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Office of the Inspector General

Deuel Vocational Institution
Medical Inspection Results
Cycle 5

January 2019

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

Office of the Inspector General
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Medical Inspection Results
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FOREWORD

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

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.

In Cycle 5, for the first time, the OIG will be inspecting institutions delegated back to CDCR from the Receivership. There is no difference in the standards used for assessment of a delegated institution versus an institution not yet delegated. At the time of the Cycle 5 inspection of Deuel Vocational Institution, the Receiver had not delegated this institution back to CDCR.

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

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EXECUTIVE SUMMARY

The OIG completed the Cycle 5 medical inspection of Deuel Vocational Institution (DVI) in November 2018. The vast majority of our inspection findings were based on DVI's health care delivery between March 2017 and December 2017. Our policy compliance inspectors performed an onsite inspection in December 2017. After reviewing the institution's health care delivery, our case review clinicians performed an onsite inspection in September 2018 to follow up on their findings.

OVERALL RATING:

Inadequate

Our clinician team, consisting of expert physicians and nurse consultants, reviewed cases (patient medical records) and interpreted our policy compliance results to determine the quality of health care the institution provided. Our compliance team, consisting of registered nurses, monitored the institution's compliance with its medical policies by answering a predetermined set of policy compliance questions.

Our clinician team reviewed 54 cases that contained 670 patient-related events. Our compliance team tested 92 policy questions by observing DVI's processes and examining 404 patient records and 1,182 data points. We distilled the results from both the case review and compliance testing into 13 health care indicators and have listed the individual indicators and ratings applicable for this institution in the *DVI Executive Summary Table* on the following page. Notably, DVI's OHU was largely non-operational during our review period. We did not rate DVI's *Specialized Medical Housing* indicator for Cycle 5. Our experts made a considered and measured opinion that the overall quality of health care at DVI was *inadequate*.

DVI Executive Summary Table

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

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

Expert Clinician Case Review Results

Our expert clinicians reviewed cases of patients with many medical needs and included a review of 670 patient care events.[1] The vast majority of our case review covered the period between April 2017 and February 2018. As depicted on the executive summary table on page *iv*, we rated 10 of the 13 indicators applicable to DVI. Of those ten applicable indicators, we rated seven *adequate* and three *inadequate.* When determining the overall adequacy of care, we paid particular attention to the clinical nursing and provider quality indicators, as adequate health care staff can sometimes overcome suboptimal compliance (i.e., performance with processes and programs). However, the opposite is not true; inadequate health care staff cannot provide adequate care, even though the established processes and programs may be adequate. We identified inadequate medical care based on the risk of significant harm to the patient, not the actual outcome.

Program Strengths — Clinical

- DVI managers scheduled two types of morning huddles. The first huddle was interdisciplinary and facilitated the transmission of important clinical information between different departments and various medical staff, as well as within the provider group. The second huddles were smaller, provider-based, and helped staff efficiently deliver care on a daily basis.

- Health care leadership provided good support to the medical staff. During the onsite interviews, all of the providers expressed excellent job satisfaction and good morale.

Program Weaknesses — Clinical

- Compared to Cycle 4, sick call performance worsened significantly. Nurses failed to properly review sick call requests and assess their patients. Nurses made inappropriate decisions that resulted in incomplete assessments, improper interventions, and lapses in care for patients with potentially emergent conditions. Sometimes these lapses caused a complete lack of health services altogether.

- Nurses often recorded incomplete, conflicting, and erroneous entries for their emergency and TTA encounters. Nurses consistently neglected to enter the time they carried out critical assessments or interventions. Because of these errors, we often experienced difficulty determining the effectiveness of care and the condition of the patients we reviewed.

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

- Nurses did not ensure continuity of care for patients arriving at DVI from other CDCR institutions and did not sufficiently assess patients that were transferring out to other institutions. Nurses often failed to conduct a face-to-face assessment for urgent or emergent needs prior to their patients boarding the transfer bus.

Compliance Testing Results

Of the 13 health care indicators applicable to DVI, compliance inspectors evaluated 10.[2] Of these, two were *proficient*, three were *adequate*, and five were *inadequate*. The vast majority of our compliance testing was of medical care that occurred between March 2017 and December 2017. There were 92 individual compliance questions within those 10 indicators, generating 1,182 data points that tested DVI's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[3] *Appendix A — Compliance Test Results* provides details for the 92 questions.

Program Strengths — Compliance

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

- The institution performed well in offering immunizations and providing preventive services for their patients, such as influenza vaccination, annual testing for tuberculosis (TB), and colorectal cancer screenings.
- DVI did well providing TB medications and monitoring patients taking TB medications timely.
- DVI staff timely and accurately scanned medical records into patient files.
- The institution's staff were excellent in providing specialty services, and providers reviewed high-priority specialty service reports timely.

Program Weaknesses — Compliance

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

- DVI providers did poorly in reviewing radiology and laboratory services. Providers also did not timely communicate radiology, laboratory, and pathology results to their patients.

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

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

- Patients arriving from other CDCR institutions did not receive ordered medications timely.
- Staff failed to list scheduled specialty service appointments on health care transfer forms (CDCR Form 7371) for patients who transferred out of DVI.
- DVI's medication lines did not follow proper security controls over narcotic medications. The institution also did not properly store non-narcotic medications that required and did not require refrigeration.
- DVI clinicians did not follow hand hygiene precautions before or after patient encounters.
- DVI's medical warehouse had multiple medical supplies that were expired.

Recommendations

The OIG recommends the following:

- The chief executive officer (CEO) should ensure all providers and nurses have access to any images and reports stored in the radiology information system-picture archive and communication system (RIS-PACS). During our inspection, we found that most of DVI's staff members were unable to access this important information.
- The pharmacist in charge (PIC) and the chief nursing executive (CNE) should implement quality improvement processes to correct the numerous medication continuity problems we found in this inspection, including issues with chronic care, hospital, reception center, and other transfer medications.
- The CNE should evaluate and improve DVI's current nursing sick call process because of the prevalence and severity of the errors we found in this inspection. The CNE should consider assigning clinic nurses, rather than TTA nurses, the responsibility of reviewing their own sick call requests and making their own triage decisions. The CNE should also consider having the staff review the sick call requests at a time other than the middle of the night when patients are reluctant to awaken for a medical evaluation. We have found the best sick call practices occur when sick call nurses review the requests before the clinic day begins. In this way, the sick call nurses can prioritize their own appointments accordingly and have an opportunity to discuss the requests during the huddles. Furthermore, patients are more likely to come to an evaluation during normal daytime hours.
- The CNE should also expand improvement efforts to advance the quality of nursing assessments and interventions in several areas, including sick call requests, transfers-in, transfers-out, and hospital returns. These efforts should include additional nurse training and monitoring.

- The CNE should implement additional training and monitoring for first medical responders and TTA nurses to ensure they accurately record the time and sequence of their assessments and interventions in accordance with the actual event.

Population-Based Metrics

In general, DVI performed comparably to other health plans as measured by population-based metrics. In comprehensive diabetes care, DVI outperformed most state and national health care plans in the five diabetic measures. However, DVI scored lower than three health care plans for diabetic eye exams, blood pressure monitoring, and blood pressure control.

With regard to immunization measures, DVI scored higher than all other health care plans for influenza immunizations for older adults but scored lower than all health care plans for immunizations for younger adults. However, the institution's score for pneumococcal immunizations was higher than two health care plans. DVI scored higher than all health care plans for colorectal cancer screening.

INTRODUCTION

Pursuant to California Penal Code Section 6126 et seq., which assigns the Office of the Inspector General (OIG) responsibility for oversight of the California Department of Corrections and Rehabilitation (CDCR), and at the request of the federal Receiver, the OIG developed a comprehensive medical inspection program to evaluate the delivery of medical care at each of CDCR's 35 adult prisons. The OIG conducted a clinical case review and a compliance inspection, ensuring a thorough, end-to-end assessment of medical care within CDCR.

Deuel Vocational Institution (DVI) was the 34th medical inspection of Cycle 5. During the inspection process, the OIG assessed the delivery of medical care to patients using the primary clinical health care indicators applicable to the institution. The *Administrative Operations* indicator is secondary because it does not reflect the actual clinical care provided.

ABOUT THE INSTITUTION

Opened in 1953, Deuel Vocational Institution (DVI) is located in the city of Tracy in San Joaquin County. DVI provides housing, programs, and services for general population and sensitive needs high-security (Level IV) and sensitive needs medium-security (Level III) patients. Besides providing housing for custody levels I and II general population patients, DVI also functions as a reception center, receiving patients from 29 northern California counties.

The institution operates several medical clinics where health care staff members handle routine requests for medical services. In addition, DVI operates a triage and treatment area (TTA) for urgent and emergent patient care, a receiving and release (R&R) clinic for assessment of arriving and departing patients, and a specialty clinic. The institution also treats patients requiring assistance with the activities of daily living in the outpatient housing unit (OHU), but the OHU was non-operational for most of the Cycle 5 review period.

CCHCS has designated DVI a "basic" care institution. Basic institutions are in rural areas away from tertiary care centers and specialty care providers whose services would likely be used by higher-risk patients. Basic institutions can provide limited specialty services and consultation for a generally healthier patient population.

Based on staffing data the OIG obtained from CCHCS as identified in the following *DVI Health Care Staffing Resources as of November 2017* table, DVI had 4.7 nurse vacancies. At the time of the OIG's inspection, DVI had four nursing staff on extended leave.

DVI Health Care Staffing Resources as of November 2017

	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff**	Total
Authorized Positions	5.00	7.00	10.50	101.40	123.90
Filled by Civil Service	5.00	7.00	10.50	96.70	119.20
Vacant	0.00	0.00	0.00	4.70	4.70
Percent Filled by Civil Service	100.00%	100.00%	100.00%	95.36%	96.21%
Filled by Telemed	0.00	0.00	0.00	0.00	0.00
Percent Filled by Telemed	0.00%	0.00%	0.00%	0.00%	0.00%
Filled by Registry	0.00	0.88	0.00	3.63	4.51
Percent Filled by Registry	0.00%	12.57%	0.00%	3.58%	3.64%
Total Filled Positions	5.00	7.88	10.50	100.33	123.71
Total Percentage Filled	100.00%	112.57%	100.00%	98.94%	99.85%
Appointments in last 12 Months	2.00	1.00	0.00	19.00	22.00
Redirected Staff	0.00	0.00	0.00	1.00	1.00
Staff on Extended Leave^	0.00	0.00	0.00	4.00	4.00
Adjusted Total: Filled Positions	5.00	7.88	10.50	95.33	118.71
Adjusted Total: Percentage Filled	100.00%	112.57%	100.00%	94.01%	95.81%

*Executive Leadership includes Chief Physician & Surgeon
**Nursing Staff includes Sr Psych Tech/Psych Tech
^In Authorized Positions

Note: The OIG did not validate the DVI Health Care Staffing Resources and Filled Positions data.

As of December 2017, the Master Registry for DVI showed that the institution had a total population of 2,211. Within that total population, 1.6 percent was designated as high medical risk, Priority 1 (High 1), and 4.8 percent was designated as high medical risk, Priority 2 (High 2). Patients' assigned risk levels are based on the complexity of their required medical care related to their specific diagnoses, frequency of higher levels of care, age, and abnormal laboratory results and procedures. High 1 has at least two high-risk conditions; High 2 has only one. Patients at high medical risk are more susceptible to poor health outcomes than those at medium or low medical risk. Patients at high medical risk also typically require more health care services than do patients with lower assigned risk levels. The table below illustrates the breakdown of the institution's medical risk levels at the end of the Cycle 5 review period.

DVI Master Registry Data as of December, 2017

Medical Risk Level	Number of Patients	Percentage
High 1	36	1.6%
High 2	106	4.8%
Medium	1,293	58.5%
Low	776	35.1%
Total	**2,211**	**100%**

OBJECTIVES, SCOPE, AND METHODOLOGY

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

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

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

The OIG does not inspect for efficiency or cost-effectiveness of medical operations. Consistent with the OIG's agreement with the Receiver, this report only addresses the quality of CDCR's medical operations and its compliance with quality-related policies. Moreover, if the OIG learns of a patient needing immediate care, the OIG notifies the chief executive officer of health care services and requests a status report. Additionally, if the OIG learns of significant departures from community standards, it may report such departures to the institution's chief executive officer or to CCHCS. Because these matters involve confidential medical information protected by state and federal privacy laws, the OIG does not include specific identifying details related to any such cases in the 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 are not necessarily indicative of deficient medical care delivery.

CASE REVIEWS

The OIG added case reviews to the Cycle 4 medical inspections at the recommendation of its stakeholders, which continues in the Cycle 5 medical inspections. The following exhibit provides definitions that describe this process.

Exhibit 1. Case Review Definitions

Case = Sample = Patient
An appraisal of the medical care provided to one patient over a specific period, which can comprise detailed or focused case reviews.

Detailed Case Review
A review that includes all aspects of one patient's medical care assessed over a six-month period. This review allows the OIG clinicians to examine many areas of health care delivery, such as access to care, diagnostic services, health information management, and specialty services.

Focused Case Review
A review that focuses on one specific aspect of medical care. This review tends to concentrate on a singular facet of patient care, such as the sick call process or the institution's emergency medical response.

Case Review Event
A direct or indirect interaction between the patient and the health care system. Examples of direct interactions include provider encounters and nurse encounters. An example of an indirect interaction includes a provider reviewing a diagnostic test and placing additional orders.

Case Review Deficiency
A medical error in procedure or in clinical judgment. Both procedural and clinical judgment errors can result in policy non-compliance, elevated risk of patient harm, or both.

Adverse Deficiency
A medical error that increases the risk of, or results in, serious patient harm. Most health care organizations refer to these errors as *adverse events*.

The OIG's clinicians perform a retrospective case review of selected patient files to evaluate the care given by an institution's primary care providers and nurses. Retrospective case review is a well-established review process used by health care organizations that perform peer reviews and patient death reviews. Currently, CCHCS uses retrospective case review as part of its death review process and in its pattern-of-practice reviews. CCHCS also uses a more limited form of retrospective case review when performing appraisals of individual primary care providers.

Patient Selection for Retrospective Case Reviews

Because retrospective case review is time consuming and requires qualified health care professionals to perform it, the OIG must carefully select a sample of patient records for clinician review. Accordingly, the group of patients the OIG targeted for case review carried the highest clinical risk and utilized the majority of medical services. The majority of patients selected for retrospective case review were high-utilizing patients with chronic care illnesses who were classified as high or medium risk. The reason the OIG targeted these patients for review is twofold:

1. The goal of retrospective case 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 is high-risk and accounts for more than half of the institution's pharmaceutical, specialty, community hospital, and emergency costs.

2. Selecting this target group for case 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 is more likely to provide 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 cases generated during death reviews, sentinel events (unexpected occurrences involving death or serious injury, or risk thereof), and hospitalizations are more likely to comprise high-risk patients.

Benefits and Limitations of Targeted Subpopulation Review

Because the patients selected utilize the broadest range of services offered by the health care system, the OIG's retrospective case review provides adequate data for a qualitative assessment of the most vital system processes (referred to as "primary quality indicators"). Retrospective case 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 institution's ability to *respond* with adequate medical 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 *respond* adequately 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.

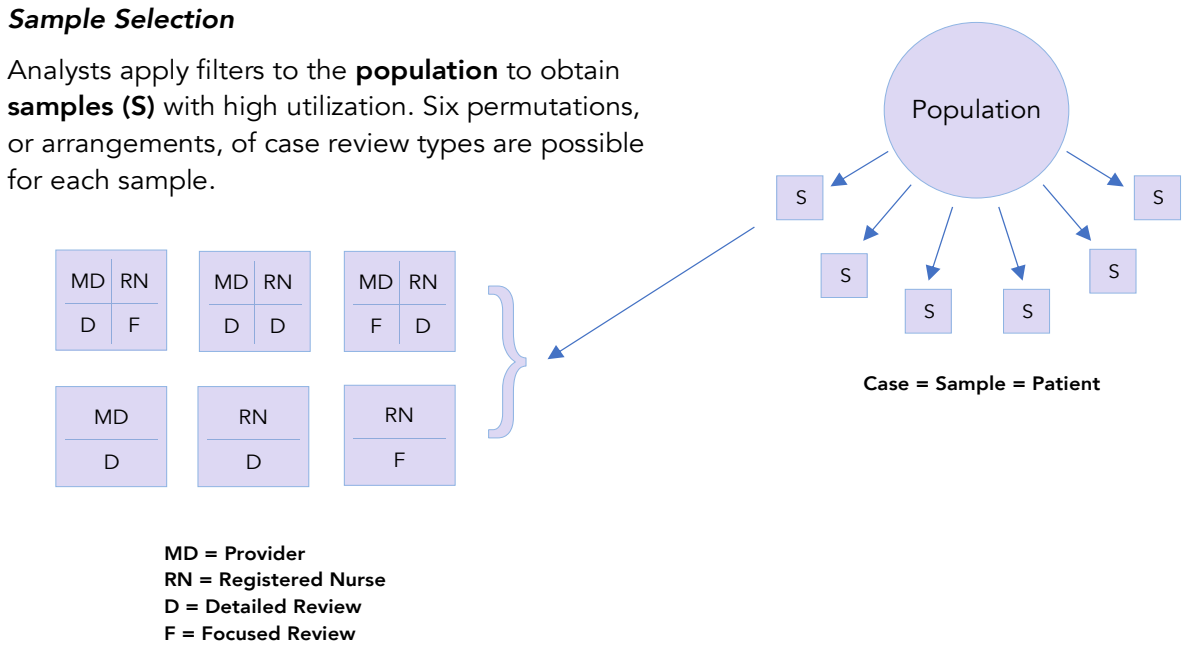
Since the targeted subpopulation does not represent the institution's general prison population, the OIG cautions against inappropriate extrapolation of medical *conditions* or *outcomes* from the retrospective case reviews to the general population. For example, if the high-risk diabetic patients reviewed have poorly controlled diabetes, one cannot conclude that all the diabetics' conditions are poorly controlled. Similarly, if the high-risk diabetic patients under review have poor outcomes, one cannot conclude that the entire diabetic population is having similarly poor outcomes. The OIG does not extrapolate *conditions* or *outcomes*, but instead extrapolates the institution's *response* for those patients needing the most care because the *response* yields valuable system information.

In the above example, if the institution responds by providing appropriate diabetic monitoring, medication therapy, and specialty referrals for the high-risk patients reviewed, then it is reasonable to infer that the institution is also responding appropriately to all the diabetics in the prison. However, if these same high-risk patients needing monitoring, medications, and referrals are not getting those needed services, it is likely that the institution is not providing appropriate diabetic services.

Case Review Sampling Methodology

Using a pre-defined case review sampling algorithm, OIG analysts apply various filters to each institution's patient population. The various filters include medical risk status, number of prescriptions, number of specialty appointments, number of clinic appointments, and other health-related data. The OIG uses these filters to narrow down the population to those patients with the highest utilization of medical resources (see Chart 1, next page). To prevent selection bias, the OIG ensures that the same clinicians who perform the case reviews do not participate in the sample selection process.

Chart 1. Case Review Sample Selection



The OIG's case sample sizes matched those of other qualitative research. The empirical findings, supported by expert statistical consultants, showed adequate conclusions after 10 to 15 cases had undergone comprehensive, or detailed, clinician review. In qualitative statistics, this phenomenon is known as "saturation." The OIG found the Cycle 4 medical inspection sample size of 30 for detailed physician reviews far exceeded the saturation point necessary for an adequate qualitative review. At the end of Cycle 4 inspections, the OIG re-analyzed the case review results using half the number of cases; there were no significant differences in the ratings. To improve inspection efficiency while preserving the quality of the inspection, the OIG reduced the number of the samples for Cycle 5 medical inspections to the current levels. For most basic institutions, the OIG samples 20 cases for detailed physician review. For intermediate institutions and several basic institutions with larger high-risk populations, the OIG samples 25 cases. For California Health Care Facility, the OIG samples 30 cases for detailed physician review.

Breadth of Case Reviews

As indicated in *Appendix B, Table B-1: DVI Sample Sets*, the OIG clinicians evaluated medical records for 54 unique cases. *Appendix B, Table B-4: DVI Case Review Sample Summary* clarifies that both nurses and physicians reviewed 12 of those cases, for 66 case reviews in total. Physicians performed detailed reviews of 20 cases, and nurses performed detailed reviews of 13 cases, totaling 33 detailed case reviews. Physicians and nurses also performed a focused review

of an additional 33 cases, while physicians performed a focused review for no additional cases. These reviews generated 670 case review events (*Appendix B, Table B-3: DVI Event – Program*).

While the sample method specifically pulled only 6 chronic care cases, i.e., 3 diabetes cases and 3 anticoagulation cases (*Appendix B, Table B-1: DVI Sample Sets*), the 54 unique cases sampled included 163 chronic care diagnoses, including 9 additional cases with diabetes (for a total of 12) and no additional anticoagulation cases (for a total of 3) (*Appendix B, Table B-2: DVI Chronic Care Diagnoses*). The OIG's sample selection tool allowed evaluation of many chronic care programs because the complex and high-risk patients selected from the different categories often had multiple medical problems. While the OIG did not evaluate every chronic disease or health care staff member, the OIG did assess for adequacy the overall operation of the institution's system and staff.

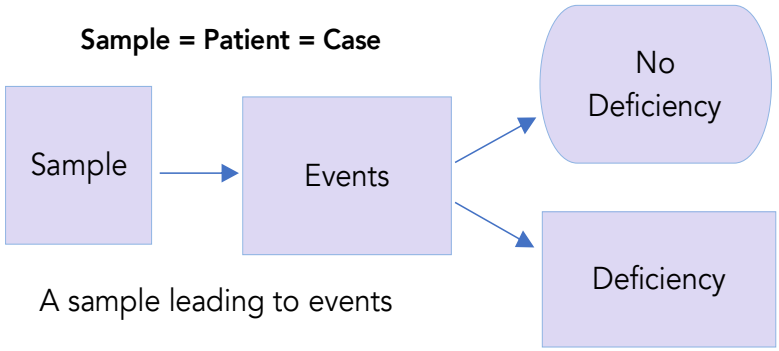
Case Review Testing Methodology

A physician, a nurse consultant, or both clinician inspectors review each case. The OIG clinician inspector can perform one of two different types of case review: detailed or focused (see Exhibit 1, page 5, and Chart 1, page 8). As the OIG clinician inspector reviews the medical record for each sample, the inspector records pertinent interactions between the patient and the health care system. These interactions are also known as case review *events*. When an OIG clinician inspector identifies a medical error, the inspector also records these errors as case review *deficiencies.* If a deficiency is of such magnitude that it caused, or had the potential to cause, serious patient harm, then the OIG clinician records it as an *adverse deficiency* (see Chart 2, next page).

Chart 2. Case Review Testing and Deficiencies

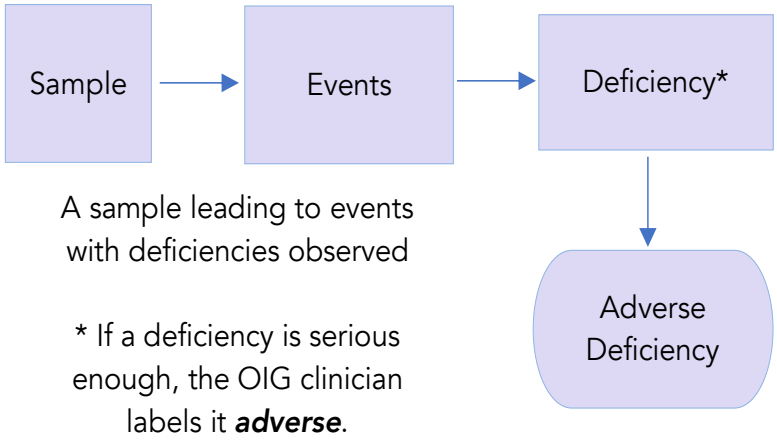
Case Review Testing

The OIG clinicians examine the chosen samples, performing a **detailed case review** or a **focused case review**, to determine the events that occurred.



Deficiencies

Not all events lead to deficiencies (medical errors); however, if there are errors, then the OIG clinicians determine whether any are **adverse**.



When the OIG clinician inspectors have reviewed all cases, they analyze the deficiencies. OIG inspectors search for similar types of deficiencies to determine if a repeating pattern of errors existed. When the same type of error occurs multiple times, the OIG inspectors identify those errors as findings. When the error is frequent, the likelihood is high that the error is regularly recurring at the institution. The OIG categorizes and summarizes these deficiencies in one or more health care quality indicators in this report to help the institution focus on areas for improvement.

Additionally, the OIG physicians also rate each of the detailed physician cases for adequacy based on whether the institution met the patient's medical needs and if it placed the patient at significant risk of harm. The cumulative analysis of these cases gives the OIG clinicians additional perspective to help determine whether the institution is providing adequate medical services or not.[4]

Based on the collective results of clinicians' case reviews, the OIG clinicians rated each quality indicator *proficient* (excellent), *adequate* (passing), or *inadequate* (failing). A separate confidential *DVI Supplemental Medical Inspection Results: Individual Case Review Summaries* report details the case reviews the 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*.

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[4] Regarding individual provider performance, the OIG did not design the medical inspection to be a focused search for poorly performing providers; rather, the inspection assesses each institution's systemic health care processes. Nonetheless, while the OIG does not purposefully sample cases to review each provider at the institution, the cases usually involve most of the institutions' providers. Providers should only escape OIG case review if institutional managers assigned poorly performing providers the care of low-utilizing and low-risk patients, or if the institution had a relatively high number of providers.

COMPLIANCE TESTING

Sampling Methods for Conducting Compliance Testing

Our registered nurse inspectors 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 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 404 individual patients and analyzed specific transactions within their records for evidence that critical events occurred. Inspectors also reviewed management reports and meeting minutes to assess certain administrative operations. In addition, during the week of December 11, 2017, registered nurse field inspectors conducted a detailed onsite inspection of DVI's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,182 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 DVI'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

After compiling the answers to the 92 questions for the 10 indicators for which compliance was applicable, the OIG derived a score for each quality indicator by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Based on those results, the OIG assigned a rating to each quality indicator of *proficient* (greater than 85 percent), *adequate* (between 75 percent and 85 percent), or *inadequate* (less than 75 percent).

OVERALL QUALITY INDICATOR RATING FOR CASE REVIEWS AND COMPLIANCE TESTING

The OIG derived the final rating for each quality indicator by combining the ratings from the case reviews and from the compliance testing, as applicable. When combining these ratings, the case review evaluations and the compliance testing results usually agreed, but there were instances for this inspection when the rating differed for a particular quality indicator. In those

instances, the inspection team assessed the quality indicator based on the collective ratings from both components. Specifically, the OIG clinicians and registered nurse inspectors discussed the nature of individual exceptions found within that indicator category and considered the overall effect on the ability of patients to receive adequate medical care.

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

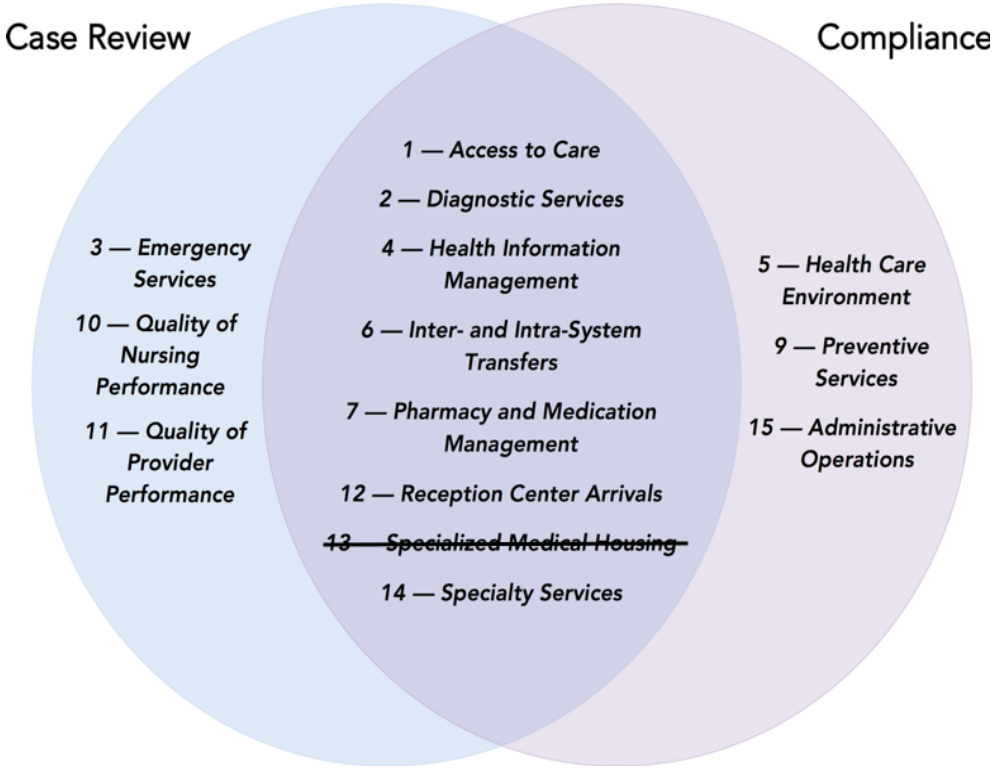
POPULATION-BASED METRICS

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

MEDICAL INSPECTION RESULTS

The OIG's case review and clinician teams use quality indicators to assess the clinical aspects of health care. The *DVI Executive Summary Table* on page *iv* of this report identifies the 13 indicators applicable to this institution. The following chart depicts their union and intersection:

Chart 3. Inspection Indicator Review Distribution



For Cycle 5, the institution's OHU was non-operational for the majority of our review period. While we did sample a small number of patient records in this category, we did not have sufficient data to reliably rate this area. For Cycle 5, the *Specialized Medical Housing* indicator rating was not applicable.

The *Administrative Operations* indicator is a secondary indicator; therefore, the OIG did not rely upon this indicator when determining the institution's overall score. Based on the analysis and results in all the primary indicators, the OIG experts made a considered and measured opinion that the quality of health care at DVI was ***inadequate***.

Summary of Case Review Results: The clinical case review component assessed 10 of the 13 health care indicators applicable to DVI. Of these ten indicators, OIG clinicians rated seven *adequate* and three *inadequate*.

The OIG physicians rated the overall adequacy of care for each of the 20 detailed case reviews they conducted. Of these 20 cases, 1 was *proficient*, 15 were *adequate*, and 4 were *inadequate*. In the 670 events reviewed, there were 165 deficiencies, 51 of which were considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

Adverse Deficiencies Identified During Case Review: Adverse deficiencies are medical errors that markedly increased the risk of, or resulted in, serious patient harm. Medical care is a complex and dynamic process with many moving parts, subject to human error even within the best health care organizations. All major health care organizations typically identify and track adverse deficiencies for the purpose of quality improvement. Adverse deficiencies are not typically representative of medical care delivered by the organization. The OIG normally identifies adverse deficiencies for the dual purposes of quality improvement and the illustration of problematic patterns of practice found during the inspection. Because of the anecdotal nature of these deficiencies, the OIG cautions against drawing inappropriate conclusions regarding the institution based solely on adverse deficiencies. The OIG identified four adverse deficiencies in the case reviews at DVI:

- In case 13, the patient had a chronic open wound on his leg, which still had not healed after nurses finished the initial order for wound care. The nurse failed to obtain an order to extend the care, and instead stopped giving wound care. As a result, the patient's wound became re-infected five days later. We also discuss this case in the *Quality of Nursing Performance* indicator.

- In case 17, the patient had an episode of dizziness, low blood pressure, and an abnormally fast heart rate. The TTA nurse inappropriately discharged the patient back to general housing without informing the provider of the patient's unstable condition. Due to the inappropriate nursing care, the patient sustained a fall from a repeat episode of low blood pressure and tachycardia. The patient required hospitalization for dehydration and an irregular heart rhythm. This hospitalization may have been prevented if the TTA nurse had notified the physician during the patient's first TTA visit. We also discuss this case in the *Emergency Services* indicator.

- Also in case 17, the patient was unstable when he returned from his hospitalization for dehydration and loss of consciousness. When he arrived at the institution, he again had low blood pressure and an abnormally fast heart rate. Instead of holding the patient in the TTA for close monitoring to determine if he needed to be transferred back to the hospital, medical staff inappropriately discharged him to his general housing unit. We also discuss this case in the *Inter- and Intra-System Transfers* indicator.

- In case 48, the nurse reviewed a patient's sick call request for coughing up blood. The patient had head and neck cancer with a left tonsil mass and was at increased risk of bleeding. The nurse who initially reviewed the patient's request should have seen this potentially high-risk patient immediately because the patient's symptoms could have represented an emergent, life-threatening condition. Instead, the nurse deferred the assessment until the following day. Fortunately, the nurse's initial delay did not result in any harm. The following day, the nurse contacted the provider who found blood collecting at the back of the patient's throat and sent him to the hospital. We also discuss this case in the *Quality of Nursing Performance* indicator.

Summary of Compliance Results: The compliance component assessed 10 of the 13 indicators applicable to DVI. Of these ten indicators, OIG inspectors rated two *proficient*, three *adequate*, and five *inadequate*. Each section of this report summarizes the results of those assessments, whereas *Appendix A* provides the details of the test questions used to assess compliance for each indicator.

1 — *ACCESS TO CARE*

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

Case Review Rating:
Adequate
Compliance Score:
Adequate
(77.2%)

Overall Rating:
Adequate

Case Review Results

We reviewed 347 provider, nursing, specialty, and hospital encounters and identified 28 deficiencies related to access to care, of which 11 were significant. The case review rating for this indicator was *adequate.*

Provider-to-Provider Follow-up Appointments

DVI continued to perform well with provider-ordered follow-up appointments since Cycle 4. Failure to ensure appointment availability can result in lapses in care, which was an infrequent problem at DVI, occurring only in cases 10, 11, 45, and the following case:

- In case 18, the provider ordered a follow-up appointment for the patient for two to three weeks, but the appointment did not occur for more than two months.

RN Sick Call Access

Patient access to RN sick call was often delayed at DVI. Current CCHCS policy requires that nurses assess their patients the first business day following review of the patient's health care services request form. Failure to promptly assess patients who submit requests can place patients at undue risk of harm. Delays in RN sick call access occurred in cases 13, 32, 35, 43, 44, 49, 56, and the two following cases:

- In case 4, the patient was experiencing problems with his ankle. The nurse did not assess the patient until three business days after reviewing the patient's request.
- In case 30, the newly-arrived patient had problems with dizziness and mobility. The nurse did not assess the patient until two business days after reviewing the patient's request.

Nurse-to-Provider Referrals

Nurses make referrals to providers for follow-up appointments with patients who require additional evaluation or treatment. We found problems related to nurse-initiated provider referrals in cases 9, 40, and in the following case:

- In case 35, the nurse referred the patient to the provider for pain and a possible lump in his collarbone area. These referrals should occur within 14 days. However, the nurse did not place the order and the provider follow-up appointment never occurred, resulting in a lapse in care.

Nurse Follow-up Appointments

Nurse follow-up appointments, whether initiated by providers or nurses, generally occurred timely. We found only one minor deficiency (case 50).

Provider Follow-Up After Specialty Service

DVI consistently provided patients with a provider follow-up appointment after specialty services. We reviewed 49 diagnostic and consultative specialty services and found all provider follow-up appointments occurred in a timely manner, with only one exception (case 14).

Reception Center and Intra-System Transfers

DVI had problems ensuring timely access for newly-arrived patients from county jails. We found a pattern of poor access for these patients in the following cases:

- In case 17, the newly-arrived patient had impaired mobility. The reception center nurse ordered a two-week provider follow-up appointment, but it was inappropriately cancelled ten days after the patient's arrival. A provider did not evaluate the patient for nearly two months, which was a serious lapse in care.

- In cases 29, 34, and 50, the patients should have been scheduled to see a provider within 7 days of their arrival to DVI, but their appointments were delayed by 1 to 12 days.

Follow-up After Hospitalization

DVI usually ensured patients received prompt provider follow-up appointments after patients returned from an outside hospital or an emergency department. We found only one deficiency in which the provider failed to see the patient as required:

- In case 13, the patient was treated for a wound at an offsite emergency department. When the patient returned to DVI, the TTA nurse ordered a provider follow-up appointment to occur in three to five days. The patient was not evaluated by a provider until 12 days later, a lapse that increased the risk of wound complications.

Follow-up After Urgent/Emergent Care

DVI usually scheduled provider follow-up appointments appropriately for patients being released from the TTA. The OIG clinicians reviewed 26 TTA encounters, 12 of which required provider or nurse follow-up appointments. All appointments occurred within the specified time frame, except in the following case:

- In case 51, the TTA nurse referred the patient who had significant pain in his left foot and swelling in both feet for a follow-up evaluation by the provider within seven days. The appointment never occurred; however, one month later, the provider evaluated the patient for a different reason.

Specialty Access and Follow-up

DVI performed well with ensuring patients had appropriate access to specialty services. We also discuss this performance in the *Specialty Services* indicator.

Clinician Onsite Inspection

In September 2018, during the time of the onsite inspection, our clinicians learned that DVI had approximately eight hundred mainline patients and one thousand reception center patients, with no backlog of provider appointments in either clinic. DVI was nearly fully staffed and had a number of highly experienced providers. Some providers worked at DVI for more than ten years, often in the same clinic. This consistency in providers ensured patients had continuity of care and allowed patients the benefit of having providers with a wealth of clinical correctional experience. There were six providers working full time in the clinics, with each provider seeing an average of 11 to 14 patients per day. DVI had recently hired a seventh provider who was scheduled to start in several weeks. The institution had also recently improved their reception center access to care by scheduling a provider to work on the weekends, decreasing the wait time for newly-arrived patients to see a provider.

Case Review Conclusion

Although DVI performed well with access to care in most areas, access to sick call nurses was extremely poor. There were numerous delays in sick call nurse evaluations, which we did not see in Cycle 4. The sick call process is a vital component in patient care and requires timely evaluations to provider care without delay. We discuss this issue further in the *Quality of Nursing Performance* indicator. Nonetheless, performance in most other areas of access to care was acceptable. Overall, we rated this indicator *adequate.*

Compliance Testing Results

The institution performed in the *adequate* range, with a score of 77.2 percent in the *Access to Care* indicator. The following tests earned scores in the *proficient* range:

- Nursing staff reviewed all 30 sampled patients' health care services request forms on the same day they collected them (MIT 1.003).
- Both sampled patients nursing staff referred to a provider and for whom the provider subsequently ordered a follow-up appointment received timely appointments (MIT 1.006).
- Patients had access to health care services request forms at all six housing units we inspected (MIT 1.101).

One test received an *adequate* score:

- Of 25 sampled patients with chronic care conditions, 21 (84.0 percent) received timely follow-up appointments. For four patients, appointments were 3 to 169 days late (MIT 1.001).

The institution had room for improvement in the following test areas:

- Provider visits occurred timely for 17 of 25 sampled patients (68.0 percent) who either transferred into DVI with a pre-existing chronic care condition requiring a follow-up appointment or who received a referral upon arriving to the institution. For five patients, provider appointments were 5 to 74 days late. For one patient, the provider appointment was 258 days late. For two patients, a provider appointment did not occur (MIT 1.002).
- For 17 of the 30 sampled patients (56.7 percent) who submitted health care services request forms, nursing staff completed a face-to-face encounter within one business day of reviewing the request. For nine patients, the nurse conducted the visit between one and three days late. For two patients, nursing staff did not provide complete documentation. For the two remaining patients, a face-to-face encounter did not occur at all (MIT 1.004).
- Among ten sampled health care services request forms on which nursing staff referred the patient for a provider appointment, five patients (50.0 percent) received timely appointments. Four patients received appointments from 5 to 20 days late, and one other patient did not receive a provider appointment at all (MIT 1.005).
- We tested 24 patients who were discharged from a community hospital to determine whether they received a provider follow-up appointment within five calendar days of their return to DVI and found 16 patients (66.7 percent) received their provider follow-up appointment timely. Six other patients received their appointments from 1 to 19 days late. For the remaining two patients, a provider's appointment did not occur at all (MIT 1.007).
- Of 26 sampled patients who received a high-priority or routine specialty service, 18 (69.2 percent) received a timely provider follow-up appointment. Five patients received their high-priority specialty service follow-up appointments from 1 to 65 days late. Two patients with high-priority specialty services and one patient with a routine specialty service did not receive provider follow-up appointments at all (MIT 1.008).

2 — *DIAGNOSTIC SERVICES*

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(55.6%)
Overall Rating:
Adequate

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

For this indicator, the case review and compliance review processes yielded different results, with the case reviewers assigning an *adequate* rating and the compliance testing resulting in an *inadequate* score. Our compliance testing found that the providers did not properly sign their diagnostic reports and did not send acceptable patient letters to communicate those results to their patients. Nonetheless, our case review testing showed that the providers were usually aware of the diagnostic results and acted on them correctly. Since the problems we identified did not appear to significantly increase the risk of harm, we determined the overall rating for this indicator was *adequate*.

Case Review Results

We reviewed 129 diagnostic events and found 13 deficiencies, of which 4 were significant. Of those 13 deficiencies, 6 were related to health information management. There was only one occurrence when staff did not complete ordered tests. The case review rating for this indicator was *adequate.*

Test Completion

DVI improved their laboratory processes since the Cycle 4 inspection. In this inspection, the institution completed the majority of laboratory tests in a timely manner. DVI also promptly completed x-rays, ultrasounds, computer tomography (CT) scans, and magnetic resonance imaging (MRI) scans. We found only one significant test completion deficiency in which there was a delay in the collection of a laboratory test (case 8).

Health Information Management

DVI timely retrieved and scanned most laboratory reports, diagnostic reports, and pathology reports into the electronic medical record, except in the following case:

- In case 18, the patient developed acute hepatitis C (a viral infection of the liver) and received treatment at an offsite hospital. Medical records staff failed to retrieve and scan

important laboratory results into the patient's electronic medical record for nearly three months. As a result, the institution's providers did not diagnose or treat the patient's infection until he was transferred to a different institution. This was a major lapse in medical care because treatment for the patient's acute hepatitis C was significantly delayed.

Providers also did not consistently sign diagnostic reports timely. We found reports that were signed late or were not signed at all (cases 7, 13, 14, and 19).

Clinician Onsite Inspection

At the onsite inspection, we discovered that providers were able to access most onsite diagnostic reports through the electronic health record system (EHRS). However, the providers were unable to view x-rays in the radiology information system-picture archive and communication system (RIS-PACS). In addition, none of the providers were able to view any offsite diagnostic reports that had been scanned into the RIS-PACS. Several providers did not even have access to the RIS-PACS and explained they had to contact the specialty scheduler when they needed to review a diagnostic report that was not available on the EHRS. This workaround process was inefficient and increased the risk of lapses in care for patients whose reports were stored in the RIS-PACS. All DVI providers should have direct and functioning access to RIS-PACS to view onsite and offsite diagnostic images and reports whenever they deem it necessary to do so.

Case Review Conclusion

DVI completed most diagnostic tests in a timely and efficient manner. Compared to Cycle 4, DVI improved its performance with completing laboratory tests appropriately. However, DVI providers were unable to access reports stored in the RIS-PACS. This problem presented a barrier, especially in the processing of offsite diagnostic reports, which were predominantly stored in the RIS-PACS. The workaround process of contacting the specialty scheduler for these reports was not only inefficient, but also interfered with patient care since these reports were not available at scheduled provider visits with patients. However, we rated this indicator *adequate* overall, as we saw some improvements in diagnostic services compared to Cycle 4.

Compliance Testing Results

The institution received an *inadequate* compliance score of 55.6 percent in the *Diagnostic Services* indicator, which encompasses radiology, laboratory, and pathology services. For clarity, we discuss each type of diagnostic service separately below:

Radiology Services

- DVI timely performed radiology services for nine of ten sampled patients (90.0 percent). For one patient, the institution received his radiology test one day late (MIT 2.001). Providers then timely reviewed the corresponding diagnostic services reports for five of the ten patients (50.0 percent). For two patients, providers reviewed their diagnostic reports from 1

to 27 days late. For the remaining three patients, we found no evidence that providers reviewed their reports (MIT 2.002). Providers timely communicated test results to only one of ten patients (10.0 percent). For six patients, providers communicated their radiology results from 1 to 27 days late. For the remaining three patients, providers did not communicate the results at all (MIT 2.003).

Laboratory Services

- Eight of ten sampled patients (80.0 percent) received their provider-ordered laboratory services timely. For two patients, the institution provided laboratory services one and two days late (MIT 2.004). Providers then timely reviewed seven of the ten laboratory services reports (70.0 percent). Providers reviewed three reports one to seven days late (MIT 2.005). Finally, providers timely communicated the results to only one of the ten patients (10.0 percent). For six patients, providers communicated the results between 13 to 46 days late. For three other patients, providers did not communicate the results at all (MIT 2.006).

Pathology Services

- The institution retrieved the final pathology report timely for seven of the nine patients sampled (77.8 percent). For two patients, the institution received their final pathology reports 30 and 31 days late (MIT 2.007). Providers then timely reviewed the pathology results for six of the eight patients sampled (75.0 percent). For two patients, providers reviewed their results one and four days late (MIT 2.008). Lastly, providers timely communicated the final pathology results to three of the eight patients sampled (37.5 percent). For four patients, providers communicated the pathology results from 4 to 19 days late. For the remaining one patient, the provider did not communicate the results at all (MIT 2.009).

3 — *EMERGENCY SERVICES*

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

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

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

Case Review Results

We reviewed 20 applicable cases and identified 18 deficiencies in various aspects of urgent and emergency medical care. Four deficiencies were significant and occurred in cases 4, 5, and 17. The case review rating for the *Emergency Services* indicator at DVI was *adequate*.

CPR Response

We reviewed emergency medical responses in four cases in which DVI staff performed CPR and found that staff responded quickly, intervened appropriately, and called 9-1-1 promptly. Custody staff did not delay CPR while waiting for medical staff to arrive. Overall, we found DVI's emergency response was good. For quality improvement purposes, the institution should review the following cases:

- In case 4, the first medical responder (FMR) did not administer supplementary oxygen before staff transported the patient to the TTA.
- In case 5, the nurse did not use the correct mask to deliver oxygen to an unresponsive patient during CPR. The nurse used an oxygen mask, which is specifically designed for patients with the ability to breath spontaneously without assistance. The nurse should have used a bag valve mask, which is specifically designed for patients unable to breath independently, to provide the patient with respirations and oxygen.

Nursing Performance

DVI nurses provided sufficient care for most of their patients with urgent or emergent conditions. Nurses usually performed assessments with sufficient depth and intervened

appropriately when needed; however, there were a few instances of errors in nursing assessment or intervention. In the majority of these instances, the nurses usually notified a provider promptly, which helped mitigate the potential harm from these errors. Nonetheless, for quality improvement purposes, the institution should review the following cases:

- In case 4, the FMR did not assess the severity of chest pain for the patient with chest pressure, dizziness, and very low blood pressure. When the patient arrived in the TTA, the TTA nurse gave the patient one dose of nitroglycerin (medication to decrease the patient's chest pain) and did not give the patient any additional doses when he continued to have chest pain. Also, the nurse did not monitor the patient's cardiac rhythm while he was in the TTA. Eventually, staff transferred the patient to an offsite hospital for evaluation of a possible heart attack.

- In case 17, the patient arrived at the TTA with very low blood pressure after falling and hitting his head in the shower. Although the patient had symptoms of dehydration and had abrasions and swelling of his head, the TTA nurse did not start fluid hydration until 90 minutes after the patient arrived at the TTA. The nurse also did not provide basic first aid wound treatment for the patient's head abrasions. The nurse did not notify the provider or schedule a follow-up appointment with the primary care team.

- In case 34, the TTA nurse evaluated the patient for a full body rash that had been present for a week. The nurse did not examine the patient's skin or reassess the patient after administering diphenhydramine (an antihistamine).

Nursing Documentation

The poor quality of nursing documentation for emergency medical services was a clear problem in many of the cases we reviewed. We found numerous cases with incomplete, inaccurate, and discrepant nursing entries for the timeline sequence of assessments and interventions provided during emergency medical response encounters. Nursing documentation deficiencies were identified in cases 13, 17, 34, and in the following cases:

- In case 1, the patient was unresponsive and was bleeding profusely from multiple stab wounds. The TTA nurse documented an insufficient description of the provided assessments and interventions, as well as an incomplete timeline sequence. The nurse did not document the methods used to control the patient's blood loss, the intravenous insertion site for fluid replacement, or the rate and quantity of intravenous fluids the nurse administered to the patient. Also missing from documentation was the time the staff used the automated external defibrillator to deliver an electrical shock.

- In case 4, the TTA nurse made numerous documentation errors and omissions. The nurse recorded the administration of two different dosages of chest pain medications and omitted the type and rate of intravenous fluids given. The nurse recorded that the patient was both stable and unstable when he transferred from the TTA to the hospital. The nurse's

documentation also contained numerous discrepancies to the timeline of events prior to and after the patient arrived at the TTA.

- In case 5, DVI staff found the patient in the shower unresponsive, lying in bloody water with multiple stab wounds to his head, neck, chest, and abdomen. The FMR did not record the reason the staff did not implement bleeding control measures or if the emergency response team continued to perform CPR on the way to the TTA.

Provider Performance

DVI providers performed satisfactorily in emergency services. The providers generally made appropriate assessments and correct decisions. However, several of the providers failed to record their patient encounters in the TTA. We saw this problem in cases 3, 4, 5, 13, 17, and 18.

Emergency Medical Response Review Committee

The Emergency Medical Response Review Committee (EMRRC) completed timely review of all unscheduled medical patients sent out for evaluation and treatment at community hospitals. The EMRRC identified many of the same deficiencies found by the OIG reviewers in the cases reviewed. For example, the EMRRC identified the need to provide additional training on accurate and thorough nursing documentation of emergency medical encounters in case 4 and the use of proper equipment in case 5, which were deficiencies we also noted in this indicator.

Clinician Onsite Inspection

The TTA was sufficiently stocked with the necessary medical equipment and supplies, which the institution's staff kept organized, clean, and maintained. The nurses verbalized knowledge and understanding of their roles and responsibilities in providing urgent and emergent care. The institution's nurse managers acknowledged their need to provide ongoing education, training, and monitoring to improve the nurses' documentation. To improve emergency response quality, nurse managers currently assign emergency roles and responsibilities each day during the interdisciplinary huddle when all team members are present. Some of these roles include code team leader, scribe, and intravenous line inserter.

Case Review Conclusion

DVI nurses and providers responded appropriately to emergency situations. Staff provided good CPR response and appropriate care in the TTA. While overall emergency care was good, we did find several areas in which there was room for improvement. Some of these areas included respiratory support during emergencies, nursing assessment, and provider and nurse documentation. We rated the *Emergency Services* indicator as *adequate*.

4 — *HEALTH INFORMATION MANAGEMENT*

Case Review Rating:
Adequate
Compliance Score:
Proficient
(85.2%)
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 medical record; whether the various medical records (internal and external, e.g., hospital and specialty reports and progress notes) are obtained and scanned timely into the patient's electronic medical record; whether records routed to clinicians include legible signatures or stamps; and whether hospital discharge reports include key elements and are timely reviewed by providers.

For this indicator, the case review and compliance review processes yielded different results, with the case reviewers assigning an *adequate* rating and the compliance testing resulting in a *proficient* score. Our case review testing showed that the providers had difficulty consistently signing diagnostic and specialty reports, and sometimes did not communicate diagnostic test results to their patients. Although there was room for improvement in these areas, the problems did not significantly increase the risk of harm. We determined the overall rating for this indicator was *adequate*.

During the OIG's testing period, DVI had converted to the new electronic health record system (EHRS) in March 2017; therefore, most testing occurred in the EHRS, with a minor portion of the testing done in the electronic unit health record (eUHR).

Case Review Results

The OIG clinicians reviewed 670 clinical events and found 19 deficiencies related to health information management. Of those 19 deficiencies, only 1 was significant. The overall rating for this indicator was *adequate*.

Inter-Departmental Transmission

We did not identify any problems when staff transmitted health information among the different medical departments within the institution.

Hospital Records

We reviewed 12 offsite emergency department and hospital visits. DVI timely retrieved, reviewed, and scanned the offsite records into the medical record. We found no deficiencies in this area.

Specialty Services

DVI timely retrieved and scanned specialty services reports into the medical record, except for one case (case 13). However, there was a mild pattern of providers failing to sign specialty reports or signing them late. We discuss these findings in detail in the *Specialty Services* indicator.

Laboratory, Diagnostic, and Pathology Reports

The institution timely retrieved and scanned laboratory results, diagnostic procedure reports, and pathology reports into the medical records. However, providers sometimes did not sign or communicate these results to their patients correctly. These findings are detailed in the *Diagnostic Services* indicator.

Urgent/Emergent Records

DVI's on-call providers performed poorly in documenting their TTA encounters with patients. Poor documentation persisted regardless of when the encounter occurred, during regular work hours or during the after-hours on-call period. We also discuss these findings in the *Quality of Provider Performance* indicator.

Scanning Performance

DVI performed satisfactorily in this area following the institution's transition to the EHRS. We did not find any mislabeled documents or documents with incorrect dates during the review process.

Legibility

Overall legibility was good following DVI's transition to the EHRS.

Clinician Onsite Inspection

We observed clinical information transmission during the daily morning interdisciplinary huddles. Also, we interviewed various health care staff regarding how they handled information, especially when clinical care occurred outside the clinic or after hours. We found DVI maintained an excellent process to transmit information between medical staff and various departments. Important after-hours clinical information was transmitted during two separate interdisciplinary huddles which occurred at the reception center and at the mainline clinic. Following the completion of the interdisciplinary huddles, each provider would meet with their respective nurses and schedulers for a provider-line huddle. It was during these provider-line huddles that staff discussed specific patients, reviewed offsite patient visits, reviewed and renewed medications, and arranged patient follow-up appointments.

Case Review Conclusion

DVI adequately retrieved and scanned medical records timely. DVI performed well with the retrieval of outside emergency room reports and hospital discharge summaries, and had appropriate scanning times for these documents. DVI continued to have an excellent process in place for transmitting clinical information between departments and various medical staff, and also within the provider group itself. However, DVI providers frequently did not sign their diagnostic and specialty reports, and also did not consistently notify their patients regarding diagnostic results. Taking these findings into account, we rated the *Health Information Management* indicator *adequate.*

Compliance Testing Results

The institution scored in the *proficient* range with a score of 85.2 percent in the *Health Information Management* indicator. The following tests were *proficient*:

- The institution timely scanned all six sampled non-dictated health care documents into the patients' electronic medical records (MIT 4.001).
- DVI scored 100 percent in labeling and filing documents scanned into patients' electronic medical records (MIT 4.006).

Two tests received *adequate* scores:

- DVI timely scanned 16 of the 20 sampled community hospital discharge reports or treatment records into patients' electronic medical records (80.0 percent). Four reports were scanned from 1 to 11 days late (MIT 4.004).
- Among 25 sampled patients admitted to a community hospital and who then returned to the institution, DVI providers timely reviewed 19 patients' corresponding hospital discharge reports within three calendar days of each patient's discharge (76.0 percent). For the other six patients, the provider reviewed their hospital discharge reports from one to seven days late (MIT 4.007).

The institution had room for improvement in the following test area:

- Staff scanned 14 of 20 specialty service consultant reports into the patient's electronic medical record within five calendar days (70.0 percent). Six documents were scanned from one to five days late (MIT 4.003).

5 — *HEALTH CARE ENVIRONMENT*

This indicator addresses the general operational aspects of the institution's clinics, including certain elements of infection control and sanitation, medical supplies and equipment management, the availability of both auditory and visual privacy for patient visits, and the sufficiency of facility infrastructure to conduct comprehensive medical examinations. The OIG rates this component entirely on the compliance testing results from the visual observations inspectors make at the institution during their onsite visit. There is no case review portion.

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(68.1%)

Overall Rating:
Inadequate

Compliance Testing Results

The institution received an *inadequate* compliance score of 68.1 percent in the *Health Care Environment* indicator. Five tests scored in the *inadequate* range:

- Clinicians followed proper hand hygiene practices in only four of the ten clinics (40.0 percent). At six clinic locations, clinicians did not wash their hands before or after patient contact, or before applying gloves (MIT 5.104).
- The non-clinic bulk medical supply storage areas did not meet the supply management needs of the medical health program, resulting in a score of zero for this test. The institution stored multiple medical supplies beyond the manufacturers' guidelines (MIT 5.106).
- Only six of the ten clinics inspected followed adequate medical supply storage and management protocols (60.0 percent). At four clinics, we found one or more of the following deficiencies: medical supplies were not clearly identifiable; medical supplies were stored directly on the floor; and medical supplies were stored beyond the manufacturers' guidelines (MIT 5.107).
- Of the nine clinics tested, six clinic examination rooms (66.7 percent) had appropriate space, configuration, supplies, and equipment to allow clinicians to perform proper clinical examinations. The remaining three clinics had one or more of the following deficiencies: clinical staff reported that confidential patient records were not shredded on a daily basis; the exam room had insufficient space; and the location of the exam room compromised the auditory privacy of the patient (MIT 5.110).
- We examined emergency medical response bags (EMRB) and crash carts in seven applicable clinics to determine if clinical staff inspected them daily, inventoried them monthly, and whether they contained all essential items. Only three of the seven clinic locations were compliant (42.9 percent). We found one or more of the following deficiencies

at four other locations: clinics stored the EMRB's medical supplies beyond the manufacturers' guidelines; staff had not inventoried the EMRBs within the last 30 days; and the emergency crash cart stored expired medical supplies (*Figure 1*) (MIT 5.111).

Figure 1: Expired crash cart medical supplies.

Two tests received scores in the *adequate* range:

- Clinical health care staff at eight of ten applicable clinics (80.0 percent) ensured that reusable invasive and non-invasive medical equipment was properly sterilized or disinfected. In one clinic, clinical staff did not properly process and package previously sterilized equipment. In another clinic, clinical staff did not mention disinfecting the examination table before the start of shift as part of their daily start-up protocol (MIT 5.102).
- Eight of the ten clinics inspected (80.0 percent) had operable sinks and sufficient quantities of hand hygiene supplies in the examination areas. In one clinic, the blood draw station did not have an operable sink within reasonable proximity. In another clinic, the patient restroom did not have sufficient quantities of hygiene supplies, such as antiseptic soap and disposable hand towels (MIT 5.103).

Four tests received scores in the *proficient* range:

- Staff appropriately disinfected, cleaned, and sanitized all ten sampled clinics. Cleaning logs were completed, indicating cleaning crews regularly cleaned the clinics (MIT 5.101).
- Health care staff at all ten clinics followed proper protocols to mitigate exposure to blood borne pathogens and contaminated waste (MIT 5.105).
- Nine of the ten clinic locations (90.0 percent) met compliance requirements for essential core medical equipment and supplies. One clinic was missing essential supplies necessary to conduct a comprehensive exam. Supply deficiencies included missing tongue depressors, lubricating jelly, and hemoccult card developer (MIT 5.108).
- Clinic common areas at nine of the ten clinics (90.0 percent) had environments conducive to providing medical services. In one clinic, the location of the blood draw station compromised patients' auditory privacy (MIT 5.109).

Non-Scored Results

We 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. We did not score this question.

- When we interviewed health care managers, they did not identify any significant concerns. At the time of our inspection, DVI had several significant infrastructure projects underway, which included renovation of the mental health office space, administrative segregation unit, specialty and staff support, the TTA, and the redesign of the ceiling above medication preparation. These projects started between fall of 2015 and fall of 2017. The institution estimated that these projects would be completed between early 2018 and late 2018 (MIT 5.999).

6 — *INTER- AND INTRA-SYSTEM TRANSFERS*

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(59.6%)
Overall Rating:
Inadequate

This indicator focuses on the management of patients' medical needs and continuity of patient care during the inter- and intra-facility transfer process. The patients reviewed for this indicator include those received from, as well as those transferring out to, other CDCR institutions. The OIG review includes evaluation of the institution's ability to provide and document health screening assessments, initiation of relevant referrals based on patient needs, and the continuity of medication delivery to patients arriving from another institution. For those patients, the OIG clinicians also review the timely completion of pending health appointments, tests, and requests for specialty services. For patients who transfer out of the institution, 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

We reviewed 21 inter- and intra-system transfer events, including 5 transfer-in cases and 5 transfer-out cases. Our review also included 11 hospitalizations and outside emergency room events, each of which resulted in a transfer back to the institution. We found DVI often delayed or did not provide provider appointments for newly-arrived patients. We also found that providers and nurses did not intervene appropriately for their patients. The appointment delays are also discussed in the *Access to Care* indicator. The case review rating for the *Inter- and Intra-System Transfers* indicator was *inadequate*.

Transfers In

When patients transfer from one institution to another, the receiving and release clinic (R&R) nurses play a crucial role in accurately assessing the incoming patients' current health conditions and ensuring continuity of health care. The nurse must ensure that the patient receives pending specialty referrals, medical equipment, and medical supplies. We found deficiencies in all five transfer-in cases. Three of the deficiencies we found were significant and occurred in the following cases:

- In case 17, the patient with numerous medical and mental health issues arrived at the institution in an American Disability Act (ADA) transport van. The R&R nurse did not refer the patient to a nurse care manager, and the patient's initial provider appointment did not occur until almost six weeks after he arrived at DVI.

- In case 23, the wheelchair-bound patient who was using continuous supplementary oxygen arrived with a portable oxygen tank at DVI in an ADA transport van. The R&R nurse did not check the oxygen level of the tank or exchange the oxygen tank. The oxygen tank was not exchanged until the following day, when custody staff informed medical staff the oxygen tank was almost empty. We also discuss this case in the *Quality of Nursing Performance* indicator.

- In case 25, the patient had several chronic medical conditions. The R&R nurse did not schedule the patient for an initial appointment with either a provider or a nurse care manager. The patient, who should have seen the provider within seven days, did not see a provider until almost three weeks after his arrival.

Transfers Out

To ensure safety during the transfer process, each transferring patient should receive a face-to-face nursing evaluation prior to boarding the transfer bus. We found deficiencies in all five transfer-out cases. In four of the five cases, the R&R nurse did not assess the patients' vital signs prior to their boarding the transfer bus (cases 18, 26, 52, and 53). By not performing a proper assessment, the nurses placed these patients at risk of potential medical complications during the transfer. We found another deficiency in the following case:

- In case 54, the patient who had recent jaw surgery was taking antibiotics for a wound infection. An oral surgeon had recently removed wire jaw support bars, and the patient had a pending follow-up appointment with the surgeon. When the R&R nurse saw the patient prior to his transfer out of DVI, the nurse documented the need to "consider" placing a medical hold on the patient's transfer. Nonetheless, the nurse did not discuss the patient's condition with a provider to consider delaying the transfer while the patient was actively receiving medical care. The nurse also did not check the patient's vital signs before transferring him out of DVI.

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.

We reviewed 11 cases where patients returned to DVI from an offsite hospital or emergency department (ED). Three cases had significant deficiencies regarding delayed provider follow-up appointments and insufficient monitoring of high-risk patients after hospital discharge:

- In case 13, the patient returned to DVI from an offsite ED after receiving treatment for a worsening wound on his right leg. The patient should have had a provider follow-up appointment within five days, but the appointment did not occur.

- In case 17, the patient returned from a hospital after receiving treatment for dizziness, confusion, very low blood pressure, and a fall from fainting in the shower. During the patient's 14-day hospitalization, doctors found the patient was dehydrated, had an irregular heart rhythm, and had sustained kidney damage. Upon his return to DVI, the TTA nurse found the patient still had extremely low blood pressure, an elevated heart rate, and refused to hydrate. The provider did not order observation or monitoring for the patient, and the TTA staff sent the patient back to his housing unit. These errors placed the patient at possible risk for further dehydration, recurrent falls, and hospital readmission. We also discuss this case in the *Quality of Provider Performance* indicator.

- In case 18, the patient returned from a hospitalization for liver inflammation. The TTA nurse did not address all of the hospital discharge recommendations, including the recommendation for the DVI provider to follow up on the pending hepatitis virus test results and to refer the patient to an infectious disease specialist. The virus test showed the patient had hepatitis C, which was ignored until the patient transferred to another institution in part because of the nurse's error. The patient's treatment for hepatitis C was significantly delayed, which was a major lapse in medical care.

Clinician Onsite Inspection

The institution had a very active reception center. On average DVI receives approximately 125 patients per week. One nurse is scheduled for the night shift, when most transfer-out departures occur, while two nurses are scheduled for the day and evening shifts, when most transfers arrive at DVI. The nurses were very familiar with the reception and release processes and demonstrated sufficient knowledge to timely process patients through the R&R area.

Case Review Conclusion

DVI did not perform well with transfer processes, especially in the areas of coordinating health care needs and ensuring appropriate follow-up appointments for patients transferring in and out of the institution. We also found significant problems when patients returned to DVI after hospital discharge. Therefore, we rated the *Inter- and Intra-System Transfers* indicator *inadequate.*

Compliance Testing Results

The institution received an *inadequate* compliance score of 59.6 percent for this indicator and had room for improvement on the following tests:

- Among nine applicable patients sampled who transferred to DVI from other CDCR institutions with an existing medication order, six received their medications without interruption (66.7 percent). Three patients incurred one or more interruptions of nurse- administered and keep-on-person medications (MIT 6.003).

- We tested 20 patients who transferred out of DVI to other CDCR institutions to determine whether staff at DVI listed their scheduled specialty service appointments on the health care transfer information form (CDCR Form 7371). Nurses listed the scheduled appointments for 6 of 19 applicable sampled patients (31.6 percent). For six patients, nurses failed to document the pending specialty service appointments on the form. For the remaining seven patients, we found no evidence the form was ever completed (MIT 6.004).

- DVI received a score of zero when we tested six applicable patients who transferred out of DVI to determine whether the patients' transfer packages included required medications and related documentation. All six transfer packages had one or more of the following required documents missing: the medication administration record, the health care transfer information form, and the transfer checklist form (MIT 6.101).

Two tests received scores in the *proficient* range:

- For all 25 sampled patients who transferred into DVI from other institutions, a nurse completed an initial health screening form (CDCR Form 7277) on the same day the patient arrived (MIT 6.001).

- Nurses timely completed the assessment and disposition sections of the screening form for all 23 applicable patients (MIT 6.002).

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7 — *PHARMACY AND MEDICATION MANAGEMENT*

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(61.9%)
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 numerous entities across various departments affect medication management, this assessment considers internal review and approval processes, pharmacy, nursing, health information systems, custody processes, and actions taken by the prescriber, staff, and patient.

For this indicator, the case review and compliance review processes yielded different results, with the case reviewers assigning an *adequate* rating and the compliance testing resulting in an *inadequate* score. Our compliance testing found significant medication continuity problems in most areas, including chronic care, hospital discharges, reception center arrivals, and transfer medications. Because lapses in these areas can place patients at risk of harm, we determined the overall rating for this indicator was *inadequate*.

Case Review Results

We evaluated 62 events related to medication management and found 9 deficiencies, 2 of which were significant (cases 13 and 46). The case review rating for this indicator was *adequate*.

Medication Continuity

DVI did not consistently maintain satisfactory medication continuity. We found deficiencies in cases 3, 13, 14, 15, 32, and the following case:

- In case 46, the patient developed worsening symptoms of indigestion and acid reflux due to the expiration of his medication two days prior. The sick call nurse did not check if the patient's medication had been renewed and did not take any steps to ensure the patient received his medication.

Medication Administration

Patients received their newly prescribed medications timely. Nurses generally documented the reasons for missed medication doses and patient refusals.

Pharmacy Performance

Because pharmacy-related processes are usually incompletely recorded in the medical record, OIG case reviewers often cannot differentiate between pharmacy or nursing errors. Nonetheless, sometimes certain deficiencies suggest problems with pharmacy processes, such as in the following case:

- In case 13, the provider prescribed a decreased dose of pain medication for the patient. The pharmacy cancelled this new prescription because of a delay in receiving approval for the non-formulary medication. A provider approved and resumed the new prescription three days after the medication was cancelled. This lapse in communication resulted in the patient missing five doses of his medication.

Clinician Onsite Inspection

We observed the clinic teams discussing general medication management issues during the interdisciplinary morning huddles. Staff then discussed and processed specific patient medication renewals during the subsequent provider line huddles. Sick call, care manager, and medication line nurses had many opportunities to discuss issues with the providers and other team members.

Case Review Conclusion

Our case reviewers found inconsistent medication continuity performance and found several instances where nurses were unable to administer medications timely. When this occurred, nurses usually recorded the reason for the missed dosages appropriately in the patient's electronic medical record. Nonetheless, the institution usually performed appropriately with medication management. We rated the *Pharmacy and Medication Management* indicator *adequate*.

Compliance Testing Results

The institution received an *inadequate* score of 61.9 percent in the *Pharmacy and Medication Management* indicator. For discussion purposes below, this indicator is divided into three sub-indicators: medication administration, observed medication practices and storage controls, and pharmacy protocols.

Medication Administration

For this sub-indicator, the institution received an *inadequate* score of 54.4 percent. The following four tests were *inadequate*:

- Among 21 applicable patients, 6 timely received their chronic care medications (28.6 percent). Eight patients did not receive their KOP medications prior to exhaustion. Five patients missed one or more doses of their nurse-administered medications and did not receive provider counseling. One patient received multiple supplies of KOP medication

within a shorter than normal replenishment time frame. For one remaining patient, there was no evidence he received or refused his medication (MIT 7.001).

- DVI's clinical staff timely provided new and previously prescribed medications to 17 of 24 patients who returned from a community hospital (70.8 percent). Six patients missed several doses of their ordered medications. One other patient received his discharge medication four days late (MIT 7.003).

- We reviewed 20 sampled patients who recently arrived at DVI from a county jail and identified 8 patients for whom a DVI provider had ordered medications upon their arrival. Of the eight applicable patients, only two (25.0 percent) received their medications timely. The six other patients received their medications from one to three days late (MIT 7.004).

- Nursing staff administered medications without interruption to only three of ten patients sampled (30.0 percent) who were transported from one institution to another and had a temporary layover at DVI. For seven patients, there was no evidence they received or refused their medications (MIT 7.006).

One test earned an *adequate* score:

- DVI timely administered or delivered newly prescribed medications to 21 of the 25 patients sampled (84.0 percent). Nursing staff administered three patients' medications from one to two doses late. For one final patient, there was no evidence the patient received or refused his medication (MIT 7.002).

One test earned a *proficient* score:

- DVI ensured that 22 of the 25 patients sampled (88.0 percent) who transferred from one housing unit to another received their ordered medications without interruption. For two patients, we found no evidence that they received or refused their medications. For one patient, nurses failed to refer the patient for provider counseling after he missed 50 percent of his scheduled nurse-administered medications within seven days (MIT 7.005).

Observed Medication Practices and Storage Controls

The institution received an *inadequate* score of 55.1 percent in this sub-indicator. The following tests scored in the *inadequate* range:

- DVI's nursing staff employed strong security controls for narcotic medications in three of seven (42.9 percent) clinic and medication line locations where the institution stored narcotics. In three clinics, two licensed nursing staff did not perform a controlled substance inventory on multiple dates. In another clinic, the medication nurse did not describe the appropriate reporting process for narcotics discrepancy (MIT 7.101).

- DVI safely stored non-refrigerated, non-narcotic medications in three of eight applicable clinic and medication line locations (37.5 percent). In four locations, oral and topical medications were not properly separated when stored. In one other location, there was no designated return-to-pharmacy area for expired prescription medications (MIT 7.102).

- Non-narcotic, refrigerated medications were not safely stored in all nine applicable clinic and medication line locations. All nine locations lacked a designated area for return-to-pharmacy refrigerated medications. In addition, one medication refrigerator was unsanitary. As a result, DVI scored zero on this test (MIT 7.103).

- Four of six inspected medication preparation and administration areas demonstrated appropriate administrative controls and protocols (66.7 percent). In two locations, medication nurses did not follow manufacturers' guidelines for proper storage of multi-use insulin vials (MIT 7.106).

One test received an *adequate* score:

- We observed the medication preparation and administration processes at six applicable medication line locations. Nursing staff was compliant with proper hand hygiene and contamination control protocols at five locations (83.3 percent). At one other location, not all nursing staff washed or sanitized their hands before re-gloving (MIT 7.104).

One test received a *proficient* score of 100 percent*:*

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

Pharmacy Protocols

DVI scored in the *proficient* range with a compliance score of 78.9 *percent* in this sub-indicator. The following tests earned *proficient* scores:

- DVI's main pharmacy followed general security, organization, and cleanliness management protocols. In addition, the main pharmacy maintained adequate controls over and properly accounted for narcotic medications (MIT 7.107, 7.108).

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

- The institution's PIC followed required protocols for 18 of 19 medication error reports and monthly statistical reports reviewed (94.7 percent). There was a lack of evidence the PIC received a timely notification for one medication error report (MIT 7.111).

The following test received an *inadequate* score:

- The main pharmacy did not properly store refrigerated or frozen medications. The refrigerator log had temperature readings that exceeded the acceptable range for the months October, November, and December of 2017 (MIT 7.109).

Non-Scored Tests

- In addition to the OIG's testing of reported medication errors, inspectors follow up on any significant medication errors found during compliance testing to determine whether the institution properly identified and reported errors. The OIG provides those results for information purposes only. At DVI, the OIG did not find any applicable medication errors (MIT 7.998).

- We interviewed patients in isolation units to determine whether they had immediate access to their prescribed KOP rescue inhalers and nitroglycerin medications. All nine of the sampled patients had access to their rescue medications (MIT 7.999).

8 — *PRENATAL AND POST-DELIVERY SERVICES*

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

As DVI does not have female patients, this indicator does not apply.

Case Review Rating:
Not Applicable
Compliance Score:
Not Applicable

Overall Rating:
Not Applicable

9 — *PREVENTIVE SERVICES*

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

Case Review Rating:
Not Applicable
Compliance Score:
Proficient
(92.7%)

Overall Rating:
Proficient

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 scored in the *proficient* range for this indicator at 92.7 percent. The following five tests earned scores in the *proficient* range:

- All 24 patients sampled received their ordered doses of tuberculosis (TB) medications in the most recent three-month period reviewed (MIT 9.001).
- All 24 sampled patients receiving TB medications also received their required monthly or weekly monitoring timely (MIT 9.002).
- We found that 28 of 30 (93.3 percent) sampled patients received annual TB screenings. For two patients, nursing staff failed to provide the TB screening during their birth months (MIT 9.003).
- During the most recent influenza season, all 25 sampled patients received or were offered influenza vaccinations timely (MIT 9.004).
- DVI offered colorectal cancer screenings to 24 of the 25 sampled patients (96.0 percent) subject to the annual screening requirement. One patient who did not have normal colonoscopies within the last ten years, was not offered a colorectal cancer screening within the previous 12 months (MIT 9.005).

One test received *inadequate* score:

- We tested whether the institution offered vaccinations for influenza, pneumonia, and hepatitis to patients who suffered from chronic conditions. Among 12 sampled patients, 8 received all recommended vaccinations at required intervals (66.7 percent). The institution failed to document whether four other patients had either received or refused a pneumovax vaccination within the past five years or a hepatitis vaccination (MIT 9.008).

10 — *QUALITY OF NURSING PERFORMANCE*

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

The *Quality of Nursing Performance* indicator is a qualitative evaluation of the institution's nursing services. The evaluation is completed entirely by OIG nursing clinicians within the case review process and does not have a score under the OIG compliance testing component. Case reviews include face-to-face encounters and indirect activities performed by nursing staff on behalf of the patient. Review of nursing performance includes all nursing services performed onsite, such as outpatient, inpatient, urgent/emergent patient transfers, care coordination, and medication management. The key focus areas for evaluation of nursing care include appropriateness and timeliness of patient triage and assessment, identification and prioritization of health care needs, use of the nursing process to implement interventions, and accurate, thorough, and legible documentation. Although the OIG reports nursing services provided in specialized medical housing units in the *Specialized Medical Housing* indicator, and those provided in the TTA or related to emergency medical responses in the *Emergency Services* indicator, this *Quality of Nursing Performance* indicator summarizes all areas of nursing services.

Case Review Results

We reviewed 255 nursing encounters, 133 of which were in the outpatient setting. Most outpatient nursing encounters were for sick call requests, walk-in visits, and nurse follow-up visits. In all, we identified 73 deficiencies related to nursing care performance, 22 of which were significant. The case review rating for the *Quality of Nursing Performance* indicator at DVI was *inadequate*.

Nursing Sick Call

We found serious problems with nurse sick call performance at DVI. Nurses frequently delayed seeing patients and often failed to properly assess or intervene for patients who submitted sick call requests. We found one or more significant deficiencies in cases 3, 4, 5, 13, 17, 18, 23, 25, 29, 30, 34, 40, 46, 48, 49, 50, 51, and 54.

Delayed Care for Potentially Urgent or Emergent Conditions

Nurses must see patients who submit sick call requests with potentially urgent or emergent conditions promptly. Failure to do so can result in delayed care or untreated conditions which can result in patient harm. The following cases are just a few examples of nurses failing to promptly examine their patients who submitted urgent sick call requests:

- In case 3, the patient developed drooping of the right side of his face and submitted a sick call request. The nurse reviewed the patient's request but did not recognize the patient's symptoms could have represented a stroke. The nurse did not assess the patient who should

have had an immediate assessment. The nurse's failure to immediately treat a potential stroke placed the patient at risk for irreversible and catastrophic harm. Approximately 16 hours later, the patient self-activated the emergency medical response system because his condition had not improved and he had not received care. Medical staff sent the patient out to a community hospital for further evaluation. Fortunately, the patient did not have a stroke.

- In case 34, the patient who arrived at DVI from a county jail submitted a sick call request for a worsening body rash. The patient was concerned he was having an allergic reaction from the several new medications he was taking. The patient should have been assessed the same day the nurse reviewed the request because medication allergies can result in serious complications. The nurse reviewed the patient's request but did not evaluate the patient until three days later. Fortunately, a provider saw the patient the following day and determined the skin condition was not severe.

- In case 48, the patient with throat cancer submitted a sick call request describing symptoms of coughing up blood. The nurse who initially reviewed the patient's request should have seen this potentially high-risk patient immediately because the patient's symptoms could have represented an emergent, life-threatening condition. Instead, the nurse deferred the assessment until the following day. Fortunately, the nurse's initial delay did not result in any harm. The following day, the nurse contacted the provider who found blood collecting at the back of the patient's throat and sent him to the hospital.

Inappropriate Sick Call Decisions

Sick call nurses often neglected their responsibility to assess their patients. One method they used was to defer all evaluation to the provider without first examining the patient. This problem occurred in cases 30, 47, and in the following cases:

- In case 29, the patient with a cardiac pacemaker arrived at DVI and submitted a sick call request for symptoms of chest and abdominal pain, knee problems, wrist swelling, and a skin condition. The sick call nurse did not assess any of the patient's health issues or determine if the patient was taking any of his prescribed medications. Instead, the nurse instructed the patient to wait for his next provider visit to discuss these issues.

- In case 50, the newly arrived patient submitted a sick call request for symptoms of foot pain and difficulty walking due to his diabetic neuropathy. The sick call nurse did not assess the patient's foot pain or difficulty walking. Instead, the nurse instructed the patient to wait for his next provider visit to discuss these issues.

Another method nurses used to avoid assessing their patients was to erroneously label sick call requests as "asymptomatic". Because CCHCS policy does not require a nurse to see a patient if the sick call request does not describe any symptoms, nurses did not assess these patients. We found examples of this poor practice in case 45 and the following cases:

- In case 49, the patient reported severe back pain from nerve damage and requested a back brace for support. The nurse reviewed the sick call request and labeled it "asymptomatic". The following day, the sick call nurse did not assess the patient.

- In case 50, the newly-arrived patient complained of difficulty walking after his stroke and he requested a cane. The nurse labeled the patient's sick call request as "asymptomatic" and did not examine the patient or evaluate the patient's ability to walk safely.

Inappropriate Sick Call Nursing Assessment

When sick call nurses assessed their patients, they also frequently made poor or incomplete assessments. DVI nurses made incomplete assessments or did not properly examine their patients in the following cases:

- In case 23, five days after arriving at DVI from another institution, the wheelchair-bound patient saw the sick call nurse for swollen legs. The nurse merely instructed the patient to elevate his legs and did not check the patient's vital signs or examine the severity or location of the leg swelling. The patient's symptoms could have represented one of several serious medical conditions that were not considered due to the nurse's error.

- In case 40, the patient reported a painful lump in his genital area. The nurse did not check for the presence of a groin mass or any associated pain. The nurse also erroneously described the patient as ambulatory when he was in fact wheelchair-bound.

- In case 51, the patient had four days of foot swelling. The sick call nurse merely noted "abnormalities", but did not describe them. The nurse did not determine the severity of the swelling or if there was any tenderness. The nurse did not intervene or develop a plan of care.

- Also in case 51, during a second sick call appointment, the patient complained his pain medication was not working for his foot pain. The sick call nurse did not examine the patient's foot or evaluate his pain level. The nurse also failed to check the patient's vital signs and did not determine the patient's compliance with his prescribed pain medications.

Nursing Assessment

With the notable exception of nursing sick call performance, nurses at DVI generally provided appropriate and timely assessments to patients in the other health care areas.

Nursing Intervention

Nurses should base appropriate nursing interventions on information gathered during their subjective and objective assessments, provider orders for treatment, nursing practice standards, and CCHCS nursing protocols. We found a frequent pattern of poor nursing intervention. These problems included insufficient monitoring, unsatisfactory wound care, delayed or non-existent

provider referrals, and poor coordination of medical equipment and supplies. We identified these deficiencies in cases 1, 2, 4, 5, 13, 14, 15, 17, 18, 23, 25, 46, 49, 50, 51, 54, and 55. The following cases are just two examples:

- In case 13, the patient transferred to DVI with a slow-healing leg wound for which he had daily wound care while in a county jail. During the patient's first two months at DVI, nurses did not measure his wound. Periodic wound measurement is needed to determine the progress of wound healing. Nurses also did not carry out the provider-ordered dressing changes on several occasions.

- In case 23, the patient arrived at DVI with a portable oxygen tank. The R&R nurse did not evaluate the level of oxygen remaining in the tank, provide the patient instructions on how to request tank replacements, or notify the nurse care manager or other staff about the patient's equipment needs. The patient did not receive a replacement oxygen tank until the day after his arrival when custody staff contacted the TTA regarding the low oxygen level in the patient's tank. We also discuss this case in the *Inter- and Intra-System Transfers* indicator.

Nursing Documentation

The institution's nursing documentation was usually appropriate, with the exception of nursing documentation related to emergency medical encounters. We also discuss this issue in the *Emergency Services* indicator.

Urgent/Emergent Care

The first medical responders and TTA nurses usually provided sufficient emergency care. We did find some instances in which TTA nurses made errors with their assessments or interventions. We also found incomplete, inaccurate, and discrepant nursing documentation entries in patients' electronic medical records. We discuss this issue further in the *Emergency Services* indicator.

Care Management

Nurse care managers should assess and monitor patients with chronic conditions or patients who are at risk of developing serious health complications. Nurse care managers should intervene as needed to reach their patients' treatment plan goals. In the cases reviewed, nurse care management at DVI was lacking. The role of the nurse care manager was relatively new, under development, and not well-defined. The patients in the two following cases did not receive sufficient nurse care management services:

- In case 13, the patient had numerous chronic health problems, including a slow-healing wound. When the order for the patient's daily wound care expired, nurses did not change the patient's dressing for five days while they waited for the provider to renew the order. Effective nurse care management could have prevented this lapse in care.

- In case 14, the patient with cancer had an intravenous catheter in his chest for chemotherapy which should be flushed monthly to prevent clotting and maintain functionality. Because the nurses misinterpreted a provider order to flush the catheter monthly "as needed," they failed to flush the catheter for three consecutive months. This type of error could easily have been prevented with effective nurse care management. Fortunately, the catheter continued to function correctly despite the lapse in care.

Medication Administration

Nurses usually administered medications accurately and timely when they were available. We found only minor nursing documentation deficiencies in this area. The lack of timely available medications was a different problem, which we discuss in detail in the *Pharmacy and Medication Management* indicator.

Hospital Returns

TTA nurses evaluate patients returning from a hospital or emergency department to ensure that patients are stable before releasing them back to their housing units. We found that nurses performed poorly in these critical situations and did not always properly assess or monitor patients that returned from a hospital. We discuss this issue further in the *Inter-and Intra-System Transfers* indicator.

Intra-System Transfers

R&R nurses performed unsatisfactorily for patients arriving from and transferring to other CDCR institutions. We found deficiencies in all transfer cases we reviewed. Nurses did not ensure appropriate continuity of care for patients arriving at DVI and failed to assess patients that were transferring out of the institution. We discuss these issues in detail in the *Inter- and Intra-system Transfers* indicator.

Reception Center

Although the institution failed to provide timely access for patients arriving from county jails, the reception center nurses delivered appropriate and timely health care services to these patients. Nursing performance in this area was satisfactory. We found only minor nursing errors with these cases.

Specialized Medical Housing

We did not perform a comprehensive review of patient care in the Outpatient Housing Unit (OHU) at DVI, which has been closed and under construction for almost two years. Because of the closure, we had an insufficient number of cases to review, and no patients were housed in the OHU during our onsite clinician visit.

Offsite Specialty Services Returns

Nurses usually provided appropriate care for the patients returning from offsite specialty appointments. We found one pattern in which nurses often neglected to check their patients' vital signs when they returned from an offsite specialty appointment. Nursing performance in this area was otherwise satisfactory.

Clinician Onsite Inspection

Due to the severity and prevalence of sick call deficiencies, we focused our onsite efforts in this area. The night shift TTA nurses were the first medical staff to receive and review sick call requests. These nurses made decisions about whether the patient needed an urgent nursing assessment or could wait to be scheduled for a sick call appointment the next business day. Many of the errors we found occurred at this first step of the sick call process. During the night shift, the TTA nurses were reluctant to call patients with potentially urgent and emergent medical issues for a sick call nursing assessment for several reasons. One reason was that patients often refused to be awakened from sleep to come to the TTA. Another reason was the additional burden on custody officers, who would need to make additional arrangements to escort the patient to the TTA during those hours. The TTA nurses claimed that they recently started going out to the housing units during the night to perform cell-side assessments for patients with potentially emergent conditions and were able to assess some patients who refused to come to the TTA.

After reviewing sick call requests, the TTA nurses provided the requests to schedulers to make any needed sick call appointments. The schedulers then scanned the requests into patients' electronic medical records. There was no communication between TTA nurses and the clinic sick call nurses regarding potentially important issues. This was problematic because the sick call nurses did not review the sick call requests themselves and did not triage their own patients. The sick call nurses would have no knowledge of the patients' issues until the sick call appointment occurred. As a result, sick call nurses were unable to discuss patient issues in the morning huddle or properly prioritize their patients' appointments.

Aside from the sick call process, we noted several nursing strengths at DVI. All medical staff participated in at least one of the two interdisciplinary huddles held each morning at the reception center or mainline clinics. At this huddle, the staff reviewed important daily matters, such as assigned roles for emergency medical responses and general patient issues. Following this huddle, each clinical team met separately in a brief provider-line huddle to discuss specific patient issues, including follow-up appointments and daily schedules for both the provider and nurse.

Case Review Conclusion

TTA nurses made inappropriate decisions when reviewing sick call requests, resulting in frequent delays in scheduling sick call appointments. These errors were especially notable when patients described potentially urgent or emergent symptoms on their request forms. Also, sick call nurses often made assessment and intervention errors. When significant deficiencies occur in any part of the nursing sick call process, patients throughout the institution are placed at increased risk of harm. We also found unsatisfactory nursing performance for patients transferring into or out of the institution and for patients returning from a community hospital. Furthermore, we found nurse care management to be ineffective. We rated the *Quality of Nursing Performance* indicator as *inadequate*

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11 — *QUALITY OF PROVIDER PERFORMANCE*

In this this indicator, the OIG physicians provide a qualitative evaluation of the adequacy of provider care at the institution. The case review clinicians review the provider care regarding appropriate evaluation, diagnosis, and management plans for programs including, but not limited to, nursing sick call, chronic care programs, TTA, specialized medical housing, and specialty services.

OIG physicians alone assess provider care. 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

We reviewed 106 medical provider encounters and identified 37 deficiencies related to provider performance. Of the 37 deficiencies identified, 15 were significant. The case review rating for the *Quality of Provider Performance* indicator was *adequate.*

Assessment and Decision-Making

DVI providers generally made sound assessments and accurate diagnoses. Poor assessment and misdiagnosis, although infrequent, did occur. We found errors in provider assessments in cases 10, 11, 12, and the following cases:

- In case 7, the provider ordered a chest x-ray, but did not record a progress note. Because this was the first time the provider saw this patient, the provider should have evaluated him.
- In case 9, the patient had open heart surgery to replace a heart valve and place a pacemaker. The patient was then temporarily cared for at another institution. When the patient returned to DVI, the provider inappropriately cancelled his 14-day follow-up appointment without any documentation to justify the cancellation.
- In case 14, the patient required monthly flushes to prevent the intravenous catheter in his chest from clotting. However, the medical provider mistakenly ordered nurses to flush the catheter monthly "as needed." As a result of this unclear order, the nurses did not flush the patient's catheter for three months which significantly increased the risk of the patient's catheter clotting. We also discuss this case in the *Quality of Nursing Performance* indicator.
- In case 17, the patient returned from a hospitalization for dehydration and loss of consciousness. The patient was unstable when he arrived at the institution and had an abnormally fast heart rate and low blood pressure. The provider failed to order observation and monitoring for the patient. Instead, the TTA staff sent the patient back to his housing unit. These errors placed the patient at possible risk for further dehydration, recurrent falls, and hospital readmission. We also discuss this case in the *Inter- and Intra-System Transfers* indicator.

Despite the above examples, we found good provider diagnostic skills in the majority of the cases. The following case is one example:

- In case 15, the providers expertly managed the patient's post-operative condition following his surgery for glaucoma (a disease that causes increased eye pressure). The providers ensured the patient received his medicated eye drops as ordered by the ophthalmologist (an eye surgeon). The providers kept track of his specialty appointments and ensured the patient had timely follow-up appointments with his ophthalmologist.

Review of Records

As in Cycle 4, we continued to identify a mild pattern of inadequate record review by the providers. Insufficient record review occurred in cases 3, 4, 7, 16, 18, and the following cases:

- In case 10, the provider did not carefully review the electronic health record system (EHRS); therefore, the provider did not realize the patient's dizziness had been previously evaluated. Furthermore, the provider did not recognize the patient's signs of dehydration, which was the cause of the patient's dizziness. As a result, the provider ordered an unnecessary medication to treat the patient's dizziness.

- Also in case 10, the provider requested an endocrinologist referral to occur within one month to evaluate the patient's uncontrolled diabetes. During a subsequent follow-up appointment, the provider failed to carefully review the EHRS. As a result, the provider did not realize the requested endocrinology evaluation never occurred. Due to this provider's oversight, the patient did not see an endocrinologist for more than four months.

- In case 14, the provider did not realize the oncology report for the patient's liver cancer was available for review because he did not carefully review the EHRS. As a result of the provider's oversight, the patient's laboratory test was not completed within the time interval requested by the specialist. Furthermore, this error resulted in a lapse in the patient's medical care since his follow-up appointment with the specialist occurred three weeks outside the requested time interval.

Emergency Care

Provider performance in emergency care continued to be excellent at DVI. The TTA and on-call providers usually made accurate assessments and triage decisions. Providers appropriately sent patients requiring higher level of care to a community hospital or emergency department. We did not identify any problems with providers' emergency care assessments or decisions. However, we did find that providers often failed to record their TTA encounters, just as they had during Cycle 4. We also discuss this problem in the *Emergency Services* indicator.

Provider-Ordered Follow-up Intervals

As we found in Cycle 4, providers sometimes did not order appropriate follow-up appointments for their patients. Inappropriate orders of provider follow-up appointments occurred in case 10 and the following case:

- In case 17, the patient sustained a recent fall with a loss of consciousness. The provider inappropriately ordered a lengthy three-month follow-up appointment. As a result, the patient sustained another fall with head trauma that required hospitalization. This hospitalization may have been prevented if the provider had ordered a follow-up appointment sooner than three months.

Chronic Care

Providers performed satisfactorily with managing chronic medical conditions, such as hypertension, asthma, and seizures. However, we identified problems in diabetes care and anticoagulation management in case 12 and the following cases:

- In case 7, the provider did not address the patient's elevated anticoagulant levels for approximately two weeks. This lapse in medical care significantly increased the patient's risk of bleeding.

- In case 10, the provider did not increase the patient's long-acting insulin to treat his uncontrolled morning fasting blood sugars. Instead, the provider mistakenly increased the patient's short-acting insulin, which would not control the patient's morning fasting sugar levels.

- In case 11, the provider did not perform routine diabetic surveillance testing for the patient over the course of six months. Because these tests were overdue, the provider should have performed or ordered diabetic eye and foot examinations and a laboratory test that measures urine protein level to check for signs of kidney disease.

Specialty Services

The institution's providers appropriately referred patients for specialty services. When available, the providers also reviewed and signed the specialty reports. Providers also appropriately acted on the specialists' recommendations. This is discussed further in the *Specialty Services* indicator.

Documentation Quality

With the exception of TTA encounters, provider documentation at DVI has improved. The many instances of insufficient documentation found during Cycle 4 were resolved during this current inspection. Legibility was no longer an issue with provider progress notes since all providers type their notes into the EHRS.

Nonetheless, we discovered some providers recorded planned interventions in their progress notes, but then failed to actually order them. These provider errors would then lead to lapses in medical care. The examples in the following cases illustrate this problem:

- In case 10, the provider recorded that the patient agreed to an increase in the frequency of his finger stick blood sugar (FSBS) checks due to his worsening diabetes. However, the provider never entered the order for increased FSBS monitoring.
- In case 16, the provider's examination revealed the patient had full range of motion of his right shoulder. Nonetheless, the provider ordered an x-ray of the patient's right shoulder and failed to document why.
- In case 17, the patient reported loss of consciousness a few days prior to his office visit. The provider intended to schedule a close follow-up appointment in several weeks, but instead ordered a lengthy 90-day follow-up appointment.
- In case 18, the provider saw the patient who had acute hepatitis with critically elevated liver function tests. The provider recorded a plan to follow up with the patient in two to three weeks. However, the provider never entered the order for the follow-up appointment, and the patient was not seen for more than two months. Since the patient's hepatitis was not monitored, this error placed the patient at risk of serious harm.

We continued to find some evidence of progress notes that were cloned, where providers inappropriately copied outdated medical information forward to a current progress note. However, we found that these cloned progress notes did not significantly impact medical care.

Provider Continuity

Provider continuity was sufficient in the majority of the outpatient cases reviewed.

Onsite Inspection

DVI continued to schedule two different huddles at different times in the morning, an interdisciplinary huddle, and the smaller provider-line huddle. The practice of staggering morning huddles facilitated transmission of clinical information between various departments and medical staff, as well as within the provider group. This is also discussed in the *Health Information Management* indicator.

Providers performed satisfactorily both individually and as a group. The institution fully committed to a primary care model of care. All providers continued to be satisfied with their primary care teams, as observed in Cycle 4. Providers reported that working as a team was both personally and professionally rewarding.

Onsite interviews with the provider staff revealed excellent job satisfaction and good provider morale. The providers reported the chief medical executive (CME) continued to be an excellent and approachable leader who provided the necessary support they needed to give quality care to their patients. At the time of the onsite inspection, the chief physician and surgeon (CP&S) position had been filled for only several months, thus provider feedback regarding the CP&S was limited.

Interviews with the CME confirmed that job performance was closely monitored. Performance was monitored in various ways, including annual clinical appraisals, CCHCS dashboard evaluations, and careful review of specialty referrals. All provider annual performance appraisals were completed and kept current. At the time of the onsite interviews, there were no problems with provider retention or provider recruitment.

Case Review Conclusion

As a whole, DVI's providers performed acceptably. The providers usually made sound and accurate diagnoses, as well as appropriate treatment plans. With only a few exceptions, providers reviewed medical records with adequate depth. Although documentation was often lacking for the TTA encounters, emergency care and diabetes management were sufficient. Chronic care management was usually satisfactory. Also, providers appropriately referred patients for specialty services. Finally, the majority of patient follow-up appointments were typically ordered within appropriate time intervals. Although we found several patterns of problems in this inspection, most of these problems did not significantly raise the risk of harm to patients. Therefore, we rated the *Quality of Provider Performance* indicator *adequate.*

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12 — *RECEPTION CENTER ARRIVALS*

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(62.9%)
Overall Rating:
Inadequate

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

Case Review Results

We reviewed nine cases in which a patient arrived at DVI from a county jail through the institution's reception center. We identified eight deficiencies, three of which were significant. The case review rating for the *Reception Center Arrivals* indicator was *inadequate*.

Provider Access

DVI had difficulty ensuring that reception center patients saw providers promptly when they arrived at the institution. Although most reception center patients have minimal health needs, these patients are new to the system and have unknown medical needs. Sometimes these patients require significant medical intervention that can only be determined during a provider appointment. CCHCS requires institutions to ensure provider appointments for reception center patients within seven days of arrival. Even slight delays with initial provider access can increase the risk of harm for these transitioning patients. We found provider access delays in cases 29, 34 and the following case:

- In case 50, the newly arrived patient should have been seen within seven days of arrival. The patient was seen 12 days late.

Nursing Performance

Nurses also occasionally made assessment errors when they saw newly arrived reception center patients:

- In case 13, the patient with a chronic slow-healing leg wound arrived from county jail, where he had been receiving daily wound care and dressing changes. When the patient arrived at DVI, the reception center nurse did not evaluate the wound, assess the condition of the dressing, or arrange for continuation of daily wound care. The patient did not receive a dressing change until he submitted a sick call request seven days later.

- In case 29, the patient had been on monthly blood glucose monitoring at the county jail. When he arrived at DVI, the reception center nurse neglected to check the patient's baseline blood glucose level.

Case Review Conclusion

Reception center nurses were thorough in providing communicable disease screening tests and ordering diagnostic laboratory work required for patients arriving from county jails. Nursing performance was satisfactory in this regard, as most nursing deficiencies we identified were minor. However, we also found that the institution did not consistently provide timely access to providers for reception center patients arriving from a county jail. Although we did not observe any harm, delays with initial provider access increases the risk of harm, which was significant at DVI given the large volume of reception center patients regularly entering the institution. We rated the *Reception Center Arrivals* indicator *adequate*.

Compliance Testing Results

The institution received an *inadequate* compliance score of 62.9 percent in the *Reception Center Arrivals* indicator. The following three tests showed areas for needed improvement:

- Providers completed reception center history and physical examinations within seven calendar days of the patient's arrival for only 5 of the 20 sampled patients (25.0 percent). For 14 patients, the history and physical was completed from 1 to 91 days late. We found no evidence that the history and physical was completed for one other patient (MIT 12.004).

- Providers reviewed and communicated the results of the intake tests timely for only 3 of the 20 patients sampled (15.0 percent). For nine patients, providers did not review and communicate the test results timely. For the remaining eight patients, we found no evidence that the test results were communicated at all (MIT 12.006).

- The institution offered or administered a coccidioidomycosis (valley fever) skin test timely to only 5 of the 20 sampled reception center patients (25.0 percent). The institution did not offer or administer a coccidioidomycosis skin test timely to 14 patients. For one other patient, we found no evidence that the institution offered or administered a coccidioidomycosis skin test at all (MIT 12.008).

One test scored in the *adequate* range:

- We sampled reception center patients to determine if they received the required intake laboratory tests. Of the 20 sampled patients, 16 (80.0 percent) received the required intake laboratory tests timely. For two patients, the institution performed the required tests late. For two other patients, the provider did not order the required intake laboratory tests for gonorrhea and chlamydia (MIT 12.005).

Three tests scored in the *proficient* range:

- We sampled reception center patients to ensure that they received timely and complete health screenings upon arrival at the institution. Nursing staff conducted timely and complete screenings for 19 of the 20 patients sampled (95.0 percent). For one patient, nursing staff did not document a complete set of vital signs (MIT 12.001).
- Reception center nursing staff timely completed, signed, and dated the assessment and disposition section of the initial health screening form for all nine patients sampled (MIT 12.002).
- We sampled reception center arrivals to ensure that each patient had a timely completed and properly documented TB skin test. All 16 of the sampled patients had their TB tests timely administered, read, and documented (MIT 12.007).

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13 — *SPECIALIZED MEDICAL HOUSING*

This indicator addresses whether the institution follows appropriate policies and procedures when admitting patients to onsite inpatient facilities, including completion of timely nursing and provider assessments. The case review assesses all aspects of medical care related to these housing units, including quality of provider and nursing care. DVI's only specialized medical housing unit is an outpatient housing unit (OHU). During the majority of this review, the OHU had no patients due to onsite construction since July 2016.

Case Review Rating:
Not Applicable
Compliance Score:
Not Applicable

Overall Rating:
Not Applicable

Case Review Results

Since the outpatient housing unit was closed for the majority of the last two years due to construction and operational issues, there were insufficient cases for us to perform a comprehensive review of this indicator. The case review rating for this indicator was *not applicable*.

14 — *SPECIALTY SERVICES*

Case Review Rating:
Adequate
Compliance Score:
Adequate
(82.5%)
Overall Rating:
Adequate

This indicator focuses on specialist care from the time a physician completes a request for services or physician's order for specialist care 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 the 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 provider updates the patient on the plan of care.

Case Review Results

We reviewed 80 events related to *Specialty Services,* which included 58 specialty consultations and procedures, and 22 nursing encounters. We found 15 deficiencies, of which only 1 was significant. The case review rating for the *Specialty Services* indicator was *adequate*.

Access to Specialty Services

We found that initial referrals to specialty services were normally completed within an acceptable time frame. The institution performed well with both routine and urgent specialty referrals, except in one case (case 10). DVI also did well with specialty follow-up appointments. Compared to Cycle 4, DVI demonstrated significant improvement in this area. While deficiencies with specialty access were uncommon, the institution can use the following case for quality improvement purposes:

- In case 10, the provider requested an endocrinology referral within one month for a patient with worsening diabetes. The patient did not receive the specialty consultation for five months.

Nursing Performance

Nurses provided appropriate care to patients returning from offsite specialty appointments. We identified only three minor nurse assessment deficiencies (cases 14 and 29).

Provider Performance

DVI providers continued to perform well when submitting referrals for specialty services. All referrals were submitted with proper priority status. The providers also acted on those recommendations appropriately.

Health Information Management

Since Cycle 4, DVI improved with the processing of specialty reports. Offsite specialty reports were usually timely retrieved and scanned into the EHRS, except in the following case:

- In case 13, the institution's staff failed to retrieve and scan the offsite CT scan report into the EHRS. This error resulted in a significant lapse in medical care because the patient had a lung infection and the CT scan report was unavailable to guide the provider's care at the follow-up visit.

Providers did not consistently sign or initial the specialty reports. While this problem was not frequent, we found that providers either did not sign specialty reports or signed them late in cases 13, 14, 15, and 21.

Utilization Management

We did not find any significant problems with DVI's utilization management program.

Clinician Onsite Inspection

As observed in Cycle 4, the telemedicine clinic continued to be clean and adequate during the current medical inspection. The nurse kept an organized tracking and scheduling system for all telemedicine appointments. No appointment backlog for telemedicine was reported.

Case Review Conclusion

DVI staff completed most specialty appointments timely, and retrieved and scanned the specialty reports correctly. The providers properly reviewed the recommendations and took appropriate action on the recommendations. The delays with specialty follow-up appointments that we identified in Cycle 4 was rectified during this inspection. DVI still has room for improvement with the processing of specialty reports. We rated the *Specialty Services* indicator *adequate*.

Compliance Testing Results

The institution received an *adequate* compliance score of 82.5 percent for this indicator, with the following three tests scoring in the *proficient* range:

- For 13 of 15 patients sampled (86.7 percent), high-priority specialty services appointments occurred within 14 calendar days of the provider's order. Two patients received their specialty services appointments three and six days late (MIT 14.001).

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

- DVI's health care management timely denied specialty services requests for 19 of 20 sampled patients (95.0 percent). Management denied one specialty services request four days late (MIT 14.006).

Two tests scored in the *adequate* range:

- Providers timely received and reviewed the high-priority specialists' reports for 12 of the 15 patients sampled (80.0 percent). For one patient, the provider received the report five days late. For another patient, the provider reviewed the report ten days late. For the remaining one patient, we found no evidence that the provider reviewed the report at all (MIT 14.002).

- For 16 patients sampled who had a specialty services request denied by DVI's health care management, 13 (81.3 percent) received timely notification of the denied service, including a provider discussion with the patient within 30 days on alternate treatment strategies. For three patients, providers did not communicate the denial status at all (MIT 14.007).

Two tests scored in the *inadequate* range:

- Providers timely received and reviewed routine specialists' reports for 9 of 13 patients sampled (69.2 percent). For three patients, providers reviewed the reports from one to eight days late. For one other patient, the provider did not review the report at all (MIT 14.004).

- Of 20 applicable sampled patients who transferred to DVI with an approved specialty service, 13 (65.0 percent) received the service within the required time frame. Three patients received their services from 4 to 114 days late. For the remaining four patients, we found no evidence the institution provided the approved specialty services (MIT 14.005).

15 — *ADMINISTRATIVE OPERATIONS (SECONDARY)*

Case Review Rating:
Not Applicable
Compliance Score:
Adequate
(82.9%)

Overall Rating:
Adequate

This indicator focuses on the institution's administrative health care oversight functions. The OIG evaluates whether the institution promptly processes patient medical appeals and addresses all appealed issues. Inspectors also verify that the institution follows reporting requirements for adverse/sentinel events and patient deaths. The OIG verifies that the Emergency Medical Response Review Committee (EMRRC) performs required reviews and that staff perform required emergency response drills. Inspectors also assess whether the Quality Management Committee (QMC) meets regularly and adequately addresses program performance. For those institutions with licensed facilities, inspectors also verify that required committee meetings are held. In addition, 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 emergency medical response certifications. The *Administrative Operations* indicator is a secondary indicator; therefore, it was not relied on for the institution's overall score.

Compliance Testing Results

The institution received a score of 82.9 percent in this indicator, with ten tests earning *proficient* scores:

- The institution promptly processed all patient medical appeals during the most recent 12-month period (MIT 15.001).
- DVI's QMC met monthly, evaluated program performance, and took action when management identified areas for improvement opportunities (MIT 15.003).
- DVI took adequate steps to ensure the accuracy of its Dashboard data reporting (MIT 15.004).
- Inspectors reviewed drill packages for three medical emergency response drills conducted in the prior quarter. All three packages contained all required summary reports and related documentation. In addition, the drills included participation by both health care and custody staff (MIT 15.101).
- Based on a sample of ten second level medical appeals, the institution's responses addressed all of the patients' appealed issues (MIT 15.102).

- All ten nurses sampled who administered medications possessed current clinical competency validations, and all nursing staff hired within the last year timely received new employee orientation training (MIT 15.105, 15.111).

- All providers at the institution were current with their professional licenses. Similarly, all nurses and the PIC were current with their professional licenses and certification requirements (MIT 15.107, 15.109).

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

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

Three tests earned *inadequate* scores:

- All 12 sampled incident packages for emergency medical responses the institution's Emergency Medical Response Review Committee (EMRRC) reviewed during the prior 12-month period failed to comply with CCHCS policy. Of the 12 non-compliant incident packages samples, 8 were not reviewed timely at the next corresponding EMRRC meeting and 4 had incomplete or missing EMRRC event checklist forms. As a result, DVI received a score of zero on this test (MIT 15.005).

- Five patient deaths occurred at DVI during our sample test period. Medical staff reviewed and timely submitted the Initial Inmate Death Report (CDCR Form 7229A/7229B) to CCHCS' Death Review Unit for three deaths, resulting in a score of 60.0 percent. For one death, DVI did not timely notify CCHCS' Death Review Unit, the notification was 3 hours and 45 minutes late. For another death, the chief of mental health or designee did not sign the CDCR Form 7229B (MIT 15.103).

- Supervisors did not properly complete the clinical performance appraisals for all six DVI providers. One or more of the following deficiencies were identified for each provider's appraisal: the supervising physician utilized the incorrect performance evaluation form, the packet did not have the required 360-degree evaluation, and the supervising physician did not discuss the results of the appraisal with the provider (MIT 15.106).

Non-Scored Results

- The OIG gathered non-scored data regarding the completion of death review reports by CCHCS' Death Review Committee (DRC). Five deaths occurred at DVI during our review period, all were unexpected (Level 1) deaths. For the Level 1 deaths, the DRC was required to complete its death review summary report within 60 calendar days from the date of death and submit the report to the institution's CEO within 7 calendar days thereafter. However, the DRC completed two reports 69 and 45 days late (129 and 105 days after the death) and submitted them to the institution's CEO 2 and 16 days late (138 and 128 days after the death). One report was completed timely but was submitted to the CEO 9 days late (59 days after the death). Lastly, for two other patient deaths that occurred on October 24, 2017 and October 29, 2017, the death review had not been completed as of early March 2018 (MIT 15.998).
- The OIG discusses the institution's health care staffing resources in the *About the Institution* section of this report (MIT 15.999).

RECOMMENDATIONS

The OIG recommends the following:

- The chief executive officer (CEO) should ensure all providers and nurses have access to any images and reports stored in the radiology information system-picture archive and communication system (RIS-PACS). During our inspection, we found that most of DVI's staff members were unable to access this important information.

- The pharmacist in charge (PIC) and the chief nursing executive (CNE) should implement quality improvement processes to correct the numerous medication continuity problems we found in this inspection, including issues with chronic care, hospital, reception center, and other transfer medications.

- The CNE should evaluate and improve DVI's current nursing sick call process because of the prevalence and severity of the errors we found in this inspection. The CNE should consider assigning clinic nurses, rather than TTA nurses, the responsibility of reviewing their own sick call requests and making their own triage decisions. The CNE should also consider having the staff review the sick call requests at a time other than the middle of the night when patients are reluctant to awaken for a medical evaluation. We have found the best sick call practices occur when sick call nurses review the requests before the clinic day begins. In this way, the sick call nurses can prioritize their own appointments accordingly, have an opportunity to discuss the requests during the huddles. Furthermore, patients are more likely to come to for an evaluation during normal daytime hours.

- The CNE should also expand improvement efforts to advance the quality of nursing assessments and interventions in several areas, including sick call requests, transfers-in, transfers-out, and hospital returns. These efforts should include additional nurse training and monitoring.

- The CNE should implement additional training and monitoring for first medical responders and TTA nurses so they accurately record the time and sequence of their assessments and interventions in accordance with the actual event.

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

Comparison of Population-Based Metrics

For the Deuel Vocational Institution, nine HEDIS measures were selected and are listed in the following *DVI 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. DVI performed very well with its management of diabetes.

When compared statewide, DVI's scores significantly exceeded Medi-Cal's in all five diabetic measures selected. When compared to Kaiser, Northern California, DVI scored higher in four of the five diabetic measures, scoring slightly lower for blood pressure control. DVI scored higher than Kaiser, Southern California, for three diabetic measures, but lower for blood pressure monitoring and diabetic eye exams.

When compared nationally, DVI outperformed Medicaid, commercial plans, and Medicare in all five diabetic measures. The institution also outperformed the United States Department of Veterans Affairs (VA) in three of the four applicable measures, with DVI scoring lower in diabetic eye exams.

Immunizations

Comparative data for immunizations was only fully available for the VA and partially available for Kaiser, commercial plans, Medicaid, and Medicare. With respect to administering influenza vaccinations to younger adults, DVI scored lower than all state and national health care plans, with the exception of Medicaid. For administering influenza vaccinations to older adults, DVI outperformed all health care plans available for comparison. With regard to administering pneumococcal vaccines to older adults, DVI scored higher than both Medicare and the VA.

Cancer Screening

With respect to colorectal cancer screening, DVI performed extremely well, outscoring all of the reporting entities: Kaiser, commercial plans, Medicare, and the VA.

Summary

DVI's population-based metrics performance reflected a well-functioning chronic care program in comparison to the other health care plans reviewed. DVI may improve its scores in administering influenza shots to younger adults by reducing patient refusals through educating patients on the benefits of these preventive services.

DVI Results Compared to State and National HEDIS Scores

Clinical Measures	California				National			
	DVI Cycle 5 Results[1]	HEDIS Medi-Cal 2017[2]	HEDIS Kaiser (No. CA) 2016[3]	HEDIS Kaiser (So. CA) 2016[3]	HEDIS Medicaid 2017[4]	HEDIS Com-mercial 2017[4]	HEDIS Medicare 2017[4]	VA Average 2016[5]
Comprehensive Diabetes Care								
HbA1c Testing (Monitoring)	**100%**	87%	94%	94%	87%	91%	94%	99%
Poor HbA1c Control (>9.0%)[6, 7]	**10%**	38%	20%	23%	43%	33%	26%	18%
HbA1c Control (<8.0%)[6]	**79%**	52%	70%	63%	47%	56%	63%	-
Blood Pressure Control (<140/90)[6]	**81%**	63%	83%	83%	60%	62%	64%	76%
Eye Exams	**71%**	57%	68%	81%	55%	54%	70%	89%
Immunizations								
Influenza Shots - Adults (18–64)	**43%**	-	56%	57%	39%	48%	-	52%
Influenza Shots - Adults (65+)	**100%**	-	-	-	-	-	71%	72%
Immunizations: Pneumococcal	**100%**	-	-	-	-	-	74%	93%
Cancer Screening								
Colorectal Cancer Screening	**95%**	-	79%	82%	-	62%	67%	82%

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

2. HEDIS Medi-Cal data was obtained from the California Department of Health Care Services *Medi-Cal Managed Care External Quality Review Technical Report (July 1, 2016 - June 30, 2017)*.

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

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

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

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

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

APPENDIX A — COMPLIANCE TEST RESULTS

Deuel Vocational Institution Range of Summary Scores: 55.6% - 92.7%	
Indicator	**Compliance Score (Yes %)**
1–***Access to Care***	77.2%
2–***Diagnostic Services***	55.6%
3–***Emergency Services***	Not Applicable
4–***Health Information Management (Medical Records)***	85.2%
5–***Health Care Environment***	68.1%
6–***Inter- and Intra-System Transfers***	59.6%
7–***Pharmacy and Medication Management***	61.9%
8–***Prenatal and Post-Delivery Services***	Not Applicable
9–***Preventive Services***	92.7%
10–***Quality of Nursing Performance***	Not Applicable
11–***Quality of Provider Performance***	Not Applicable
12–***Reception Center Arrivals***	62.9%
13–***Specialized Medical Housing (OHU, CTC, SNF, Hospice)***	Not Applicable
14–***Specialty Services***	82.5%
15–***Administrative Operations***	82.9%

Reference Number	1–*Access to Care*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
1.001	Chronic care follow-up appointments: Was the patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter?	21	4	25	84.0%	0
1.002	For endorsed patients received from another CDCR institution: If the nurse referred the patient to a provider during the initial health screening, was the patient seen within the required time frame?	17	8	25	68.0%	0
1.003	Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received?	30	0	30	100.0%	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?	17	13	30	56.7%	0
1.005	Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter?	5	5	10	50.0%	20
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	0	2	100.0%	28
1.007	Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame?	16	8	24	66.7%	1
1.008	Specialty service follow-up appointments: Do specialty service primary care physician follow-up visits occur within required time frames?	18	8	26	69.2%	4
1.101	Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms?	6	0	6	100.0%	0
Overall percentage:					**77.2%**	

Reference Number	2–*Diagnostic Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
2.001	Radiology: Was the radiology service provided within the time frame specified in the provider's order?	9	1	10	90.0%	0
2.002	Radiology: Did the primary care provider review and initial the diagnostic report within specified time frames?	5	5	10	50.0%	0
2.003	Radiology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	1	9	10	10.0%	0
2.004	Laboratory: Was the laboratory service provided within the time frame specified in the provider's order?	8	2	10	80.0%	0
2.005	Laboratory: Did the primary care provider review and initial the diagnostic report within specified time frames?	7	3	10	70.0%	0
2.006	Laboratory: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	1	9	10	10.0%	0
2.007	Pathology: Did the institution receive the final diagnostic report within the required time frames?	7	2	9	77.8%	0
2.008	Pathology: Did the primary care provider review and initial the diagnostic report within specified time frames?	6	2	8	75.0%	1
2.009	Pathology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	3	5	8	37.5%	1
Overall percentage:					**55.6%**	

3–*Emergency Services*

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

Reference Number	4–*Health Information Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated healthcare documents (provider progress notes) scanned within 3 calendar days of the patient encounter date?	6	0	6	100.0%	0
4.002	Are dictated/transcribed documents scanned into the patient's electronic health record within five calendar days of the encounter date?	Not Applicable				
4.003	Are High-Priority specialty notes (either a Form 7243 or other scanned consulting report) scanned within the required time frame?	14	6	20	70.0%	0
4.004	Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge?	16	4	20	80.0%	0
4.005	Are medication administration records (MARs) scanned into the patient's electronic health record within the required time frames?	Not Applicable				
4.006	During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files?	24	0	24	100.0%	0
4.007	For patients discharged from a community hospital: Did the preliminary hospital discharge report include key elements and did a primary care provider review the report within three calendar days of discharge?	19	6	25	76.0%	0
Overall percentage:					**85.2%**	

Reference Number	5–*Health Care Environment*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
5.101	Are clinical health care areas appropriately disinfected, cleaned and sanitary?	10	0	10	100.0%	0
5.102	Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	8	2	10	80.0%	0
5.103	Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	8	2	10	80.0%	0
5.104	Does clinical health care staff adhere to universal hand hygiene precautions?	4	6	10	40.0%	0
5.105	Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	10	0	10	100.0%	0
5.106	Warehouse, Conex and other non-clinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program?	0	1	1	0.0%	0
5.107	Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	6	4	10	60.0%	0
5.108	Do clinic common areas and exam rooms have essential core medical equipment and supplies?	9	1	10	90.0%	0
5.109	Do clinic common areas have an adequate environment conducive to providing medical services?	9	1	10	90.0%	0
5.110	Do clinic exam rooms have an adequate environment conducive to providing medical services?	6	3	9	66.7%	1
5.111	Emergency response bags: Are TTA and clinic emergency medical response bags inspected daily and inventoried monthly, and do they contain essential items?	3	4	7	42.9%	3
Overall percentage:					**68.1%**	

Reference Number	6–*Inter- and Intra-System Transfers*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
6.001	For endorsed patients received from another CDCR institution or COCF: Did nursing staff complete the initial health screening and answer all screening questions on the same day the patient arrived at the institution?	25	0	25	100.0%	0
6.002	For endorsed patients received from another CDCR institution or COCF: When required, did the RN complete the assessment and disposition section of the health screening form; refer the patient to the TTA, if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening?	23	0	23	100.0%	2
6.003	For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption?	6	3	9	66.7%	16
6.004	For patients transferred out of the facility: Were scheduled specialty service appointments identified on the patient's health care transfer information form?	6	13	20	31.6%	1
6.101	For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents?	0	6	6	0.0%	4
Overall percentage:					**59.6%**	

Reference Number	*7–Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.001	Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows?	6	15	21	28.6%	4
7.002	Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames?	21	4	25	84.0%	0
7.003	Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames?	17	7	24	70.8%	1
7.004	For patients received from a county jail: Were all medications ordered by the institution's reception center provider administered, made available, or delivered to the patient within the required time frames?	2	6	8	25.0%	12
7.005	Upon the patient's transfer from one housing unit to another: Were medications continued without interruption?	22	3	25	88.0%	0
7.006	For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption?	3	7	10	30.0%	0
7.101	All clinical and medication line storage areas for narcotic medications: Does the Institution employ strong medication security over narcotic medications assigned to its clinical areas?	3	4	7	42.9%	3
7.102	All clinical and medication line storage areas for non-narcotic medications: Does the Institution properly store non-narcotic medications that do not require refrigeration in assigned clinical areas?	3	5	8	37.5%	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	9	9	0.0%	1
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	83.3%	4
7.105	Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients?	6	0	6	100.0%	4
7.106	Medication preparation and administration areas: Does the Institution employ appropriate administrative controls and protocols when distributing medications to patients?	4	2	6	66.7%	4
7.107	Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and satellite pharmacies?	1	0	1	100.0%	0

Reference Number	7–*Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.108	Pharmacy: Does the institution's pharmacy properly store non-refrigerated medications?	1	0	1	100.0%	0
7.109	Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications?	0	1	1	0.0%	0
7.110	Pharmacy: Does the institution's pharmacy properly account for narcotic medications?	1	0	1	100.0%	0
7.111	Does the institution follow key medication error reporting protocols?	18	1	19	94.7%	6
Overall percentage:					**61.9%**	

8–*Prenatal and Post-Delivery Services*

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

Reference Number	9–*Preventive Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
9.001	Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed?	24	0	24	100.0%	0
9.002	Patients prescribed TB medication: Did the institution monitor the patient monthly for the most recent three months he or she was on the medication?	24	0	24	100.0%	0
9.003	Annual TB Screening: Was the patient screened for TB within the last year?	28	2	30	93.3%	0
9.004	Were all patients offered an influenza vaccination for the most recent influenza season?	25	0	25	100.0%	0
9.005	All patients from the age of 50 - 75: Was the patient offered colorectal cancer screening?	24	1	25	96.0%	0
9.006	Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy?	Not Applicable				
9.007	Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy?	Not Applicable				
9.008	Are required immunizations being offered for chronic care patients?	8	4	12	66.7%	13
9.009	Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	Not Applicable				
Overall percentage:					**92.7%**	

10–*Quality of Nursing Performance*

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

11–*Quality of Provider Performance*

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

Reference Number	12–*Reception Center Arrivals*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
12.001	For patients received from a county jail: Did nursing staff complete the initial health screening and answer all screening questions on the same day the patient arrived at the institution?	19	1	20	95.0%	0
12.002	For patients received from a county jail: When required, did the RN complete the assessment and disposition section of the health screening form, and sign and date the form on the same day staff completed the health screening?	9	0	9	100.0%	11
12.003	For patients received from a county jail: If, during the assessment, the nurse referred the patient to a provider, was the patient seen within the required time frame?	Not Applicable				
12.004	For patients received from a county jail: Did the patient receive a history and physical by a primary care provider within seven calendar days?	5	15	20	25.0%	0
12.005	For patients received from a county jail: Were all required intake tests completed within specified timelines?	16	4	20	80.0%	0
12.006	For patients received from a county jail: Did the primary care provider review and communicate the intake test results to the patient within specified timelines?	3	17	20	15.0%	0
12.007	For patients received from a county jail: Was a tuberculin test both administered and read timely?	16	0	16	100.0%	4
12.008	For patients received from a county jail: Was a Coccidioidomycosis (Valley Fever) skin test offered, administered, read, or refused timely?	5	15	20	25.0%	0
Overall percentage:					**62.9%**	

Reference Number	13–*Specialized Medical Housing*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient on the day of admission, or within eight hours of admission to CMF's Hospice?	3	0	3	100.0%	0
13.002	For CTC and SNF only: Was a written history and physical examination completed within the required time frame?	Not Applicable				
13.003	For OHU, CTC, SNF, and Hospice: Did the primary care provider complete the Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes on the patient at the minimum intervals required for the type of facility where the patient was treated?	0	2	2	0.0%	1
13.101	For OHU and CTC Only: Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter patient's cells?	Not Applicable				
Overall percentage:					**50.0% (N/A)**	

Note: For Cycle 5, DVI's OHU was non-operational during our review period. However, we found evidence of DVI's occasional usage of the OHU area for patient care. The institution did not provide an explanation for this occasional use. Our testing in this area was insufficient to determine any meaningful results. For Cycle 5, the Specialized Medical Housing rating is N/A.

Reference Number	14–*Specialty Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	Did the patient receive the high priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service?	13	2	15	86.7%	0
14.002	Did the primary care provider review the high priority specialty service consultant report within the required time frame?	12	3	15	80.0%	0
14.003	Did the patient receive the routine specialty service within 90 calendar days of the primary care provider order or Physician Request for Service?	15	0	15	100.0%	0
14.004	Did the primary care provider review the routine specialty service consultant report within the required time frame?	9	4	13	69.2%	2
14.005	For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames?	13	7	20	65.0%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	19	1	20	95.0%	0
14.007	Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame?	13	3	16	81.3%	4
Overall percentage:					**82.5%**	

Reference Number	15–*Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.001	Did the institution promptly process inmate medical appeals during the most recent 12 months?	12	0	12	100.0%	0
15.002	Does the institution follow adverse / sentinel event reporting requirements?	Not Applicable				
15.003	Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified?	6	0	6	100.0%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	1	0	1	100.0%	0
15.005	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	0	12	12	0.0%	0
15.006	For institutions with licensed care facilities: Does the Local Governing Body (LGB), or its equivalent, meet quarterly and exercise its overall responsibilities for the quality management of patient health care?	Not Applicable				
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?	3	0	3	100.0%	0
15.102	Did the institution's second level medical appeal response address all of the patient's appealed issues?	10	0	10	100.0%	0
15.103	Did the institution's medical staff review and submit the initial inmate death report to the Death Review Unit in a timely manner?	3	2	5	60.0%	0
15.104	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	Not Applicable				
15.105	Are nursing staff who administer medications current on their clinical competency validation?	10	0	10	100.0%	0
15.106	Are structured clinical performance appraisals completed timely?	0	6	6	0.0%	0
15.107	Do all providers maintain a current medical license?	9	0	9	100.0%	0
15.108	Are staff current with required medical emergency response certifications?	2	0	2	100.0%	1
15.109	Are nursing staff and the Pharmacist-in-Charge current with their professional licenses and certifications, and is the pharmacy licensed as a correctional pharmacy by the California State Board of Pharmacy?	5	0	5	100.0%	2

Reference Number	15–*Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.110	Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	1	0	1	100.0%	0
15.111	Are nursing staff current with required new employee orientation?	1	0	1	100.0%	0
Overall percentage:					**82.9%**	

APPENDIX B — CLINICAL DATA

Table B-1: DVI Sample Sets

Sample Set	Total
Anticoagulation	3
CTC/OHU	2*
Death Review/Sentinel Events	2
Diabetes	3
Emergency Services - CPR	2
Emergency Services - Non-CPR	2
High Risk	4
Hospitalization	4
Intra-system Transfers-In	3
Intra-system Transfers-Out	3
RN Sick Call	21
Reception Center Transfers	3
Specialty Services	2
	54

* *For Cycle 5, DVI's OHU was non-operational during our review period. However, we found evidence of DVI's occasional usage of the OHU area for patient care. The institution did not provide an explanation for this occasional use. Our testing in this area was insufficient to determine any meaningful results. For Cycle 5, the Specialized Medical Housing rating is N/A.*

Table B-2: DVI Chronic Care Diagnoses

Diagnosis	Total
Anemia	3
Anticoagulation	3
Arthritis/Degenerative Joint Disease	9
Asthma	9
COPD	5
Cancer	5
Cardiovascular Disease	13
Chronic Kidney Disease	4
Chronic Pain	22
Cirrhosis/End-Stage Liver Disease	3
Coccidioidomycosis	2
Diabetes	12
Gastroesophageal Reflux Disease	7
HIV	4
Hepatitis C	15
Hyperlipidemia	12
Hypertension	17
Mental Health	10
Migraine Headaches	2
Seizure Disorder	4
Thyroid Disease	2
	163

Table B-3: DVI Event - Program

Program	Total
Diagnostic Services	124
Emergency Care	36
Hospitalization	19
Intra-system Transfers-In	12
Intra-system Transfers-Out	5
Not Specified	1
Outpatient Care	289
Reception Center Care	47
Specialized Medical Housing	53*
Specialty Services	84
	670

**For Cycle 5, DVI's OHU was non-operational during our review period. However, we found evidence of DVI's occasional usage of the OHU area for patient care. The institution did not provide an explanation for this occasional use. Our testing in this area was insufficient to determine any meaningful results. For Cycle 5, the Specialized Medical Housing rating is N/A.*

Table B-4: DVI Review Sample Summary

	Total
MD Reviews Detailed	20
MD Reviews Focused	0
RN Reviews Detailed	13
RN Reviews Focused	33
Total Reviews	66
Total Unique Cases	54
Overlapping Reviews (MD & RN)	12

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

Deuel Vocational Institution (DVI)

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Access to Care			
MIT 1.001	Chronic Care Patients (25)	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • **Randomize**
MIT 1.002	Nursing Referrals (25)	OIG Q: 6.001	• See ***Intra-system Transfers***
MITs 1.003-006	Nursing Sick Call (5 per clinic) (30)	MedSATS	• Clinic (each clinic tested) • Appointment date (2–9 months) • **Randomize**
MIT 1.007	Returns from Community Hospital (25)	OIG Q: 4.007	• See ***Health Information Management (Medical Records)*** (returns from community hospital)
MIT 1.008	Specialty Services Follow-up (30)	OIG Q: 14.001 & 14.003	• See ***Specialty Services***
MIT 1.101	Availability of Health Care Services Request Forms (6)	OIG onsite review	• Randomly select one housing unit from each yard
Diagnostic Services			
MITs 2.001–003	Radiology (10)	Radiology Logs	• Appointment date (90 days–9 months) • **Randomize** • Abnormal
MITs 2.004–006	Laboratory (10)	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • **Randomize** • Abnormal
MITs 2.007–009	Pathology (9)	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 (6)	OIG Qs: 1.001, 1.002, & 1.004	• Non-dictated documents • 1st 10 IPs MIT 1.001, 1st 5 IPs MITs 1.002, 1.004
MIT 4.002	(0)	OIG Q: 1.001	• Dictated documents • First 20 IPs selected
MIT 4.003	(20)	OIG Qs: 14.002 & 14.004	• Specialty documents • First 10 IPs for each question
MIT 4.004	(20)	OIG Q: 4.007	• Community hospital discharge documents • First 20 IPs selected
MIT 4.005	(0)	OIG Q: 7.001	• MARs • First 20 IPs selected
MIT 4.006	(0)	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.007	Returns From Community Hospital (25)	Inpatient claims data	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • **Randomize** (each month individually) • First 5 patients from each of the 6 months (if not 5 in a month, supplement from another, as needed)
Health Care Environment			
MIT 5.101-105 MIT 5.107–111	Clinical Areas (10)	OIG inspector onsite review	• Identify and inspect all onsite clinical areas.
Inter- and Intra-System Transfers			
MIT 6.001-003	Intra-System Transfers (25)	SOMS	• Arrival date (3–9 months) • Arrived from (another CDCR facility) • Rx count • **Randomize**
MIT 6.004	Specialty Services Send-Outs (20)	MedSATS	• Date of transfer (3–9 months) • **Randomize**
MIT 6.101	Transfers Out (10)	OIG inspector onsite review	• R&R IP transfers with medication

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Pharmacy and Medication Management			
MIT 7.001	Chronic Care Medication (25)	OIG Q: 1.001	*See* ***Access to Care*** • At least one condition per patient—any risk level • **Randomize**
MIT 7.002	New Medication Orders (25)	Master Registry	• Rx count • **Randomize** • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns from Community Hospital (25)	OIG Q: 4.007	• See ***Health Information Management (Medical Records)*** *(returns from community hospital)*
MIT 7.004	RC Arrivals – Medication Orders (20)	OIG Q: 12.001	• See ***Reception Center Arrivals***
MIT 7.005	Intra-Facility Moves (25)	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • **Randomize**
MIT 7.006	En Route (10)	SOMS	• Date of transfer (2–8 months) • Sending institution (another CDCR facility) • **Randomize** • NA/DOT meds
MITs 7.101-103	Medication Storage Areas (varies by test)	OIG inspector onsite review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–106	Medication Preparation and Administration Areas (varies by test)	OIG inspector onsite review	• Identify and inspect onsite clinical areas that prepare and administer medications
MITs 7.107-110	Pharmacy (1)	OIG inspector onsite review	• Identify & inspect all onsite pharmacies
MIT 7.111	Medication Error Reporting (19)	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 (9)	Onsite active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in isolation units
Prenatal and Post-Delivery Services			
MIT 8.001-007	Recent Deliveries *(N/A at this institution)*	OB Roster	• Delivery date (2–12 months) • **Most recent** deliveries (within date range)
	Pregnant Arrivals *(N/A at this institution)*	OB Roster	• Arrival date (2–12 months) • **Earliest** arrivals (within date range)

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Preventive Services			
MITs 9.001–002	TB Medications (24)	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • **Randomize**
MIT 9.003	TB Evaluation, Annual Screening (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • Birth Month • **Randomize**
MIT 9.004	Influenza Vaccinations (25)	SOMS	• Arrival date (at least 1 year prior to inspection) • **Randomize** • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening (25)	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • **Randomize**
MIT 9.006	Mammogram *(N/A at this institution)*	SOMS	• Arrival date (at least 2 yrs prior to inspection) • Date of birth (age 52–74) • **Randomize**
MIT 9.007	Pap Smear *(N/A at this institution)*	SOMS	• Arrival date (at least three yrs prior to inspection) • Date of birth (age 24–53) • **Randomize**
MIT 9.008	Chronic Care Vaccinations (25)	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • **Randomize** • Condition must require vaccination(s)
MIT 9.009	Valley Fever (number will vary) *(N/A at this institution)*	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • **All**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Reception Center Arrivals			
MITs 12.001–008	RC (20)	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • **Randomize**
Specialized Medical Housing			
MITs 13.001–003	OHU (3)	CADDIS	• Admit date (1–6 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • **Randomize**
MIT 13.101	Call Buttons OHU (all)	OIG inspector onsite review	• Review by location
Specialty Services			
MITs 14.001–002	High-Priority (15)	MedSATS	• Approval date (3–9 months) • **Randomize**
MITs 14.003–004	Routine (15)	MedSATS	• Approval date (3–9 months) • Remove optometry, physical therapy or podiatry • **Randomize**
MIT 14.005	Specialty Services Arrivals (20)	MedSATS	• Arrived from (other CDCR institution) • Date of transfer (3–9 months) • **Randomize**
MIT 14.006-007	Denials (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 samples)	Data Source	Filters
Administrative Operations			
MIT 15.001	Medical Appeals (all)	Monthly medical appeals reports	• Medical appeals (12 months)
MIT 15.002	Adverse/Sentinel Events (0)	Adverse/sentinel events report	• Adverse/sentinel events (2–8 months)
MITs 15.003–004	QMC Meetings (6)	Quality Management Committee meeting minutes	• Meeting minutes (6 months)
MIT 15.005	EMRRC (12)	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.006	LGB (0)	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills (3)	Onsite summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	2nd Level Medical Appeals (10)	Onsite list of appeals/closed appeals files	• Medical appeals denied (6 months)
MIT 15.103	Death Reports (5)	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.104	RN Review Evaluations (0)	Onsite supervisor periodic RN reviews	• RNs who worked in clinic or emergency setting six or more days in sampled month • **Randomize**
MIT 15.105	Nursing Staff Validations (10)	Onsite nursing education files	• On duty one or more years • Nurse administers medications • **Randomize**
MIT 15.106	Provider Annual Evaluation Packets (6)	Onsite provider evaluation files	• All required performance evaluation documents
MIT 15.107	Provider licenses (9)	Current provider listing (at start of inspection)	• Review all

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

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

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Administrative Operations			
MIT 15.110	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations (all)	Onsite listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 15.111	Nursing Staff New Employee Orientations (all)	Nursing staff training logs	• New employees (hired within last 12 months)
MIT 15.998	Death Review Committee (5)	OIG summary log - deaths	• Between 35 business days & 12 months prior • CCHCS death reviews

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

January 3, 2019

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

Dear Mr. Wesley:

The Office of the Receiver has reviewed the draft report of the Office of the Inspector General (OIG) Medical Inspection Results for Deuel Vocational Institution (DVI) conducted from December 2017 to September 2018. California Correctional Health Care Services (CCHCS) acknowledges the 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) 691-3747.

Sincerely,

DeANNA GOULDY
Associate Director
Risk Management Branch
California Correctional Health Care Services

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