectors, three were rated by case review clinicians only, and two were rated by compliance inspectors only; both secondary indicators were rated by compliance inspectors only. See the *Health Care Quality Indicators* table on page *ii*. Based on that analysis, OIG experts made a considered and measured overall opinion that the quality of health care at ASP was ***adequate***.

Health Care Quality Indicators

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

Overall Assessment: Adequate

Overall Assessment Rating:

Adequate

Based on the clinical case reviews and compliance testing, the OIG's overall assessment rating of ASP was *adequate*. Of the 12 primary (clinical) quality indicators applicable to ASP, the OIG found one *proficient*, nine *adequate*, and two *inadequate*. Of the two secondary (administrative) quality indicators, the OIG found one *adequate* and one *inadequate*. To determine the overall assessment of ASP, the OIG considered individual clinical ratings and individual compliance question scores within each of the indicator categories, putting emphasis on the primary indicators. Based on that analysis, OIG experts made a considered and measured overall opinion about the quality of health care observed at ASP.

Clinical Case Review and OIG Clinician Inspection Results

The clinicians' case reviews sampled patients with high medical needs and included a review of 925 patient care events.[1] Of the 12 primary indicators applicable to ASP, ten were evaluated by clinician case review, and all ten 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.

Program Strengths — Clinical

- ASP providers delivered good care, making appropriate assessments and sound medical plans for most patients.
- ASP performed very well with nursing sick call access. Nurses consistently used established encounter forms in addressing patient health problems. There were no backlogs in the sick call process.
- ASP performed well with the primary care model. Clinic primary care providers (PCP) and nurses had good collaboration in managing patients in their assigned yards.
- ASP provided effective access to care. Of the four clinics visited, each had an office technician who ensured that all provider and nursing appointments were completed.

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

Program Weaknesses — Clinical

- ASP had some problems with health information management. Many outside specialty services reports, hospital reports, and laboratory reports were scanned into the eUHR without provider signatures. However, even though the reports were unsigned, providers did review them, but in another system, the ASP shared drive, which was accessible in all clinical areas. Progress notes supported the effectiveness of this local system. The institution had started an improvement process during the time of the clinician onsite visit to correct the signature deficiencies.

- There was one unsafe condition. In case 2, the patient returned from a hospitalization with the diagnosis of pneumonia. Though the provider prescribed antibiotics for ten days, the prescription was not filled, placing the patient at risk of harm. Fortunately, no harm resulted from this error.

Compliance Testing Results

Of the 14 total health care indicators applicable to ASP, 11 were evaluated by compliance inspectors.[2] There were 92 individual compliance questions within those 11 indicators, generating 1,246 data points, testing ASP's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[3] Those 92 questions are detailed in *Appendix A — Compliance Test Results*. The institution's inspection scores in the 11 applicable indicators ranged from 65.6 percent to 94.7 percent, with the primary indicator *Pharmacy and Medication Management* receiving the lowest score, and the primary indicator *Specialized Medical Housing* receiving the highest. Of the nine primary indicators applicable to compliance testing, the OIG rated two *proficient,* four *adequate,* and three *inadequate.* Of the two secondary indicators, which involve administrative health care functions, one was *adequate* and one, *inadequate*.

Program Strengths — Compliance

As the *ASP Executive Summary Table* on page *vii* indicates, the institution's compliance ratings were *proficient,* above 85 percent, in the following two primary indicators: *Health Care Environment* and *Specialized Medical Housing*. The following are some of ASP's strengths based on its compliance scores on individual questions in all the primary health care indicators:

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

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

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

- All clinical health care areas were disinfected, cleaned, and sanitary, and the general clinical environment was proficiently maintained, as evidenced by the majority of tests in the health care environment indicator having scores of 100 percent.

- Nursing staff practiced appropriate administrative controls and protocols when they prepared and distributed medication for inmate-patients.

- Nursing staff timely administered required doses of anti-tuberculosis medication to patients who tested positive for tuberculosis, and ASP timely offered colorectal cancer screenings and influenza vaccinations to applicable patients.

- For patients in the outpatient housing unit (OHU), nurses timely completed initial patient assessments and providers timely evaluated patients upon admission.

- Patients timely received approved specialty services.

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

- ASP timely processed patient medical appeals and addressed all appealed issues.

- All providers, nursing staff, and the PIC were current with their professional licenses and certifications; all providers, nurses, and custody staff were current with their emergency response certifications.

- Nursing staff hired within the last year timely received new employee orientation training, and all nursing staff who administered medications possessed current clinical competency validations.

Program Weaknesses — Compliance

The institution received ratings of *inadequate*, scoring below 75 percent, in the following three primary indicators: *Health Information Management*, *Pharmacy and Medication Management*, and *Preventive Services*. The institution also received an *inadequate* score in the secondary indicator *Job Performance, Training, Licensing, and Certifications*. The following are some of the weaknesses identified by ASP's compliance scores on individual questions in all the primary health care indicators:

- Primary care providers (PCPs) did not conduct timely appointments with most of the patients the OIG sampled. This included patients who required a PCP follow-up visit after discharge from a community hospital or after receiving a specialty service, patients who required a PCP sick call follow-up appointment, and patients who had been referred to a PCP by nursing staff upon their transfer to ASP from another institution.

- Health records staff did not timely scan transcribed documents into patients' electronic health records, and they did not always properly label or file documents into patients' electronic health records.

- For most sampled patients who transferred out of ASP with approved pending specialty service appointments, the institution did not identify the approved services on their health care transfer forms.

- Nursing staff did not always timely administer prescribed medications to patients returning from a community hospital, did not always monitor patients receiving anti-tuberculosis medications, and did not follow required protocols for administering and reading annual tuberculosis skin tests.

- The institution maintained poor security controls over narcotic medications assigned to its clinical areas; in its main pharmacy, the institution did not properly store refrigerated or non-refrigerated medications and did not follow key medication error reporting protocols.

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

- The institution did not always provide timely specialty service appointments to inmate-patients who transferred into ASP with previously approved or scheduled specialty appointments at the sending institution.

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

- ASP's Quality Management Committee did not discuss the methods used to train staff who collected Dashboard data.

- Clinical supervisors did not timely conduct probationary or annual appraisals of providers and did not sufficiently conduct periodic reviews of nursing staff.

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

ASP Executive Summary Table

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

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

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

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

Population-Based Metrics

In general, ASP performed adequately as measured by population-based metrics. In four of the five comprehensive diabetes care measures, ASP outperformed or performed similarly to other State and national organizations. This included Medi-Cal as well as Kaiser Permanente (typically one of the highest-scoring health organizations in California), Medicaid, Medicare, commercial entities, and the United States Department of Veterans Affairs (VA). The fifth diabetic measure, blood pressure control, was lower for ASP than for Kaiser and the VA.

With regard to immunization measures for younger adults, the institution scored higher than all the other entities that reported data except the VA; however, that score was lower by only 1 percentage point. For colorectal cancer screenings, ASP scored significantly lower than the other entities. ASP routinely offered inmate-patients colorectal cancer preventive services, but many of them refused the offers, so these refusals adversely affected the institution's score.

Overall, ASP's performance demonstrated by the population-based metrics comparison indicates that comprehensive diabetes care, immunizations, and cancer screening were adequate in comparison to other State and national health care organizations.

INTRODUCTION

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

Avenal State Prison (ASP) was the 18th medical inspection of Cycle 4. During the inspection process, the OIG assessed the delivery of medical care to patients in 12 primary clinical health care indicators and two secondary administrative health care indicators applicable to the institution. It is important to note that while the primary quality indicators represent the clinical care being provided by the institution at the time of the inspection, the secondary quality indicators are purely administrative and are not reflective of the actual clinical care provided.

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

ABOUT THE INSTITUTION

Avenal State Prison is designated a low-medium security institution and currently provides housing for both general population and sensitive needs yard custody inmates; it is comprised of six separate, semi-autonomous facilities. As a reentry programming hub, ASP is geared to ensure that, upon release, offenders are ready for the transition back into society. ASP is also designated an enhanced programming facility (EPF). The purpose of the EPF is to create incentives for inmates who, based on their own behaviors and choices, are ready to take full advantage of programming opportunities.

The institution operates seven clinics where staff members handle non-urgent requests for medical services, including six facility clinics and a specialty clinic. ASP also conducts screenings in its receiving and release clinical area; treats patients needing urgent or emergency care in its triage and treatment area (TTA); and treats patients who require assistance with the activities of daily living, but who do not require a higher level of inpatient care, in its outpatient housing unit (OHU). California Correctional Health Care Services (CCHCS) has designated ASP a "basic" care institution. Basic institutions are located in rural areas 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 inmate-patient population.

On August 16, 2015, the institution received national accreditation from the Commission on Accreditation for Corrections. This accreditation program is a professional peer review process based on national standards set by the American Correctional Association.

According to information provided by the institution, ASP's overall vacancy rate among medical managers, primary care providers, nursing supervisors, and non-supervisory nurses was 6 percent in December 2015. As indicated in the following table, ASP had 95.7 budgeted health care positions, of which 90 were filled. Based on its authorized and filled positions, the institution reported 5.7 vacant positions. The chief physician and surgeon's position was the only authorized and filled health care management position at ASP. However, the institution also had three additional health care management positions as of December 2015. These included a chief nurse executive position that ASP funded under the institution's "blanket" resources[4] and both a chief executive officer and chief medical executive who were shared with Pleasant Valley State Prison (PVSP); both positions were funded by PVSP. Lastly, the CEO reported that in December 2015, there were three staff members under disciplinary review, none of whom was redirected to a non-patient-care setting.

ASP Health Care Staffing Resources as of December 2015

	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff		Totals	
Description	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Authorized positions	1	1%	8.5	9%	11.5	12%	74.7	78%	95.7	100%
Filled positions	1	100%	8	94%	11	96%	70	94%	90	94%
Vacancies	0	0%	0.5	6%	0.5	4%	4.7	6%	5.7	6%
Recent hires (within 12 months)	0	0%	2	25%	1	9%	19	27%	22	24%
Staff utilized from registry	0	0%	0	0%	0	0%	0	0%	0	0%
Redirected staff (to non-patient-care areas)	0	0%	0	0%	0	0%	0	0%	0	0%
Staff on long-term medical leave	0	0%	0	0%	1	9%	4	6%	5	5%

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

[4] Blanket resources are those available to the institution from salary savings related to authorized positions that are not currently filled. At management's discretion, blanket resources can be used to temporarily redirect funds from one unit within the institution to another.

As of December 14, 2015, the Master Registry for ASP showed that the institution had 3,376 inmate-patients. Within that total population, 0.2 percent were designated High-Risk, Priority 1 (High 1), and 0.3 percent were designated High-Risk, Priority 2 (High 2). Patients' assigned risk levels are based on the complexity of their required medical care related to their specific diagnoses, frequency of higher levels of care, age, and abnormal labs and procedures. High 1 has at least two high-risk conditions; High 2 has only one. High-risk patients are more susceptible to poor health outcomes than medium- or low-risk patients. High-risk patients also typically require more health care services than do patients with lower assigned risk levels. The chart below illustrates the breakdown of the institution's medical risk levels at the start of the OIG medical inspection.

ASP Master Registry Data as of December 14, 2015

Medical Risk Level	# of Inmate-Patients	Percentage
High 1	6	0.2%
High 2	9	0.3%
Medium	1,628	48.2%
Low	1,733	51.3%
Total	**3,376**	**100.0%**

Commonly Used Abbreviations

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

OBJECTIVES, SCOPE, AND METHODOLOGY

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

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

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

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

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

CASE REVIEWS

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

PATIENT SELECTION FOR RETROSPECTIVE CASE REVIEWS

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

1. The goal of retrospective chart review is to evaluate all aspects of the health care system. Statewide, high-risk and high-utilization patients consume medical services at a

disproportionate rate; 11 percent of the total patient population are considered high-risk and account for more than half of the institution's pharmaceutical, specialty, community hospital, and emergency costs.

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

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

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

2. The health of less complex patients is more likely to be affected by processes such as timely appointment scheduling, medication management, routine health screening, and immunizations. To review these processes, the OIG simultaneously performs a broad compliance review.

3. Patient charts generated during death reviews, sentinel events (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, ASP Sample Sets*, the OIG clinicians evaluated medical charts for 76 unique inmate-patients. *Appendix B, Table B–4,* ASP *Case Review Sample Summary,* clarifies that both nurses and physicians reviewed charts for 13 of those patients, for 89 reviews in total. Physicians performed detailed reviews of 30 charts, and nurses performed detailed reviews of 15 charts, totaling 45 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 44 inmate-patients. These generated 925 clinical events for review (*Appendix B, Table B-3, ASP Event/Program*). The reporting format provides details on whether the encounter was adequate or had significant deficiencies, and identifies deficiencies by programs and processes to help the institution focus on improvement areas.

While the sample method specifically pulled only seven chronic care diabetic patient records, (*Appendix B, Table B–1, ASP Sample Sets*), the 76 unique inmate-patients sampled included patients with 201 chronic care diagnoses, including six additional patients with diabetes (for a total of 13) (*Appendix B, Table B–2, ASP Chronic Care Diagnoses*). The OIG's sample selection tool evaluated many chronic care programs because the complex and high-risk patients selected from the different categories often had multiple medical problems. While the OIG did not evaluate every chronic disease or health care staff member, the overall operation of the institution's system and staff were assessed for adequacy. The OIG's case review methodology and sample size matched other qualitative research. The empirical findings, supported by expert statistical consultants, showed adequate conclusions after 10 to 15 charts had undergone full clinician review. In qualitative statistics, this phenomenon is known as "saturation." The OIG asserts that the physician sample size of over 30 detailed reviews certainly far exceeds the saturation point necessary for an adequate qualitative review. With regard to reviewing charts from different providers, the case review is not intended to be a focused search for poorly performing providers; rather, it is focused on how the system cares for those patients who need

care the most. Nonetheless, while not sampling cases by each provider at the institution, the OIG inspections adequately review most providers. Providers would only escape OIG case review if institutional management successfully mitigated patient risk by having the more poorly performing providers care for the less complicated, low-utilizing, and lower-risk patients. The OIG's clinicians concluded that the case review sample size was more than adequate to assess the quality of services provided.

Based on the collective results of clinicians' case reviews, the OIG rated each quality indicator as either *proficient* (excellent), *adequate* (passing), *inadequate* (failing), or *not applicable*. A separate confidential *ASP 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 2016, deputy inspectors general and registered nurses attained answers to 92 objective medical inspection test (MIT) questions designed to assess the institution's compliance with critical policies and procedures applicable to the delivery of medical care. To conduct most tests, inspectors randomly selected samples of inmate-patients for whom the testing objectives were applicable and reviewed their electronic unit health records. In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed health records for 427 individual inmate-patients and analyzed specific transactions within their records for evidence that critical events occurred. Inspectors also reviewed management reports and meeting minutes to assess certain administrative operations. In addition, during the week of January 11, 2016, field inspectors conducted a detailed onsite inspection of ASP's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,246 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 ASP's plant infrastructure, protocols for tracking medical appeals and local operating procedures, and staffing resources.

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

SCORING OF COMPLIANCE TESTING RESULTS

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

- Primary indicators: *Access to Care*, *Diagnostic Services*, *Health Information Management (Medical Records)*, *Health Care Environment*, *Inter- and Intra-System Transfers*, *Pharmacy and Medication Management*, *Preventive Services*, *Specialized Medical Housing (OHU, CTC, SNF, Hospice)*, and *Specialty Services*.

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

After compiling the answers to the 92 questions, the OIG derived a score for each primary and secondary quality indicator identified above by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Based on those results, the OIG assigned a rating to each quality indicator of *proficient* (greater than 85 percent), *adequate* (between 75 percent and 85 percent), or *inadequate* (less than 75 percent).

DASHBOARD COMPARISONS

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

OVERALL QUALITY INDICATOR RATING FOR CASE REVIEWS AND COMPLIANCE TESTING

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

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

POPULATION-BASED METRICS

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

MEDICAL INSPECTION RESULTS

PRIMARY (CLINICAL) QUALITY INDICATORS OF HEALTH CARE

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

Summary of Case Review Results: The clinical case review component assessed 10 of the 12 primary (clinical) indicators applicable to ASP. The OIG clinicians rated all ten of these indicators *adequate*. The OIG physicians rated the overall adequacy of care for each of the 30 detailed case reviews they conducted. Of these 30 cases, two were *proficient*, 27 were *adequate*, and one was *inadequate*. Among the 925 events reviewed, there were 119 deficiencies, of which eight were considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

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

- A lung cancer patient returned to ASP following treatment for pneumonia at an outside community hospital. The hospital advised an additional seven days of antibiotics at the institution. The physician's orders for the antibiotics, as well as other analgesic and cough medications, were not implemented. Fortunately, despite antibiotic omissions, no harm resulted to the patient.

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

ACCESS TO CARE

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

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

Overall Rating:
Adequate

Case Review Results

The OIG clinicians reviewed 404 outpatient provider and nurse encounters and identified six minor deficiencies relating to *Access to Care*. ASP performed well with regard to *Access to Care*, so the OIG clinicians rated this indicator *adequate*.

Nurse-to-Provider Referrals

Nurses performing sick call assessments are required to refer the patient to a provider if a situation requires a higher level of care. There were 189 outpatient nursing encounters reviewed with two deficiencies in which provider appointments did not occur timely or did not occur at all:

- In case 15, a nurse treated the patient for a rash and made a routine (within 14 days) provider appointment. However, the appointment occurred more than six weeks later.

- In case 45, a nurse evaluated the patient for back and neck pain. The nurse documented that the patient had a provider appointment the following week, but the appointment did not occur.

Provider-to-Provider Follow-up Appointments

ASP performed well with provider-ordered follow-up appointments. These are among the most important aspects of the *Access to Care* indicator. Failure to accommodate provider-ordered appointments can often result in lapses in care or in patients being lost to follow-up. The OIG identified two deficiencies when provider-to-provider appointments did not occur timely or did not occur at all:

- In case 54, a provider evaluated the patient after a hernia repair and requested to have the patient follow-up with a provider in 14 days. However, the appointment occurred 28 days later.

- In case 73, a provider treated a patient for bronchitis and requested follow-up in 14 days. However, the appointment did not occur timely.

Provider Follow-up After Specialty Service

The low compliance score of 65 percent was due to provider follow-ups after specialty services occurring past policy-dictated time frames; however, the case review of 87 specialty service encounters revealed that most of the appointments did occur, and the specialist recommendations were addressed. There were only two delays that compromised the quality of care:

- In case 51, the patient was seen by hematology but was not followed up on with a provider within the required time frame of 14 days.

- In case 62, the patient was seen by endocrinology but was not followed up on with a provider within the required time frame of 14 days.

Intra-System Transfer

OIG clinicians reviewed three patients who transferred into ASP. Nurses assessed the patients and appropriately referred them to a provider. The providers evaluated the patients timely. There were no deficiencies.

Follow-up After Hospitalization

The low compliance score of 31 percent was due to provider follow-ups after hospitalizations occurring past policy-dictated time frames; however, the case review of 27 hospital or outside emergency department events revealed that the provider follow-up visits did occur, and the hospital recommendations were addressed. There were no instances in which delays in follow-up compromised the quality of care.

Specialized Medical Housing

The providers saw patients in the outpatient housing unit (OHU) appropriately and timely.

Clinician Onsite Inspection

The OIG clinicians interviewed ASP staff regarding issues with access to care. Each of the four clinics visited had an office technician who attended the morning huddles and used a tracking process to ensure provider follow-up appointments were completed. There were no backlogs in the four clinics. The providers reported seeing 14 to 18 patients each day, and the clinic nurses saw 8 to 10 patients each day on the nurse line.

Compliance Testing Results

The institution received an *adequate* compliance score of 79.4 percent in the *Access to Care* indicator, scoring within the *proficient* range in five of the nine areas tested, as described below:

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

- For all 34 sampled service requests submitted by patients across all facility clinics, nursing staff reviewed the request on the same day it was received, and for 33 of the 34 patients (97 percent), nursing completed a face-to-face encounter within one business day of reviewing the request. For the remaining patient, the nurse conducted the visit one day late (MIT 1.003, 1.004).

- Routine appointments for 27 out of 30 sampled patients with chronic care conditions were timely (90 percent). Three patients' appointments occurred from 9 to 53 days late (MIT 1.001).

- For seven health care services requests sampled on which nursing staff referred the patient for a PCP appointment, six patients (86 percent) timely received or refused their appointment. One patient received his appointment one day late (MIT 1.005).

The institution has opportunity for improvement in the following four areas:

- Of the 16 sampled patients who had been discharged from a community hospital, only six (38 percent) received a timely follow-up appointment with a PCP upon their return to ASP. The other 10 patients received their appointments between one and 15 days late (MIT 1.007).

- Of the three patients whom nursing staff referred to a PCP and for whom the PCP subsequently ordered a follow-up appointment, two (67 percent) received their appointments timely. One patient received his appointment 13 days late (MIT 1.006).

- Of 24 patients sampled who had received a specialty service, 16 (67 percent) were offered a timely PCP follow-up appointment and either received or refused it. For seven patients (four receiving high-priority specialty services and three receiving routine specialty services), follow-up visits were from one to eight days late. One other patient's routine specialty service follow-up appointment did not occur at all (MIT 1.008).

- Among 24 patients sampled who had transferred into ASP from another institution and been referred to a PCP based on nursing staff's initial health care screening of the patient, only 17 (71 percent) were seen timely. For six patients, appointments were held from 11 to 20 days late; one other patient never received his appointment at all (MIT 1.002).

Recommendations

No specific recommendations.

DIAGNOSTIC SERVICES

Case Review Rating:
Adequate
Compliance Score:
Adequate
(82.2%)

Overall Rating:
Adequate

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

Case Review Results

The OIG clinicians reviewed 118 events in diagnostic services and found five deficiencies. Most reviewed tests were performed as ordered, reviewed timely by providers, and relayed quickly to patients. The OIG clinicians rated *Diagnostic Services* at ASP *adequate* since deficiencies were infrequent.

ASP staff performed most laboratory tests, x-rays, and electrocardiograms (EKG) as ordered; however, diagnostic orders were not done as ordered in the following cases:

- In case 50, an EKG ordered by a provider was not completed.
- In case 52, a provider-ordered laboratory Helicobacter pylori serology (stomach ulcer test) was not performed.
- In case 54, a provider ordered an EKG be completed in one week, but it was not done until 12 days later.

There were two deficiencies related to health information management in *Diagnostic Services*:

- In case 2, a pathology report was scanned into the eUHR without a provider signature.
- In case 47, a pathology report was not retrieved or scanned into the eUHR.

Scanning of Radiology Imaging Results

During the case review process, OIG clinicians were able to consistently locate radiology reports in patients' eUHR files due to ASP practice of scanning radiology results despite the prohibition on this practice enacted by separate memoranda issued in August 2014 and February 2016 by CCHCS' Deputy Director of Medical Services. CCHCS' directive designated the Radiology

Information System (RIS), a separate non-eUHR system, as the sole repository of all radiology studies because RIS preserves images of higher quality than the eUHR does. The OIG disagrees with CCHCS' directive and concurs with the institution's practice of scanning the written radiology reports into the eUHR because providers routinely access the eUHR during record reviews. Providers are able to see the written reports, but they are still able to access RIS to view the radiology images if needed.

Compliance Testing Results

The institution received an *adequate* compliance score of 82.2 percent in the *Diagnostic Services* indicator, which encompasses radiology, laboratory, and pathology services. For clarity, each type of diagnostic service is discussed separately below:

Radiology Services

- Among the ten radiology services sampled, all were timely performed and the diagnostic report results were timely communicated to the patient (MIT 2.001, 2.003). Providers also properly evidenced their review of the radiology results for nine of the ten (90 percent). For one patient, the provider initialed the report but the report lacked a review date, so inspectors were unable to determine the timeliness of the review (MIT 2.002).

Laboratory Services

- Laboratory services were completed within the time frame specified in the provider's order for eight of ten patients sampled (80 percent). Two patients' laboratory services were received one day late (MIT 2.004). Also, providers properly evidenced their review of the laboratory test results timely for all ten patients sampled (MIT 2.005). Finally, providers timely communicated nine of the ten diagnostic laboratory reports to the patient (90 percent). The only exception was when a PCP communicated results to a patient seven days late (MIT 2.006).

Pathology Services

- The institution received the final pathology report for all ten patients sampled (MIT 2.007). However, providers only timely reviewed the final reports for four of those ten patients (40 percent). For five patients, providers did not initial and date the report to evidence their timely review of the final results; the remaining patient had his pathology results reviewed four days late (MIT 2.008). Providers timely communicated the final pathology results to only four of the ten sampled patients (40 percent). For the other six patients, the provider communicated the pathology test results from one to 34 days late (MIT 2.009).

Recommendation for CCHCS

The OIG recommends that CCHCS revise its radiological report storage policy to mandate that written radiology reports be stored in the patient's eUHR medical record as well as RIS.

Recommendations for ASP

No specific recommendations**.**

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 21 urgent or emergent events and found four deficiencies. All the deficiencies were minor and unlikely to affect patient care. The OIG rated *Emergency Services* at ASP *adequate*.

Provider Performance

The providers generally evaluated the patients timely and made appropriate assessments and plans during urgent or emergent events. The OIG identified two provider performance deficiencies. These cases are also described in the *Quality of Provider Performance* indicator:

- In case 52, a TTA provider evaluated the patient with abdominal pain, but did not address a urine lab test finding of an elevated (greater than 3) bilirubin level (test that indicates liver disease). The patient was later transferred to community hospital where he was diagnosed with acute hepatitis and an elevated bilirubin level.

- Also in case 52, TTA staff evaluated the patient for abdominal pain and shortness of breath. A provider was consulted via telephone, who ordered a nebulizer treatment for the patient and transfer to a community hospital. However, there was no provider progress note for this emergent event.

Nursing Performance

Nurses generally evaluated patients timely and made appropriate assessments and interventions during urgent or emergent events. Transfer of care between ASP nursing staff and local emergency medical services (EMS) staff was proficient. The OIG identified two nursing deficiencies:

- In case 1, nursing staff successfully performed CPR on the patient, and his breathing and pulse returned. However, the breathing was shallow and gasping, but medical records did not show that nursing continued to provide rescue breathing. Nursing staff did not document the time the EMS paramedic departed the institution.

- In case 52, TTA staff evaluated the patient for shortness of breath and wheezing. The on-call provider ordered a nebulizer treatment, but the nurse did not document the type of nebulizer treatment given.

Emergency Medical Response Review Committee (EMRRC)

ASP conducted EMRRC meetings timely with good attendance of custody and health care team representatives. ASP staff performed and analyzed routine emergency drills and identified areas for improvement.

Onsite Clinical Inspection

ASP had a well-equipped TTA. The TTA was readily accessible through the back entrance of each yard, and staffed with two nurses each shift and one provider during business hours. ASP reported that it had taken corrective action regarding its emergency response bags based on discussions with the OIG compliance team inspectors during their onsite inspection in January 2016. ASP's bags had contained additional items that were not included on CCHCS's Medical Emergency Response Bag Checklist. For compliance purposes, the OIG only tests whether the institution follows CCHCS's Emergency Medical Response Bag procedures and verifies that the bags are inspected daily and inventoried monthly, and that they contain all essential items. However, CCHCS policy limits the emergency response bag contents to only items on the checklist. To address this issue, ASP added a second bag for additional important emergency medications (naloxone and glucagon) and other emergency supplies, and implemented a local operating procedure addressing the use of the emergency medications.

Conclusion

Overall, the ASP providers, nurses, and custody staff provided timely and appropriate urgent and emergent care in a coordinated process. The identified deficiencies were minor and did not affect the quality of the patient care. The OIG clinicians rated the *Emergency Services* indicator adequate.

Recommendations

No specific recommendations.

HEALTH INFORMATION MANAGEMENT (MEDICAL RECORDS)

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(68.6%)

Overall Rating:
Adequate

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

For this indicator, the OIG 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 the factors leading to both scores and ultimately rated this indicator *adequate*. The case review cited only a few misfiled and mislabeled documents. In addition, aside from two tests that significantly affected the overall score, the majority of compliance tests scores were *proficient.* As a result, the case review test results were deemed a more accurate reflection of the appropriate overall rating.

Case Review Results

The OIG clinicians identified 43 deficiencies related to *Health Information Management*. ASP performed well with retrieval of specialty reports and hospital discharge summaries. However, many outside specialty services reports, hospital reports, and laboratory reports were scanned into the eUHR without provider signatures. Even though unsigned, providers reviewed these reports in another system, the ASP shared drive, that was accessible in all clinical areas. Progress notes supported the effectiveness of this local system. The institution had started an improvement process during the time of the clinician onsite visit to correct the signature deficiencies. Overall, the *Health Information Management* processes were *adequate.*

Hospital Records

- Most hospital records were timely retrieved, reviewed, and scanned into the eUHR. However, case 74 had a significant deficiency as the hospital discharge summary was not retrieved or scanned into the eUHR.

- In cases 2, 47, 50, 51, 52, 53, 54, 58, 73, 75, and 76, the providers did not properly sign hospital discharge summaries, but did address the hospital recommendations.

Missing Documents (Progress Notes and Forms)

Most nursing and provider progress notes were scanned into the eUHR. However, in cases 26, 45, 74, and the following two cases, progress notes were missing:

- In case 3, the patient's blood sugar log was not scanned into the eUHR.
- In case 63, the provider evaluated a patient and documented that progress note was dictated; however, the dictated progress note was not retrieved or scanned into the eUHR.

Scanning Performance

There was one misfiled document. In case 75, a medical record of a different patient was scanned into the eUHR.

Specialty Services Reports

Specialty reports were not properly signed by a provider. In case 54, the surgeon's consultation report described the post-operative care for a patient who had a recent hernia repair. The report also included a request to see the patient for a re-check in two weeks. ASP staff did not retrieve or scan the consultation report into the eUHR. Also, the follow-up surgical visit did not occur.

Diagnostic Reports

The OIG clinicians found that most diagnostic reports were retrieved and scanned into the eUHR. There was one significant deficiency: In case 47, the patient had an arm lesion that a provider excised and sent to pathology; however, ASP staff did not retrieve or scan the pathology report into the eUHR.

Legibility

Most provider and nursing progress notes were dictated or legible. However, on four occasions, progress notes were illegible.

Conclusion

ASP medical record staff were prompt in retrieving and scanning specialty reports and hospital discharge summaries. The reports were scanned into the eUHR soon after being received for the providers to review on follow-up visits. Some reports lacked a provider signature.

Compliance Testing Results

The institution received an *inadequate* compliance score of 68.6 percent in the *Health Information Management (Medical Records)* indicator. Although ASP scored well in six of the eight tests conducted, the following two areas dropped the score significantly:

- ASP scored zero in its labeling and filing of documents scanned into inmate-patients' eUHRs. The most common errors were incorrectly labeled documents, and there was one missing dictated progress note (MIT 4.006).

- Inspectors tested 20 PCP-dictated progress notes to determine if staff scanned the documents within five days of the encounter date; only three documents (15 percent) were scanned timely. Staff had scanned 17 of the documents between one and nine days late (MIT 4.002).

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

- The OIG reviewed community hospital discharge reports and treatment records for 16 sampled patients whom ASP sent to an outside hospital. For 15 of the 16 patients (94 percent), the discharge summary reports were complete and timely reviewed by ASP providers. For one patient, the provider reviewed the hospital discharge summary report two days late (MIT 4.008).

- For 18 of 20 specialty service consultant reports sampled (90 percent), ASP staff scanned the reports into the inmate-patient's eUHR file within five calendar days. Two documents were scanned two days late (MIT 4.003).

- Health records administrative staff timely scanned medication administration records (MARs) into patients' eUHR files, with 18 of 20 sampled documents (90 percent) scanned within the required time frames. Staff scanned the other two MARs one day late (MIT 4.005).

- Health records administrative staff timely scanned community hospital discharge reports or treatment records into patients' eUHRs for 14 of the 16 sampled reports (88 percent); two reports were scanned one and five days late (MIT 4.004).

- Among 32 samples of various medical documents, such as hospital discharge reports, initial health screening forms, keep-on-person (KOP) MARs, and specialty service reports, clinical staff legibly documented their names on 28 (88 percent). Two of the four exceptions related to nurses not having legibly signed KOP MARs; in the other two instances, a provider did not legibly sign a specialty service report (MIT 4.007).

- Health records administrative staff timely scanned miscellaneous documents, such as non-dictated providers' progress notes, initial health screening forms, and patients' requests for health care services. Specifically, 17 of the 20 documents sampled (85 percent) were timely scanned into the patient's eUHR within three calendar days of the patient's encounter. For three patients, a provider's progress note was scanned between one and three days late (MIT 4.001).

Recommendations

No specific recommendation**s.**

HEALTH CARE ENVIRONMENT

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

Case Review Rating:
Not Applicable
Compliance Score:
Proficient
(87.3%)

Overall Rating:
Proficient

Clinician Comments

Although the OIG clinicians did not rate the health care environment at ASP, they observed the following during their onsite visit:

- ASP medical clinics had adequate space needed to provide patient care with auditory privacy. The clinics had ample lighting and were well stocked with medications and medical equipment.

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

- Morning huddles were attended by providers, clinic and medication nurses, care coordinators, office technicians, and custody officers. These meetings were productive, as staff discussed pertinent matters of nurse and provider lines, as well as any custody issues related to access to care.

Compliance Testing Results

The institution received a *proficient* compliance score of 87.3 percent in the *Health Care Environment* indicator. The institution performed at a *proficient* level in 8 of the indicator's 11 test areas, described below:

- ASP appropriately disinfected, cleaned, and sanitized all ten clinics observed (MIT 5.101). Also, the ten clinics all had operable sinks and sufficient quantities of hygiene supplies in clinical areas (MIT 5.103).

- ASP was compliant at all ten clinics regarding mitigation of exposure to blood-borne pathogens and contaminated waste (MIT 5.105).

- The non-clinic medical storage area in ASP's main medical storage warehouse generally met the supply management process and support needs of the medical health care program. ASP scored 100 percent on this test (MIT 5.106).

- All ten clinics inspected followed adequate medical supply storage and management protocols in their clinical areas (MIT 5.107). Also, all ten clinics had an environment adequately conducive to providing medical services (MIT 5.109).

- The institution scored 100 percent when inspectors examined emergency response bags in ten clinics to determine if clinical staff inspected the bags daily and inventoried them monthly, and whether the bags contained all essential items (MIT 5.111).

- The exam rooms or treatment spaces in nine of ten inspected clinics (90 percent) were compliant with space, configuration, supplies, and equipment to allow clinicians to perform a proper clinical exam. However, in one exam room, supplies stored under the exam table were not well organized and labeled, and the placement of the exam table did not allow the patient to lie in a fully extended position (MIT 5.110).

The institution performed well in the two areas below:

- Clinicians adhered to universal hand hygiene precautions in eight of ten clinics (80 percent). At two clinics, nursing staff failed to sanitize hands or wear gloves prior to intentional physical contact with patients (MIT 5.104).

- Clinic common areas and exam rooms at eight of the ten clinics (80 percent) included core equipment and other essential supplies necessary to conduct a comprehensive exam. Two clinics had expired calibration stickers on nebulizer units; the calibrations expired from 2012 to 2014 (MIT 5.108).

The institution received an *inadequate* score on one test:

- In only one of ten applicable clinics inspected (10 percent), clinical health care staff ensured that reusable invasive and non invasive medical equipment was properly sterilized or disinfected. Staff were unable to disinfect exam tables or other equipment prior to the start of each shift because the clinics did not have appropriate environmental surface hospital-grade disinfectant available (MIT 5.102).

Other Information Obtained from Non-Scored Results

The OIG gathered information to determine if the institution's physical infrastructure was maintained in a manner that supported health care management's ability to provide timely or adequate health care. The OIG did not score this question. When OIG inspectors interviewed ASP's health care management in January 2016, they did not identify any concerns. The

institution reported having one project underway, the Health Care Facility Improvement Program, Phase I (Statewide Medication Distribution Project). The construction was in progress at the time of the inspection and on target for completion in February 2016 (MIT 5.999).

Recommendations

No specific recommendations.

INTER- AND INTRA-SYSTEM TRANSFERS

Case Review Rating:
Adequate
Compliance Score:
Adequate
(75.5%)

Overall Rating:
Adequate

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

Case Review Results

The OIG clinicians reviewed 59 encounters relating to *Inter- and Intra-System Transfers,* including information from both the sending and receiving institutions. These included hospitalization and emergency department transfers back to the institution. The OIG clinicians rated the *Inter- and Intra-System Transfer*s processes at ASP *adequate*.

Transfers In

The patients who transferred into ASP received timely initial nursing assessments, appropriate referrals, and chronic medications. However, there was one minor deficiency:

- In case 45, the RN did not adequately assess the patient's severe headache. There was no documentation of location nor of precipitating and alleviating factors.

Transfers Out

As patients were transferred out to other institutions, nursing staff timely completed the Health Care Transfer Information forms (CDCR Form 7371), which included pertinent medical conditions, medications, and pending specialty appointments. There were no deficiencies found for patients transferring out of ASP.

Hospitalizations

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

The ASP hospital return process worked well. Nurses in the TTA evaluated patients returning from an outside hospital with good assessments to ensure that the patients received needed medications and follow-up appointments. However, there was one minor deficiency:

- In case 50, the nurse did not notify the provider of the patient's elevated blood pressure of 142/92 mmHg when the patient returned from the hospital.

Clinician Onsite Inspection

ASP had a receiving and release area where a nurse performed the initial health screenings and assessments. The area was equipped with necessary medical supplies and medications such as inhalers. For patients transferring out of ASP, nurses completed transfer information forms one week in advance of the transfers and performed brief face-to-face assessments before the patients boarded the bus for the transfer.

Conclusion

Overall, the OIG clinicians found *Inter- and Intra-System Transfer*s at ASP *adequate*.

Compliance Testing Results

The institution obtained an *adequate* compliance score of 75.5 percent in the *Inter- and Intra-System Transfers* indicator, scoring in the *proficient* and *adequate* ranges in three of the five tests, as described below:

- Nursing staff timely completed the assessment and disposition sections of the screening form for all 30 patients (MIT 6.002).

- Sixteen of the sampled patients who transferred into ASP had an existing medication order upon arrival. Inspectors tested those patients' records to determine if they received their medications without interruption; 14 of the 16 patients (88 percent) received their medications timely. One patient received his directly observed therapy medication one day late and his prescribed KOP medication, which did not arrive with him, was not reissued; the KOP medication was discontinued one week later. A second patient did not receive a scheduled dose of one of his nurse-administered medications (MIT 6.003).

- ASP scored 80 percent when the OIG tested five inmate-patients who transferred out of ASP during the onsite inspection to determine whether the patients' transfer packages

included required medications and related documentation. Four packages were compliant, but for one patient who had KOP medication prescriptions; the medications were not in the transfer package at the time of transfer (MIT 6.101).

The institution displayed room for improvement in the two areas below:

- Inspectors sampled 20 patients who transferred out of ASP to other CDCR institutions to determine whether the institution listed the patients' pending specialty service appointments on the Health Care Transfer Information form (CDCR Form 7371). ASP nursing staff documented the previously approved and still pending appointments for only 12 of the patients (60 percent), but failed to do so for eight others (MIT 6.004).

- The OIG tested 30 patients who transferred into ASP from other CDCR institutions; nursing staff completed an initial health screening assessment on the same day of the patient's arrival for 15 of the patients (50 percent). For 15 patients, nursing staff neglected to answer the medication question on the patient's Initial Health Screening form (CDCR Form 7277). Specifically, nurses did not list medications and instead referenced "see med recon"; however, the new arrival medication reconciliation was not found in the eUHR (MIT 6.001).

Recommendations

No specific recommendations.

PHARMACY AND MEDICATION MANAGEMENT

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

Overall Rating:
Inadequate

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

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*. Both the case review and compliance inspectors scored medication administration *adequate*. However, two compliance sub-indicators, Observed Medication Practices and Storage Controls and Pharmacy Protocols, both received *inadequate* scores. As a result, the compliance review rating of *inadequate* was deemed a more appropriate reflection of the overall indicator rating.

Case Review Results

The OIG clinicians evaluated *Pharmacy and Medication Management* as it relates to the quality of clinical care provided. Compliance testing was a more targeted approach and was heavily relied on for the overall rating of this indicator. For case reviews, the clinicians identified two deficiencies related to pharmacy and medication management. The case review rating for *Pharmacy and Medication Management* was *adequate*.

New Prescriptions

In the majority of the cases, patients received their medications timely and as prescribed. However, in two cases, prescriptions were not processed, or not processed timely:

- In case 2, the patient returned from hospitalization with a diagnosis of pneumonia, and the provider prescribed the antibiotic amoxicillin clavulanate for ten days. The medication was not filled, placing the patient at risk of harm. Fortunately, there was no harm to the patient.

- In case 36, a nurse ordered clotrimazole cream to treat the patient for tinea pedis (fungal infection of the foot). The order was faxed to central pharmacy on the same day, but the patient did not receive the medication until six days later.

Chronic Care Medication Continuity

ASP performed well with chronic care medication continuity. Overall, ASP was able to deliver and administer prescribed medications to patients in a timely manner, and there was no interruption of essential chronic medications.

Intra-System and Intra-Facility Transfers and Medication Continuity

Medication continuity was maintained in the majority of the reviewed transfer cases. Patients transferring into ASP received timely nursing assessments to ensure continuity of all chronic medications.

Compliance Testing Results

The institution received an *inadequate* compliance score of 65.6 percent in the *Pharmacy and Medication Management* indicator. For discussion purposes below, this indicator is divided into three sub-indicators: Medication Administration, Observed Medication Practices and Storage Controls, and Pharmacy Protocols.

Medication Administration

This sub-indicator consists of four applicable questions in which the institution received an *adequate* average score of 79 percent, with *proficient* scores in the following two areas:

- ASP timely administered or delivered new medication orders to 28 of the 30 patients sampled (93 percent). Two patients received their medication one day late (MIT 7.002).

- When the OIG sampled 30 inmate-patients who had transferred from one housing unit to another within ASP, 27 of the patients (90 percent) received their prescribed medications without interruption. On the day of their housing relocation, two patients did not receive one dose of their prescribed medication; another patient received the previously ordered dosage of two medications, even though the prescribed dosages had been changed on the date of his housing relocation (MIT 7.005).

The institution performed in the *adequate* or *inadequate* range in the following tests:

- Nursing staff timely dispensed long-term chronic care medications to 23 of the 29 inmate-patients sampled (79 percent). Four of the other six patients did not timely receive refills of one or more of their KOP medications; two other patients did not receive their directly observed therapy medications on one or more days (MIT 7.001).

- Clinical staff timely provided new and previously prescribed medications to only 8 of 15 patients sampled who had been discharged from a community hospital (53 percent). Seven patients received their medications from one to 21 days late (MIT 7.003).

Observed Medication Practices and Storage Controls

This sub indicator consists of six applicable questions on which the institution received an average score of 70 percent. The institution showed room for improvement in the following two areas:

- When the OIG tested 14 clinic locations to determine if non-narcotic medications that required refrigeration were stored properly, none of the 14 locations were in compliance. The facility's pharmacist in charge (PIC) indicated that the institution had no process in place to store refrigerated medication separately for return to pharmacy. ASP scored zero on this test (MIT 7.103).

- The OIG interviewed nursing staff and inspected narcotics storage areas at eight applicable clinic and pill line locations. Nursing staff had strong medication security controls over narcotic medications at only three locations (38 percent). At five locations, medication nurses did not have a second nurse who assisted at the beginning or end of the shift in reconciling narcotics pill totals (MIT 7.101).

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

- Inspectors observed the medication preparation and administration processes for six medication line locations. Nursing staff were generally compliant with proper hand hygiene contamination control protocols at five of the medication lines (83 percent). At one of the medication lines, a nurse failed to sanitize hands during a glove change and prior to re-gloving (MIT 7.104).

The institution scored 100 percent in the following three tests:

- Non-narcotic medications that did not require refrigeration were properly stored at all 14 clinic and medication line storage locations inspected (MIT 7.102).

- Nursing staff followed appropriate administrative controls during medication preparation at all six of the inspected medication preparation and administration locations (MIT 7.105). In addition, at all six sampled locations, nursing staff followed appropriate administrative controls when distributing medications to inmate-patients (MIT 7.106).

Pharmacy Protocols

This sub-indicator consists of five applicable questions in which the institution received an *inadequate* average score of 49 percent, displaying room for improvement in the following three pharmacy operational areas:

- In its main pharmacy, ASP did not properly store non-refrigerated medications; staff stored food items on counters used to prepare medications for distribution (*Figure 1*) (MIT 7.108).

Figure 1: Food stored in medication preparation area

- Similarly, in its main pharmacy, staff stored personal food items in a refrigerator/freezer unit that was used to store frozen vaccines; there was no label on the freezer indicating whether it was for staff use or medication storage use; and the institution did not maintain a temperature log for the freezer. Also, the PIC indicated there was no process requiring staff to properly segregate medications recently returned from clinical areas (MIT 7.109).

- ASP followed key medication error reporting protocols in only 14 of 30 sampled incidents (47 percent). In the other 16 incidents, the PIC did not timely share the error report with the institution's local Pharmacy and Therapeutics Committee or Patient Safety Committee within 30 days of the PIC's review (MIT 7.111).

The institution scored 100 percent in the following two tests:

- ASP's main pharmacy followed general security, organization, and cleanliness management protocols (MIT 7.107).

- ASP's PIC documented and retained evidence to support the required oversight review for sampled clinic and medication line storage locations' monthly narcotics inventory results. (MIT 7.110).

Non-Scored Tests

In addition to testing reported medication errors, OIG inspectors followed up on any significant medication errors found during the case reviews or compliance testing to determine whether the institution properly identified and reported the errors. At ASP, the OIG did not find any applicable medication errors (MIT 7.998).

Inspectors also determine whether inmate-patients in isolation housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications (MIT 7.999). Effective June 2015, ASP did not have an isolation housing unit located at the institution. ASP housed its administratively segregated inmates at the Pleasant Valley State Prison (PVSP); those inmate-patients who are prescribed rescue inhalers and nitroglycerin medications will be tested during the PVSP inspection, scheduled for later in 2016.

Recommendations

No specific recommendations.

PREVENTIVE SERVICES

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

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(74.4%)

Overall Rating:
Inadequate

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

Compliance Testing Results

The institution performed in the *inadequate* range in the *Preventive Services* indicator with a compliance score of 74.4 percent, receiving low scores in four of seven test areas:

- ASP scored 43 percent for conducting annual tuberculosis screenings. Although all 30 patients sampled were screened for tuberculosis within the prior year, only 5 of the 15 patients classified as Code 22 (requiring a tuberculosis skin test in addition to screening of signs and symptoms) were properly tested. For the other ten Code 22 patient screenings, inspectors identified one or both of the following deficiencies: the 48-to-72-hour window to read test results was not clear because nursing staff did not document either the administered (start) or read (end) date and time of the skin test, or an LVN, rather than an RN, public health nurse, or primary care provider, read the test results. In addition to the sampled Code 22 patients, inspectors also sampled 15 patients classified as Code 34 (those who have previously tested positive for tuberculosis and do not receive a skin test). For eight patients, nursing staff properly completed the CDCR Form 7331; however, six patients had an incomplete history section, and, for one patient, the signs and symptoms section was not completed (MIT 9.003).

- The institution completed required weekly or monthly monitoring for only 17 of 30 sampled patients who were prescribed anti-tuberculosis medications (57 percent). Twelve patients did not receive required monthly monitoring for one month; another patient did not timely receive monitoring for one week and, for another week, the monitoring form was not timely scanned into the patient's eUHR (MIT 9.002).

- The OIG tested whether patients who suffered from a chronic care condition were offered vaccinations for influenza, pneumonia, and hepatitis. At ASP, only 8 of 14 patients sampled (57 percent) received all recommended vaccinations at the required interval. Six

patients had no record of ever being offered or receiving the recommended pneumonia or hepatitis vaccine (MIT 9.008).

- The OIG sampled 20 patients at high risk for contracting the coccidioidomycosis infection (valley fever), identified as medically restricted and ineligible to reside at ASP, to determine if the patients were transferred out of the institution within 60 days from the time they were determined ineligible. ASP was compliant for 14 of the 20 patients sampled, scoring 70 percent. Five patients were transferred out of the institution from 63 to 110 days after they had been identified as ineligible to reside there, meaning they were transferred out of ASP from 3 to 50 days late. One other patient transferred out of ASP in April 2016, which was more than six months after he was determined medically restricted and ineligible to reside at the institution (MIT 9.009).

The institution scored at the *proficient* level in the following three areas:

- ASP offered colorectal cancer screenings to all 30 sampled patients aged 50 to 75 and subject to the annual screening requirement (MIT 9.005).

- ASP offered annual influenza vaccinations to 29 of 30 sampled patients subject to the annual screening requirement (97 percent). The OIG could not ascertain if one patient received or refused the vaccine because he declined the vaccine on the Patient Influenza Vaccine Documentation (CDCR Form 7466), but the nurse also completed and signed the administration section of the form. As a result of the poor documentation, the institution received a "No" answer for this patient (MIT 9.004).

- ASP scored 97 percent for timely administering anti-tuberculosis medications (INH) to patients with tuberculosis. Of the 30 sampled inmates, 29 patients received their medication timely, while one patient missed a required INH dose prior to transfer and did not receive the required provider counseling for the missed dosage (MIT 9.001).

Recommendations

No specific recommendations.

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 (CDCR Form 7362), urgent walk-in visits, referrals for medical services by custody staff, RN case management, RN utilization management, clinical encounters by licensed vocational nurses (LVNs) and licensed psychiatric technicians (LPTs), and any other nursing service performed on an outpatient basis. The OIG case review also includes activities and processes performed by nursing staff that are not considered direct patient encounters, such as the initial receipt and review of CDCR Form 7362 service requests and follow-up with primary care providers and other staff on behalf of the patient. Key focus areas for evaluation of outpatient nursing care include appropriateness and timeliness of patient triage and assessment, identification and prioritization of health care needs, use of the nursing process to implement interventions including patient education and referrals, and documentation that is accurate, thorough, and legible. Nursing services provided in the outpatient housing unit (OHU) are reported under the *Specialized Medical Housing* indicator. Nursing services provided in the triage and treatment area (TTA) or related to emergency medical responses are reported under *Emergency Services.*

Case Review Results

The OIG clinicians rated the *Quality of Nursing Performance* at ASP *adequate.* Among the 267 evaluated outpatient-nursing encounters, there were 20 deficiencies, none of which was significant. In general, ASP outpatient nursing services were performed well.

Nursing Sick Calls

Sick call nurses appropriately assessed complaints and symptoms, provided necessary interventions, and timely referred the patients to a provider when necessary. Nurses were proficient in providing patient care by utilizing appropriate nursing encounter forms and following established nursing protocols. In addition, most of the nurses were diligent in following up and documenting whether a patient's health problem had resolved. Only a few deficiencies were identified:

- In case 8, the patient had an elevated blood pressure of 152/99 mmHg. The sick call nurse did not recheck the patient's blood pressure prior to releasing the patient back to his cell.

- In case 45, the patient complained of heartburn and hearing problems. The sick call nurse did not address the hearing problems.

Nursing Assessment

The majority of nursing encounters demonstrated adequate assessment. The OIG clinicians reviewed documentation to determine if the nurse asked pertinent questions, performed necessary measurements, examined pertinent areas of the body, and noted the presence or absence of common accompanying signs and symptoms. Although most of the nursing assessments were good, the following cases demonstrated areas for nursing improvement:

- In case 47, the patient returned from a treadmill stress test and had not received his morning blood pressure medications. His blood pressure was elevated at 143/99 mmHg, and the nurse did not administer the missed medications, recheck the blood pressure, or contact the provider about the elevated blood pressure.

- In case 53, the LVN contacted the TTA nurse about a patient with acute, severe knee pain and foot numbness. The TTA nurse did not assess the patient urgently, but deferred the assessment to the clinic nurse on the following day.

Medication Management and Administration

The outpatient medication administration was generally timely and reliable. There were minor deficiencies identified, further discussed in the *Pharmacy and Medication Management* indicator.

Emergency Care

Emergency nursing care and medical emergency first response were adequate. Documentation of the emergency events revealed adequate nursing decision-making and good performance during challenging cases. Most deficiencies were minor and unlikely to contribute to patient harm.

Clinician Onsite Inspection

Nurses in outpatient clinic settings at ASP were active participants in the primary care team morning huddles. Morning huddles were held in each yard clinic. The huddles started and ended on time and were well attended by the providers, sick call nurses, nurse case managers, medication line nurses, schedulers, and custody officers. Yard providers facilitated morning huddles and discussed hospitalized and returned patients, TTA visits, physician-on-call reports, mental health concerns, chronic care related issues, and new arrivals to the yard. All staff members had the opportunity to participate in the team discussions. The primary care nurses facilitated the morning huddles on days that providers were not assigned to the yard. Custody officers provided information about any inmates that could potentially pose danger to others and

medical staff, and reminded medical staff to inform officers if they would be seeing these patients.

The nursing staff verbalized having no major barriers with initiating communication with nursing supervisors, providers, and custody officers regarding patient care needs. At the time of the OIG clinicians' onsite inspection, ASP had only recently implemented care coordination, with an LVN in each clinic functioning as a care coordinator. The LVN care coordinators found the care coordination process was a great deal to learn, but that they received the support they needed from their clinic nurses and nursing supervisors. The LVN care coordinators worked collaboratively with the clinic nurses and clinic providers to manage chronic care patients, and they used information from the CCHCS quality management database. The clinic nurses reported no backlogs in nurse lines and that they had a good working relationships with the clinic providers, never hesitating to consult the providers if needed. Each yard had a dedicated exam room for the nurses, LVN care coordinators, and providers. The clinics were organized, clean, and equipped with necessary supplies and medical equipment.

The public health nurse was knowledgeable about ASP's inmate population surveillance data regarding reportable medical conditions, and the receiving and release nurses demonstrated knowledge of processes established at ASP to assess the health care status and needs of incoming inmates. All the nurses interviewed expressed high job satisfaction and pride in their jobs. Nursing staff at ASP is to be commended for their knowledge about assigned patients, specific processes and procedures for their individual assignments, and institution-wide nursing practice policies.

Recommendations

The OIG recommends that nursing supervisors implement ongoing quality improvement strategies to ensure all sick call nurses proficiently perform the following tasks:

- Conduct a focused subjective and objective nursing assessment based on both the patient's current complaints and past health history.
- Address each medical complaint by completing and documenting a focused physical assessment.

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 225 medical provider encounters and identified 35 deficiencies related to provider performance. Of those 35 deficiencies, one was significant. As a whole, ASP provider performance was *adequate*.

Assessment and Decision-Making

In most cases, ASP providers made appropriate assessments and sound medical plans. There was one significant deficiency:

- In case 2, the patient returned from a community hospital and was admitted to the OHU at ASP with the diagnosis of pneumonia. The discharge instructions were to continue antibiotics for an additional ten days. Although the provider ordered the antibiotics, the pharmacy did not fill the prescription. The provider caring for the patient in the OHU failed to review the medication administration record, and was unaware the patient did not receive the antibiotics. Despite this significant deficiency, no harm came to the patient.

There were minor deficiencies:

- In case 2, the patient was scheduled for a computed tomography (CT) scan with intravenous contrast; the provider should have held metformin (diabetes medication) 48 hours prior to the procedure to decrease the risk of renal toxicity.

- In case 2, the patient had two elevated hemoglobin A1c (average blood sugar level over a two- to three-month period) of 7.4 and 8.1 percent, which were consistent with the diagnosis of diabetes. The provider should have started the patient on treatment for diabetes.

- In case 46, the patient had multiple pulmonary nodules suspicious for malignancy; the provider should have ordered an urgent, instead of a three-month routine, positron emission tomography (PET) scan.

- In case 76, the patient had abnormal liver laboratory tests (alanine transaminase of 288 U/L and aspartate transaminase of 373 U/L); the provider should have discontinued simvastatin (cholesterol medication) as this medication can cause liver toxicity.

Emergency Care

Providers generally made appropriate triage decisions when patients presented emergently to the TTA. In addition, they generally were available for consultation with the TTA nursing staff. However, there was one deficiency identified related to the quality of provider care in emergency services. The case below is also discussed in the *Emergency Services* indicator:

- In case 52, a provider evaluated the patient, who had a history of hepatitis C infection, for abdominal pain, but did not address a urine lab test finding of a bilirubin level of 3+, indicating liver disease. The patient was eventually transferred to community hospital where he was diagnosed with acute hepatitis and an elevated serum bilirubin of 10 mg/dL.

Hospital Returns

ASP providers did not properly sign several hospital discharge summaries; however, the providers timely addressed all the recommendations.

Chronic Care

Chronic care performance was adequate as most providers demonstrated good care with regard to hypertension, asthma, hepatitis C infection, and cardiovascular disease. ASP providers' thorough documentations showed sound assessments and plans, demonstrating that they provided good care for their patients.

- In case 74, the patient had persistent asthma and was using three different inhalers; the provider was concerned when the patient was confused about which inhaler to use on a regular basis and which inhaler to use as needed for shortness of breath. The provider asked the patient to go back to his cell and retrieve all his inhalers, then educated and instructed the patient on the use of different inhalers.

The OIG clinicians identified the following deficiencies in the chronic care program:

- In case 2, the provider documented that the patient had a 17.9 percent risk for a heart attack or stroke within the next ten years; however, the provider did not document the reason for not prescribing a statin (medication to lower cholesterol).

- In case 52, the patient had mild persistent asthma. The provider inappropriately discontinued mometasone, an inhaled corticosteroid recommended for persistent asthma.

- In case 54, the patient had a calculated 12.8 percent ten-year risk of heart disease or stroke; the provider failed to place the patient on a moderate- to high-intensity statin. Based on the patient's age and risk for heart disease and stroke, the provider also failed to start the patient on 81 mg of aspirin daily.

Patients' hypertension and dyslipidemia were well controlled, and vaccinations, especially pneumococcal vaccines, were up to date. Also, most providers demonstrated excellent diabetic management skills.

- In case 60, the patient had poorly controlled diabetes, and the providers appropriately adjusted his basal insulin every two days until his fasting blood glucose was in target ranges.

However, the OIG clinicians did identify the following minor deficiencies in diabetic care:

- In case 2, the patient had new onset diabetes; however, the provider did not refer the patient for a retinal exam.

- In case 61, the patient had poorly controlled diabetes and required a recent adjustment of insulin; the provider should have followed up with the patient sooner than seven weeks later for further insulin adjustments.

- In case 65, on the basis of the patient's age and diabetes condition, the provider should have prescribed a statin.

Specialty Services

ASP providers generally referred patients appropriately and reviewed specialty reports timely; however, providers did not properly sign all of the reports, and occasionally the providers failed to address all recommendations. The following deficiencies were identified:

- In case 57, a provider evaluated the patient after a recent urology visit, but failed to order a kidney, ureter, and bladder (KUB) x-ray as recommended prior to the urology follow-up appointment.

- In case 61, the patient had a prostate nodule, and the ordered prostate ultrasound was suboptimal as it was only a limited examination of the prostate. The provider should have ordered an endorectal ultrasound exam as recommended to appropriately evaluate this prostate nodule.

- In case 71, the patient had a transurethral resection of the prostate (TURP). However, the provider failed to review the urology consultation after surgery, and subsequently failed to address recommendations to discontinue finasteride and tamsulosin (used to treat prostate gland enlargement).

Health Information Management

The providers generally documented outpatient, TTA, and OHU encounters on the day they occurred. Most progress notes were dictated and legible.

Clinician Onsite Inspection

At the time of the OIG inspection, there was one provider vacancy. Most ASP providers were enthusiastic about their work and expressed satisfaction with nursing, specialty, and diagnostic services. Each provider was mainly assigned to one clinic to ensure continuity of care, and each of the three mid-level providers worked closely with a physician as a patient care team. All providers attended the daily provider meeting, where they discussed significant TTA encounters and hospital returns occurring on the previous day. Morning huddles were productive, led by providers and attended by nurses, the care coordinator, custody staff, and the office technician. The chief medical executive (CME) was committed to patient care and quality improvement, and the providers were supportive of the CME. Most providers expressed general job satisfaction, and the overall morale was good.

Conclusion

Overall, the ASP providers delivered good care. Two cases were *proficient*, 27 were *adequate*, and one was *inadequate*. The OIG rated the *Quality of Provider Performance* at ASP *adequate*.

Recommendations

No specific recommendations.

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

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

Case Review Rating:
Adequate
Compliance Score:
Proficient
(94.7%)

Overall Rating:
Adequate

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

Case Review Results

The OHU had 27 medical beds, with each bed in an individual room. None of the rooms provided negative pressure, which is necessary to minimize the spread of airborne infections for patients with active infections such as tuberculosis. Of the 107 encounters reviewed, there were three significant deficiencies identified: cases 2, 47, and 68. The OIG clinicians rated the *Specialized Medical Housing* indicator *adequate.*

Provider Performance

The provider performance in the OHU was adequate. The providers performed admission exams and addressed active medical conditions for all patients admitted to the OHU. There was one significant provider deficiency likely to contribute to patient harm:

- In case 2, a provider performed the intake history and physical, but did not address the patient's pneumonia and unfilled antibiotic amoxicillin clavulanate. The patient was not receiving the recommended antibiotic.

There were two minor provider deficiencies:

- In case 54, a provider admission history and physical exam note was illegible.
- In case 71, urology evaluated the patient after prostatic resection and recommended discontinuing finasteride and tamsulosin (medications for benign prostate hypertrophy). An OHU provider did not review the urology consultation and did not address the recommendation to discontinue the two medications.

Nursing Performance

Overall, the nursing care provided to patients in the OHU was adequate, with appropriate assessments, timely interventions, and thorough documentations. However, two significant nursing deficiencies were identified:

- In case 47, when the patient returned from a specialty appointment, a nurse failed to notify a provider of an elevated blood pressure of 143/99 mmHg, and did not administer the patient's evening blood pressure medications.

- In case 68, an OHU nurse did not adequately monitor a patient's temperature of 102 F°, and did not alert the provider when the patient continued to have a fever after administering acetaminophen.

Clinician Onsite Inspection

The OHU was clean, organized, and staffed with a registered nurse (RN) on the second shift and a licensed vocational nurse (LVN) on each of the first and third shifts. The TTA RN assisted the OHU LVN as needed. ASP also placed patients in the OHU if they were scheduled for a surgery to ensure the patients complied with any necessary preparations, such as a bowel cleanse prior to colonoscopy.

Conclusion

The OHU staff provided good and coordinated patient care. The OIG clinicians found *Specialized Medical Housing* to be *adequate.*

Compliance Testing Results

The institution received a *proficient* compliance score of 94.7 percent in the *Specialized Medical Housing* indicator, receiving *proficient* scores in four of the indicator's five test areas, as follows:

- Inspectors tested the working order of ASP's OHU patient room call buttons and found that they were in good working condition. According to staff interviewed who regularly worked in the OHU, custody staff and clinicians were able to expeditiously access and enter a patient's locked room when an emergent event occurred. As a result, ASP received a score of 100 percent on this test (MIT 13.101).

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

- Providers evaluated all ten sampled inmate-patients within 24 hours of admission. Providers also completed a history and physical within 72 hours of admission for nine of

the ten patients (90 percent). For one patient, a completed history and physical could not be found in the eUHR (MIT 13.002, 13.003).

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

- Providers completed their Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes at required 14-day intervals for five of the six sampled patients (83 percent). Providers missed a required 14-day interval for one patient by six days (MIT 13.004).

Recommendations

No specific recommendations.

SPECIALTY SERVICES

Case Review Rating:
Adequate
Compliance Score:
Adequate
(83.5%)

Overall Rating:
Adequate

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

Case Review Results

The OIG clinicians reviewed 83 events related to S*pecialty Services*, and identified 29 deficiencies. Most of the deficiencies were minor and related to the health information management process, so the case review rating for *Specialty Services* was *adequate*.

Provider Performance

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

Specialty Access

On two occasions, specialty services did not occur within the requested time frame:

- In case 57, a urology follow-up appointment occurred three weeks late.
- In case 58, a provider requested an urgent (within 14 days) chest computed tomography (CT) scan, but the patient did not receive the test until 26 days later.

On two occasions, specialty services appointments did not occur:

- In case 54, a follow-up appointment with general surgery did not occur.
- In case 58, a requested pulmonology follow-up appointment did not occur.

Health Information Management

The OIG identified one specialty report, a surgery consultation (case 54), was not retrieved or scanned into the eUHR. The OIG also identified 21 specialty reports not properly signed by the providers prior to eUHR scanning.

Clinician Onsite Inspection

At the time of the OIG inspection, the specialty services nurses had an effective tracking process to ensure patients received their necessary specialty appointments and diagnostic procedures timely. They reported a slight backlog with optometry appointments, primarily due to the volume of patients. ASP also had an effective process to ensure specialty reports were retrieved and scanned into the eUHR.

Compliance Testing Results

The institution received an *adequate* compliance score of 83.5 percent in the *Specialty Services* indicator. ASP scored in the *proficient* or *adequate* range in the following test areas:

- ASP received a score of 100 percent when the OIG tested the timeliness of ASP's denials of providers' specialty services requests for 20 inmate-patients (MIT 14.006).

- All 15 of the patients sampled received their routine specialty service appointments within 90 days of the provider's order (MIT 14.003).

- For 14 of the 15 patients sampled (93 percent), the patient's high-priority specialty services appointment occurred within 14 calendar days of the provider's order. One patient received his specialty service six days late (MIT 14.001).

- Providers timely received and reviewed the specialists' reports for 11 of the 12 sampled patients who received a high-priority specialty service (92 percent). For one patient, there was no evidence in the patient's eUHR that the report was received (MIT 14.002). Similarly, for routine specialty services, providers timely received and reviewed specialists' reports for 11 of 13 patients sampled (85 percent). One patient's report was reviewed one day late, while another patient's report showed no evidence of review at all (MIT 14.004).

The institution has room for improvement in the following areas:

- Among 20 sampled patients who had a specialty service denied by ASP's health care management, 14 (70 percent) received timely notification of the denied service, including the provider meeting with the patient within 30 days to discuss alternate treatment strategies. For two patients, this requirement was not met at all; four other patients received a follow-up visit from 5 to 177 days late.(MIT 14.007).

- When patients are approved or scheduled for specialty services appointments at one institution and then transfer to another, policy requires that the receiving institution ensure a patient's appointment is timely rescheduled or scheduled and held. Only 9 of the 20 patients sampled (45 percent) received their specialty services appointment within the

required action date. Four patients received appointments from 5 to 113 days late. For seven other patients, there was no evidence that a scheduled specialty appointment occurred at all (MIT 14.005).

Recommendations

No specific recommendations.

SECONDARY (ADMINISTRATIVE) QUALITY INDICATORS OF HEALTH CARE

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

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

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

INTERNAL MONITORING, QUALITY IMPROVEMENT, AND ADMINISTRATIVE OPERATIONS

Case Review Rating:
Not Applicable
Compliance Score:
Adequate
(75.8%)

Overall Rating:
Adequate

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

Compliance Testing Results

Overall, ASP scored in the *adequate* range in the *Internal Monitoring, Quality Improvement, and Administrative Operations* indicator, receiving a compliance score of 75.8 percent. The following four individual test areas received scores of 100 percent:

- The institution promptly processed all inmate medical appeals in each of the most recent 12 months (MIT 15.001).
- ASP's QMC met monthly, evaluated program performance, and took action when improvement opportunities were identified (MIT 15.003).
- Based on a sample of ten second-level medical appeals, the institution's responses addressed all of the patients' appealed issues (MIT 15.102).
- Medical staff reviewed and timely submitted the Initial Inmate Death Report (CDCR Form 7229A) to CCHCS's Death Review Unit for all three deaths that occurred during the testing period (MIT 15.103).

The institution showed room for improvement in the following administrative areas:

- The OIG inspected incident review packages for 11 emergency medical response incidents reviewed by ASP's Emergency Medical Response Review Committee (EMRRC) during the prior 12-month period. Eight of the sampled incident packages (73 percent) complied with policy. Two of the packages tested did not answer questions regarding the response time adequacy and staff compliance. The third package did not

include the EMRRC checklist, and the March 26, 2015, incident was not timely reviewed at the next scheduled committee meeting in April 2015; the incident was not reviewed until May 21, 2015 (MIT 15.007).

- ASP improved or reached targeted performance objectives for two of three quality improvement initiatives identified in its 2015 Performance Improvement Work Plan, resulting in a score of 67 percent. For one initiative, there was insufficient evidence regarding whether the institution had either improved or reached all applicable targeted performance objectives (MIT 15.005).

- Inspectors reviewed drill packages for three medical emergency response drills conducted in the prior quarter. Two of the drills included actual participation by custody staff, as CCHCS policy requires. One of the drill packages did not include a required Crime Incident Report (CDCR Form 837). As a result, ASP scored 67 percent on this test (MIT 15.101).

- Based on information obtained from the institution's CEO and the Quality Management Committee (QMC) meeting minutes, the institution took adequate steps to ensure the accuracy of its Dashboard data. Specifically, the QMC meetings discussed methodologies used to conduct periodic validation and testing of Dashboard data. However, the committee did not discuss methodologies used to train staff who collected Dashboard data, scoring zero on this test (MIT 15.004).

Other Information Obtained from Non-Scored Areas

- The OIG gathered non-scored data regarding death review reports and found that CCHCS's Death Review Committee did not timely complete its death review summary for each of the three deaths that occurred during the testing period. The CCHCS Death Review Committee is required to complete a death review summary within 30 business days of the death and submit it to the institution's CEO five business days later. However, the committee completed its three summary reports from 19 to 93 days late (from 63 to 137 days after the deaths). As a result, CCHCS did not timely submit any of its reports to the institution's CEO (MIT 15.996).

- Inspectors met with the institution's CEO to inquire about ASP's protocols for tracking medical appeals. The institution's health care appeals coordinator provides management with weekly appeal summary reports and a monthly appeals tracking log to monitor the aging of appeals. The reports break down appeals received, completed, open, and overdue; and appeals processed and their disposition. The reports also list appealed issues by category, which management uses to track potential problem areas. The CEO follows the progressive discipline matrix and closely monitors these areas to ensure issues are addressed immediately. In the previous six months, ASP addressed inmate-patients'

concerns about provider performance and pain management medication complaints (MIT 15.997).

- Non-scored data gathered regarding the institution's practices for implementing local operating procedures (LOPs) indicated that the institution had an effective process in place for developing LOPs but had a high number of LOPs that still did not have a written policy. At the time of the inspection, the institution had implemented 22 of the 47 applicable stakeholder-recommended LOPs (47 percent). If existing LOPs needed revision, the health program specialist worked with subject matter experts to create or edit the LOPs. Once the LOPs were evaluated by the experts, they were sent to the medical subcommittee and Quality Management Committee for approval. When a new or revised policy and procedure was received from CCHCS headquarters, the executive management team, the health program specialist from each area (mental health, dental, and healthcare) and the experts reviewed and conducted an analysis of the statewide policies and procedures to determine the impact of implementing the institutional LOP. Once statewide policies and procedures were reviewed and LOPs were drafted as needed, the approved LOPS were emailed to all staff (MIT 15.998).

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

Recommendations

No specific recommendations.

JOB PERFORMANCE, TRAINING, LICENSING, AND CERTIFICATIONS

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

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(67.5%)

Overall Rating:
Inadequate

Compliance Testing Results

The institution received an *inadequate* compliance score of 67.5 percent in the *Job Performance Training, Licensing, and Certifications* indicator. The following three areas display opportunities for improvement:

- ASP's pharmacy and providers who prescribed controlled substances were not current with their Drug Enforcement Agency (DEA) registrations, scoring zero on this test. The PIC did not have a system or process in place to ensure providers maintained current DEA registrations (MIT 16.106).

- Among ASP's nine providers, zero had a proper clinical performance appraisal completed. For eight providers, although a Unit Health Record Clinical Appraisal was completed in the past year, a performance appraisal was not timely completed. Appraisals were from one month to eight years late. For the ninth provider, no evidence was found in the employee's file of either a probationary report or an annual performance appraisal (MIT 16.103).

- Nursing supervisors properly completed monthly nursing reviews for only two of five nurses sampled (40 percent). For three nurses, the supervisor did not complete the required number of monthly reviews nor include required aspects of the reviews. In addition, the supervisor did not document evidence that the evaluation results were discussed with two of them (MIT 16.101).

ASP received *proficient* scores of 100 percent in all five of the following administrative areas:

- All providers were current with their professional licenses, and nursing staff and the pharmacist in charge were current with their professional licenses and certification requirements (MIT 16.001, 16.105).

- All of the ten sampled nurses who administered medications possessed current clinical competency validations, and all nursing staff hired within the last year timely received new employee orientation training (MIT 16.102, 16.107).

- All active duty providers, nurses, and custody staff were current with their emergency response certifications (MIT 16.104).

Recommendations

No specific recommendations.

POPULATION-BASED METRICS

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

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

Methodology

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

Comparison of Population-Based Metrics

For Avenal State Prison, seven of nine HEDIS measures were applicable for comparison, as shown in the following *ASP 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. ASP performed well in the management of diabetes.

When compared to health care organizations in California, ASP outperformed Medi-Cal in all five diabetic measures selected, and outperformed Kaiser in all diabetic measures except blood pressure control. When compared nationally, ASP outperformed Medicaid, Medicare, and commercial health plans in each of the five diabetic measures listed. In addition, ASP outperformed the U.S. Department of Veterans Affairs (VA) in all applicable diabetic measures except blood pressure control and eye exams; ASP scored only 4 percentage points lower for each measure.

Immunizations

Comparative data for immunizations was only fully available for the VA and partially available for Kaiser and commercial plans. Regarding the administration of influenza shots to younger adults, ASP outperformed Kaiser and commercial plans; ASP scored just 1 percentage point lower than the VA.

At the start of the inspection, ASP only had one patient over the age of 65. Due to the small population, no comparative data was presented for adults aged 65 and older for influenza or pneumococcal vaccinations.

Cancer Screening

For colorectal cancer screening, ASP's scores were lower than the scores of all the other entities that reported data (Kaiser, commercial plans, Medicare, and the VA). However, all 41 patients the OIG sampled were offered the screening timely, but 22 patients (54 percent) subsequently refused it, negatively affecting the institution's scores.

Summary

Overall, ASP's HEDIS performance reflects an adequate chronic care program, corroborated by the institution's *adequate* ratings in the *Quality of Provider Performance, Quality of Nursing Performance,* and *Access to Care* indicators. Patients refusing to receive the services significantly affected the institution's scores for colorectal cancer screenings. ASP has an opportunity to improve its scores by making interventions to lower the rate of patient refusals.

ASP Results Compared to State and National HEDIS Scores

Clinical Measures	California				National			
	ASP Cycle 4 Results[1]	HEDIS Medi – Cal 2014[2]	HEDIS Kaiser (No. CA) 2015[3]	HEDIS Kaiser (So.CA) 2015[3]	HEDIS Medicaid 2015[4]	HEDIS Com –- mercial 2015[4]	HEDIS Medicare 2015[4]	VA Average 2012[5]
Comprehensive Diabetes Care								
HbA1c Testing (Monitoring)	**100%**	83%	95%	94%	86%	91%	93%	99%
Poor HbA1c Control (>9.0%)[6, 7]	**3%**	44%	18%	24%	44%	31%	25%	19%
HbA1c Control (<8.0%)[6]	**92%**	47%	70%	62%	47%	58%	65%	-
Blood Pressure Control (<140/90)[6]	**76%**	60%	84%	85%	62%	65%	65%	80%
Eye Exams	**86%**	51%	69%	81%	54%	56%	69%	90%
Immunizations								
Influenza Shots - Adults (18–64)[8]	**64%**	-	54%	55%	-	50%	-	65%
Influenza Shots - Adults (65+)[9]	-	-	-	-	-	-	72%	76%
Immunizations: Pneumococcal[9]	-	-	-	-	-	-	70%	93%
Cancer Screening								
Colorectal Cancer Screening	**46%**	-	80%	82%	-	64%	67%	82%

1. Unless otherwise stated, data was collected in January 2016 by reviewing medical records from a sample of ASP's population of applicable inmate-patients. These random statistical sample sizes were based on a 95 percent confidence level with a 15 percent maximum margin of error.

2. HEDIS Medi-Cal data was obtained from the California Department of Health Care Services 2014 HEDIS Aggregate Report for the Medi-Cal Managed Care Program.

3. Data was obtained from Kaiser Permanente November 2015 reports for the Northern and Southern California regions.

4. National HEDIS data for Medicaid, commercial plans, and Medicare was obtained from the 2015 State of Health Care Quality Report, available on the NCQA website: www.ncqa.org. The results for commercial plans were based on data received from various health maintenance organizations.

5. The Department of Veterans Affairs (VA) data was obtained from the VHA Facility Quality and Safety Report - Fiscal Year 2012 Data.

6. For this indicator, the entire applicable ASP population was tested.

7. For this measure only, a lower score is better. For Kaiser, the OIG derived the Poor HbA1c Control indicator using the reported data for the <9.0% HbA1c control indicator.

8. The VA data is for the age range 50–64.

9. Population limited to only one inmate-patient over the age of 65; therefore, sample omitted from the comparative analysis.

APPENDIX A — COMPLIANCE TEST RESULTS

Avenal State Prison Range of Summary Scores: 65.57% - 94.67%	
Indicator	**Overall Score (Yes %)**
Access to Care	79.38%
Diagnostic Services	82.22%
Emergency Services	Not Applicable
Health Information Management (Medical Records)	68.59%
Health Care Environment	87.27%
Inter- and Intra-System Transfers	75.50%
Pharmacy and Medication Management	65.57%
Prenatal and Post-Delivery Services	Not Applicable
Preventive Services	74.35%
Quality of Nursing Performance	Not Applicable
Quality of Provider Performance	Not Applicable
Reception Center Arrivals	Not Applicable
Specialized Medical Housing (OHU, CTC, SNF, Hospice)	94.67%
Specialty Services	83.52%
Internal Monitoring, Quality Improvement, and Administrative Operations	75.76%
Job Performance, Training, Licensing, and Certifications	67.50%

Reference Number	*Access to Care*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
1.001	**Chronic care follow-up appointments:** Was the inmate-patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter?	27	3	30	90.00%	0
1.002	**For endorsed inmate-patients received from another CDCR institution:** If the nurse referred the inmate-patient to a provider during the initial health screening, was the inmate-patient seen within the required time frame?	17	7	24	70.83%	6
1.003	**Clinical appointments:** Did a registered nurse review the inmate-patient's request for service the same day it was received?	34	0	34	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?	33	1	34	97.06%	0
1.005	**Clinical appointments:** If the registered nurse determined a referral to a primary care provider was necessary, was the inmate-patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter?	6	1	7	85.71%	27
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?	2	1	3	66.67%	31
1.007	**Upon the inmate-patient's discharge from the community hospital:** Did the inmate-patient receive a follow-up appointment within the required time frame?	6	10	16	37.50%	0
1.008	**Specialty service follow-up appointments:** Do specialty service primary care physician follow-up visits occur within required time frames?	16	8	24	66.67%	6
1.101	**Clinical appointments:** Do inmate-patients have a standardized process to obtain and submit health care services request forms?	6	0	6	100.00%	0
Overall percentage:					**79.38%**	

Reference Number	*Diagnostic Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
2.001	**Radiology:** Was the radiology service provided within the time frame specified in the provider's order?	10	0	10	100.00%	0
2.002	**Radiology:** Did the primary care provider review and initial the diagnostic report within specified time frames?	9	1	10	90.00%	0
2.003	**Radiology:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	10	0	10	100.00%	0
2.004	**Laboratory:** Was the laboratory service provided within the time frame specified in the provider's order?	8	2	10	80.00%	0
2.005	**Laboratory:** Did the primary care provider review and initial the diagnostic report within specified time frames?	10	0	10	100.00%	0
2.006	**Laboratory:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	9	1	10	90.00%	0
2.007	**Pathology:** Did the institution receive the final diagnostic report within the required time frames?	10	0	10	100.00%	0
2.008	**Pathology:** Did the primary care provider review and initial the diagnostic report within specified time frames?	4	6	10	40.00%	0
2.009	**Pathology:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	4	6	10	40.00%	0
Overall percentage:					**82.22%**	

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

Reference Number	*Health Information Management (Medical Records)*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated progress notes, initial health screening forms, and health care service request forms scanned into the eUHR within three calendar days of the inmate-patient encounter date?	17	3	20	85.00%	0
4.002	Are dictated / transcribed documents scanned into the eUHR within five calendar days of the inmate-patient encounter date?	3	17	20	15.00%	0
4.003	Are specialty documents scanned into the eUHR within the required time frame?	18	2	20	90.00%	0
4.004	Are community hospital discharge documents scanned into the eUHR within three calendar days of the inmate-patient date of hospital discharge?	14	2	16	87.50%	0
4.005	Are medication administration records (MARs) scanned into the eUHR within the required time frames?	18	2	20	90.00%	0
4.006	During the eUHR review, did the OIG find that documents were correctly labeled and included in the correct inmate-patient's file?	0	12	12	0.00%	0
4.007	Did clinical staff legibly sign health care records, when required?	28	4	32	87.50%	0
4.008	**For inmate-patients discharged from a community hospital:** Did the preliminary hospital discharge report include key elements and did a PCP review the report within three calendar days of discharge?	15	1	16	93.75%	0
Overall percentage:					**68.59%**	

Reference Number	*Health Care Environment*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
5.101	**Infection Control:** Are clinical health care areas appropriately disinfected, cleaned, and sanitary?	10	0	10	100.00%	0
5.102	**Infection control:** Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	1	9	10	10.00%	0
5.103	**Infection Control:** Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	10	0	10	100.00%	0
5.104	**Infection control:** Does clinical health care staff adhere to universal hand hygiene precautions?	8	2	10	80.00%	0
5.105	**Infection control:** Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	10	0	10	100.00%	0
5.106	**Warehouse, Conex and other non-clinic storage areas:** Does the medical supply management process adequately support the needs of the medical health care program?	1	0	1	100.00%	0
5.107	**Clinical areas:** Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	10	0	10	100.00%	0
5.108	**Clinical areas:** Do clinic common areas and exam rooms have essential core medical equipment and supplies?	8	2	10	80.00%	0
5.109	**Clinical areas:** Do clinic common areas have an adequate environment conducive to providing medical services?	10	0	10	100.00%	0
5.110	**Clinical areas:** Do clinic exam rooms have an adequate environment conducive to providing medical services?	9	1	10	90.00%	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?	10	0	10	100.00%	0
5.999	**For information only:** Does the institution's health care management believe that all clinical areas have physical plant infrastructures sufficient to provide adequate health care services?	Information Only				
Overall percentage:					**87.27%**	

Reference Number	*Inter- and Intra-System Transfers*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
6.001	**For endorsed inmate-patients received from another CDCR institution or COCF:** Did nursing staff complete the initial health screening and answer all screening questions on the same day the inmate-patient arrived at the institution?	15	15	30	50.00%	0
6.002	**For endorsed inmate-patients received from another CDCR institution or COCF:** When required, did the RN complete the assessment and disposition section of the health screening form; refer the inmate-patient to the TTA, if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening?	30	0	30	100.00%	0
6.003	**For endorsed inmate-patients received from another CDCR institution or COCF:** If the inmate-patient had an existing medication order upon arrival, were medications administered or delivered without interruption?	14	2	16	87.50%	14
6.004	**For inmate-patients transferred out of the facility:** Were scheduled specialty service appointments identified on the Health Care Transfer Information Form 7371?	12	8	20	60.00%	0
6.101	**For inmate-patients transferred out of the facility:** Do medication transfer packages include required medications along with the corresponding Medical Administration Record (MAR) and Medication Reconciliation?	4	1	5	80.00%	4
Overall percentage:					**75.50%**	

Reference Number	*Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.001	Did the inmate-patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows?	23	6	29	79.31%	1
7.002	Did health care staff administer or deliver new order prescription medications to the inmate-patient within the required time frames?	28	2	30	93.33%	0
7.003	**Upon the inmate-patient's discharge from a community hospital:** Were all medications ordered by the institution's primary care provider administered or delivered to the inmate-patient within one calendar day of return?	8	7	15	53.33%	1
7.004	**For inmate-patients received from a county jail:** Were all medications ordered by the institution's reception center provider administered or delivered to the inmate-patient within the required time frames?	Not Applicable				
7.005	**Upon the inmate-patient's transfer from one housing unit to another:** Were medications continued without interruption?	27	3	30	90.00%	0
7.006	**For inmate-patients en route who lay over at the institution:** If the temporarily housed inmate-patient had an existing medication order, were medications administered or delivered without interruption?	Not Applicable				
7.101	**All clinical and medication line storage areas for narcotic medications:** Does the institution employ strong medication security controls over narcotic medications assigned to its clinical areas?	3	5	8	37.50%	8
7.102	**All clinical and medication line storage areas for non-narcotic medications:** Does the institution properly store non-narcotic medications that do not require refrigeration in assigned clinical areas?	14	0	14	100.00%	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?	0	14	14	0.00%	2
7.104	**Medication preparation and administration areas:** Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes?	5	1	6	83.33%	10
7.105	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when preparing medications for inmate-patients?	6	0	6	100.00%	10
7.106	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when distributing medications to inmate-patients?	6	0	6	100.00%	10
7.107	**Pharmacy:** Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and satellite pharmacies?	1	0	1	100.00%	0

7.108	**Pharmacy:** Does the institution's pharmacy properly store non-refrigerated medications?	0	1	1	0.00%	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	**Pharmacy:** Does the institution follow key medication error reporting protocols?	14	16	30	46.67%	0
7.998	**For information only:** During eUHR compliance testing and case reviews, did the OIG find that medication errors were properly identified and reported by the institution?	Information Only				
7.999	**For information only:** Do inmate-patients in isolation housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications?	Information Only				
Overall percentage:					**65.57%**	

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

Reference Number	*Preventive Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
9.001	**Inmate-patients prescribed INH:** Did the institution administer the medication to the inmate-patient as prescribed?	29	1	30	96.67%	0
9.002	**Inmate-patients prescribed INH:** Did the institution monitor the inmate-patient monthly for the most recent three months he or she was on the medication?	17	13	30	56.67%	0
9.003	**Annual TB Screening:** Was the inmate-patient screened for TB within the last year?	13	17	30	43.33%	0
9.004	Were all inmate-patients offered an influenza vaccination for the most recent influenza season?	29	1	30	96.67%	0
9.005	**All inmate-patients from the age of 50 through the age of 75:** Was the inmate-patient offered colorectal cancer screening?	30	0	30	100.00%	0
9.006	**Female inmate-patients from the age of 50 through the age of 74:** Was the inmate-patient offered a mammogram in compliance with policy?	Not Applicable				
9.007	**Female inmate-patients from the age of 21 through the age of 65:** Was the inmate-patient offered a pap smear in compliance with policy?	Not Applicable				
9.008	Are required immunizations being offered for chronic care inmate-patients?	8	6	14	57.14%	16
9.009	Are inmate-patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	14	6	20	70.00%	0
Overall percentage:					**74.35%**	

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

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

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

Reference Number	*Specialized Medical Housing (OHU, CTC, SNF, Hospice)*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	**For all higher level care facilities:** Did the registered nurse complete an initial assessment of the inmate-patient on the day of admission, or within eight hours of admission to CMF's Hospice?	10	0	10	100.00%	0
13.002	**For OHU, CTC, & SNF only:** Did the primary care provider for OHU or attending physician for a CTC & SNF evaluate the inmate-patient within 24 hours of admission?	10	0	10	100.00%	0
13.003	**For OHU, CTC, & SNF only:** Was a written history and physical examination completed within 72 hours of admission?	9	1	10	90.00%	0
13.004	**For all higher level care facilities:** Did the primary care provider complete the Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes on the inmate-patient at the minimum intervals required for the type of facility where the inmate-patient was treated?	5	1	6	83.33%	4
13.101	**For OHU and CTC Only:** Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter inmate-patient's cells?	1	0	1	100.00%	0
Overall percentage:					**94.67%**	

Reference Number	*Specialty Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	Did the inmate-patient receive the high-priority specialty service within 14 calendar days of the PCP order?	14	1	15	93.33%	0
14.002	Did the PCP review the high priority specialty service consultant report within the required time frame?	11	1	12	91.67%	3
14.003	Did the inmate-patient receive the routine specialty service within 90 calendar days of the PCP order?	15	0	15	100.00%	0
14.004	Did the PCP review the routine specialty service consultant report within the required time frame?	11	2	13	84.62%	2
14.005	**For endorsed inmate-patients received from another CDCR institution:** If the inmate-patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames?	9	11	20	45.00%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	20	0	20	100.00%	0
14.007	Following the denial of a request for specialty services, was the inmate-patient informed of the denial within the required time frame?	14	6	20	70.00%	0
Overall percentage:					**83.52%**	

Reference Number	*Internal Monitoring, Quality Improvement, and Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.001	Did the institution promptly process inmate medical appeals during the most recent 12 months?	12	0	12	100.00%	0
15.002	Does the institution follow adverse/sentinel event reporting requirements?	Not Applicable				
15.003	Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified?	6	0	6	100.00%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	0	1	1	0.00%	0
15.005	For each initiative in the Performance Improvement Work Plan (PIWP), has the institution performance improved or reached the targeted performance objective(s)?	2	1	3	66.67%	1
15.006	**For institutions with licensed care facilities:** Does the Local Governing Body (LGB), or its equivalent, meet quarterly and exercise its overall responsibilities for the quality management of patient health care?	Not Applicable				
15.007	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	8	3	11	72.73%	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 inmate-patient's appealed issues?	10	0	10	100.00%	0
15.103	Did the institution's medical staff review and submit the initial inmate death report to the Death Review Unit in a timely manner?	3	0	3	100.00%	0
15.996	**For information only:** Did the CCHCS Death Review Committee submit its inmate death review summary to the institution timely?	Information Only				
15.997	**For information only:** Identify the institution's protocols for tracking medical appeals.	Information Only				
15.998	**For information only:** Identify the institution's protocols for implementing health care local operating procedures.	Information Only				
15.999	**For information only:** Identify the institution's health care staffing resources.	Information Only				
Overall percentage:					**75.76%**	

Reference Number	*Job Performance, Training, Licensing, and Certifications*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
16.001	Do all providers maintain a current medical license?	10	0	10	100.00%	0
16.101	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	2	3	5	40.00%	0
16.102	Are nursing staff who administer medications current on their clinical competency validation?	10	0	10	100.00%	0
16.103	Are structured clinical performance appraisals completed timely?	0	9	9	0.00%	1
16.104	Are staff current with required medical emergency response certifications?	3	0	3	100.00%	0
16.105	Are nursing staff and the pharmacist in charge current with their professional licenses and certifications?	4	0	4	100.00%	2
16.106	Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	0	1	1	0.00%	0
16.107	Are nursing staff current with required new employee orientation?	1	0	1	100.00%	0
Overall percentage:					**67.50%**	

APPENDIX B — CLINICAL DATA

Table B-1: ASP Sample Sets	
Sample Set	**Total**
CTC/OHU	5
Death Review/Sentinel Events	3
Diabetes	7
Emergency Services — Non-CPR	5
High Risk	5
Hospitalization	5
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	35
Specialty Services	5
	76

Table B-2: ASP Chronic Care Diagnoses	
Diagnosis	**Total**
Anemia	2
Arthritis/Degenerative Joint Disease	9
Asthma	12
COPD	11
Cancer	2
Chronic Kidney Disease	1
Chronic Pain	18
Coccidioidomycosis	4
Diabetes	13
Diagnosis	18
Gastroesophageal Reflux Disease	16
Hepatitis C	23
Hyperlipidemia	22
Hypertension	31
Mental Health	10
Migraine Headaches	2
Seizure Disorder	5
Thyroid Disease	2
	201

Table B-3: ASP Event/Program	
Program	**Total**
Diagnostic Services	118
Emergency Care	25
Hospitalization	48
Intra-System Transfers In	13
Intra-System Transfers Out	10
Not Specified	14
Outpatient Care	487
Specialized Medical Housing	107
Specialty Services	103
	925

Table B-4: ASP Case Review Sample Summary	
	Total
MD Reviews Detailed	30
MD Reviews Focused	0
RN Reviews Detailed	15
RN Reviews Focused	44
Total Reviews	89
Total Unique Cases	76
Overlapping Reviews (MD & RN)	13

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

Avenal State Prison			
Quality Indicator	**Sample Category (number of samples)**	**Data Source**	**Filters**
Access to Care			
MIT 1.001	Chronic care patients (30)	Master Registry	• Chronic care conditions (at least one condition per inmate-patient—any risk level) • **Randomize**
MIT 1.002	Nursing Referrals (30)	OIG Q: 6.001	• See ***Intra-system Transfers***
MITs 1.003–006	Nursing sick call (5 per clinic) (34)	MedSATS	• Clinic (each clinic tested) • Appointment date (2–9 months) • **Randomize**
MIT 1.007	Returns from community hospital (16)	OIG Q: 4.008	• See ***Health Information Management (Medical Records)*** (returns from community hospital)
MIT 1.008	Specialty services follow-up (30)	OIG Q: 14.001 & 14.003	• See ***Specialty Services***
MIT 1.101	Availability of health care services request forms (6)	OIG onsite review	• Randomly select one housing unit from each yard
Diagnostic Services			
MITs 2.001–003	Radiology (10)	Radiology Logs	• Appointment date (90 days–9 months) • **Randomize** • Abnormal
MITs 2.004–006	Laboratory (10)	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • **Randomize** • Abnormal
MITs 2.007–009	Pathology (10)	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • **Randomize**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Health Information Management (Medical Records)			
MIT 4.001	Timely scanning (20)	OIG Qs: 1.001, 1.002, & 1.004	• Non-dictated documents • 1st 10 IPs MIT 1.001, 1st 5 IPs MITs 1.002, 1.004
MIT 4.002	(20)	OIG Q: 1.001	• Dictated documents • First 20 IPs selected
MIT 4.003	(20)	OIG Qs: 14.002 & 14.004	• Specialty documents • First 10 IPs for each question
MIT 4.004	(16)	OIG Q: 4.008	• Community hospital discharge documents • First 20 IPs selected
MIT 4.005	(20)	OIG Q: 7.001	• MARs • First 20 IPs selected
MIT 4.006	(12)	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (12 or more = No)
MIT 4.007	Legible signatures & review (32)	OIG Qs: 4.008, 6.001, 6.002, 7.001, 12.001, 12.002 & 14.002	• First 8 IPs sampled • One source document per IP
MIT 4.008	Returns from community hospital (16)	Inpatient claims data	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • **Randomize** (each month individually) • First 5 inmate-patients from each of the 6 months (if not 5 in a month, supplement from another, as needed)
Health Care Environment			
MIT 5.101–111	Clinical areas (10)	OIG inspector onsite review	• Identify and inspect all onsite clinical areas.
Inter- and Intra-System Transfers			
MIT 6.001–003	Intra-system transfers (30)	SOMS	• Arrival date (3–9 months) • Arrived from (another CDCR facility) • Rx count • **Randomize**
MIT 6.004	Specialty services send-outs (20)	MedSATS	• Date of transfer (3–9 months) • **Randomize**
MIT 6.101	Transfers out (9)	OIG inspector onsite review	• R&R IP transfers with medication

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
Pharmacy and Medication Management			
MIT 7.001	Chronic care medication (30)	OIG Q: 1.001	*See* ***Access to Care*** • At least one condition per inmate-patient—any risk level • **Randomize**
MIT 7.002	New Medication Orders (30)	Master Registry	• Rx count • **Randomize** • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns from Community Hospital (16)	OIG Q: 4.008	• See ***Health Information Management (Medical Records)*** *(returns from community hospital)*
MIT 7.004	RC arrivals – medication orders *N/A at this institution*	OIG Q: 12.001	• See ***Reception Center Arrivals***
MIT 7.005	Intra-facility moves *(30)*	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • **Randomize**
MIT 7.006	En Route *N/A at this institution*	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 (16)	OIG inspector onsite review	• Identify and inspect onsite clinical areas that prepare and administer medications
MITs 7.107–110	Pharmacy (1)	OIG inspector onsite review	• Identify & inspect all onsite pharmacies
MIT 7.111	Medication error reporting (30)	Monthly medication error reports	• All monthly statistic reports with Level 4 or higher • Select a total of 5 months
MIT 7.999	Isolation unit KOP medications *N/A at this institution*	Onsite active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in isolation units
Prenatal and Post-Delivery Services			
MIT 8.001–007	Recent Deliveries *N/A at this institution*	OB Roster	• Delivery date (2–12 months) • **Most recent** deliveries (within date range)
	Pregnant Arrivals *N/A at this institution*	OB Roster	• Arrival date (2–12 months) • **Earliest** arrivals (within date range)

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
Preventive Services			
MITs 9.001–002	TB medications (30)	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • **Randomize**
MIT 9.003	TB Code 22, annual TST (15)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (22) • **Randomize**
	TB Code 34, annual screening (15)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (34) • **Randomize**
MIT 9.004	Influenza vaccinations (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • **Randomize** • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal cancer screening (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • **Randomize**
MIT 9.006	Mammogram *N/A at this institution*	SOMS	• Arrival date (at least 2 yrs prior to inspection) • Date of birth (age 52–74) • **Randomize**
MIT 9.007	Pap smear *N/A at this institution*	SOMS	• Arrival date (at least three yrs prior to inspection) • Date of birth (age 24–53) • **Randomize**
MIT 9.008	Chronic care vaccinations (30)	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • **Randomize** • Condition must require vaccination(s)
MIT 9.009	Valley fever (number will vary) (20)	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • **All**

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
Reception Center Arrivals			
MITs 12.001–008	RC *N/A at this institution*	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • **Randomize**
Specialized Medical Housing			
MITs 13.001–004	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 Access			
MITs 14.001–002	High-priority (15)	MedSATS	• Approval date (3–9 months) • **Randomize**
MITs 14.003–004	Routine (15)	MedSATS	• Approval date (3–9 months) • Remove optometry, physical therapy or podiatry • **Randomize**
MIT 14.005	Specialty services arrivals (20)	MedSATS	• Arrived from (other CDCR institution) • Date of transfer (3–9 months) • **Randomize**
MIT 14.006–007	Denials (10)	InterQual	• Review date (3–9 months) • **Randomize**
	(10)	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • **Randomize**

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
Internal Monitoring, Quality Improvement, & Administrative Operations			
MIT 15.001	Medical appeals (all)	Monthly medical appeals reports	• Medical appeals (12 months)
MIT 15.002	Adverse/sentinel events (0)	Adverse/sentinel events report	• Adverse/sentinel events (2–8 months)
MITs 15.003–004	QMC Meetings (6)	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.005	Performance improvement work plans (PIWP) (4)	Institution PIWP	• PIWP with updates (12 months) • Medical initiatives
MIT 15.006	LGB *N/A at this institution*	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.007	EMRRC (11)	EMRRC meeting minutes	• Meeting minutes (6 months)
MIT 15.101	Medical emergency response drills (3)	Onsite summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	2nd level medical appeals (10)	Onsite list of appeals/closed appeals files	• Medical appeals denied (6 months)
MIT 15.103	Death Reports (3)	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.996	Death Review Committee (3)	OIG summary log — deaths	• Between 35 business days & 12 months prior • CCHCS death reviews
MIT 15.998	Local operating procedures (LOPs) (all)	Institution LOPs	• All LOPs

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Job Performance, Training, Licensing, and Certifications			
MIT 16.001	Provider licenses (10)	Current provider listing (at start of inspection)	• Review all
MIT 16.101	RN Review Evaluations (5)	Onsite supervisor periodic RN reviews	• RNs who worked in clinic or emergency setting six or more days in sampled month • **Randomize**
MIT 16.102	Nursing Staff Validations (10)	Onsite nursing education files	• On duty one or more years • Nurse administers medications • **Randomize**
MIT 16.103	Provider Annual Evaluation Packets (all)	OIG Q:16.001	• All required performance evaluation documents

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

MIT 16.105	Nursing staff and Pharmacist in Charge Professional Licenses and Certifications (all)	OIG Inspector Onsite Review	• All licenses and certifications
MIT 16.106	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations (all)	OIG Inspector Onsite Review	• All current DEA registrations
MIT 16.107	Nursing Staff New Employee Orientations (all)	OIG Inspector Onsite Review	• New employees (within the last 12 months)

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

August 1, 2016

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

Dear Mr. Barton:

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

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

Sincerely,

Janet Lewis

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

cc: Clark Kelso, Receiver
Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
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