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Office of the Inspector General

California State Prison, Los Angeles County Medical Inspection Results Cycle 4

January 2017

Fairness ◆ Integrity ◆ Respect ◆ Service ◆ Transparency

Office of the Inspector General
CALIFORNIA STATE PRISON, LOS ANGELES COUNTY
Medical Inspection Results
Cycle 4

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EXECUTIVE SUMMARY

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

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

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

The OIG performed its Cycle 4 medical inspection at LAC from April to June 2016. The inspection included in-depth reviews of 87 inmate-patient files conducted by clinicians, as well as reviews of documents from 445 inmate-patient files, covering 1,359 objectively scored tests of compliance with policies and procedures applicable to the delivery of medical care. The OIG assessed the case review and compliance results at LAC using 14 health care quality indicators applicable to the institution, made up of 12 primary clinical indicators and 2 secondary administrative indicators. To conduct clinical case reviews, the OIG employs a clinician team consisting of a physician and a registered nurse consultant, while compliance testing is done by a team of deputy inspectors general and registered nurses trained in monitoring medical policy compliance. Of the 12 primary indicators, 7 were rated by both case review clinicians and compliance inspectors, 3 were rated by case review clinicians only, and 2 were rated by compliance inspectors only; both secondary indicators were rated by compliance inspectors only. See the *Health Care Quality Indicators* table on page *ii*. Based on that analysis, OIG experts made a considered and measured overall opinion that the quality of health care at LAC was *inadequate*.

Health Care Quality Indicators

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

Overall Assessment: Inadequate

Overall Assessment Rating:

Inadequate

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

Clinical Case Review and OIG Clinician Inspection Results

The clinicians' case reviews sampled patients with high medical needs and included a review of 1,725 patient care events.[1] Of the 12 primary indicators applicable to LAC, 10 were evaluated by clinician case review; 6 were *adequate*, and 4 were *inadequate.* When determining the overall adequacy of care, the OIG paid particular attention to the clinical nursing and provider quality indicators, as adequate health care staff can sometimes overcome suboptimal processes and programs. However, the opposite is not true; inadequate health care staff cannot provide adequate care, even though the established processes and programs onsite may be adequate. The OIG clinicians identify inadequate medical care based on the risk of significant harm to the patient, not the actual outcome. While the nursing and provider performance at LAC was generally adequate, it was unable to overcome multiple critical system failures in emergency services, diagnostic services, access to care, and transfer processes.

Program Strengths — Clinical

- Providers at LAC reported that the new medical leadership was supportive and approachable.
- The new medical leadership had already begun systematically reviewing various processes at LAC and had identified and remedied some system issues found during case review.
- The daily provider morning report meetings and morning huddles in the clinics were informative, pertinent, and effective in relaying necessary information.

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

Program Weaknesses — Clinical

- While the medical care by providers at LAC was rated adequate, it was notably suboptimal at times.
- Health information management was poor at LAC. Diagnostic reports were routinely reviewed late, and documents were not always available for review in the eUHR.
- Radiology reports were not readily available and accessible to providers.
- Legibility was sometimes an issue with providers and, more notably, with nurses.
- Emergency services functioned poorly, mainly due to inadequate nursing care.
- Medical care in the correctional treatment center (CTC) was fragmented, likely due to the high number of providers covering the CTC. However, at the time of the OIG clinicians' onsite visit in June 2016, the medical leadership reported a solution had already been put in place.
- The inter- and intra-system transfer processes functioned poorly.

Compliance Testing Results

Of the 14 health care indicators applicable to LAC, 11 were evaluated by compliance inspectors.[2] There were 108 individual compliance questions within those 11 indicators, generating 1,359 data points, that tested LAC's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[3] Those 108 questions are detailed in *Appendix A — Compliance Test Results*. The institution's inspection scores in the 11 applicable indicators ranged from 64.5 percent to 86.8 percent, with the primary (clinical) indicator *Health Information Management (Medical Records)* receiving the lowest score, and the secondary (administrative) indicator *Job Performance, Training, Licensing, and Certifications* receiving the highest. Of the nine primary indicators applicable to compliance testing, the OIG rated two *adequate* and seven *inadequate.* Of the two secondary indicators, which involve administrative health care functions, one was rated *proficient* and one, *inadequate*.

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

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

Program Strengths — Compliance

As the *LAC Executive Summary Table* on page *viii* indicates, the institution's compliance rating was *proficient*, scoring above 85 percent, in only one indicator, the secondary indicator *Job Performance, Training, Licensing, and Certifications*. The following are some of LAC's strengths based on its compliance scores on individual questions in all the primary health care indicators:

- For all patients sampled, nursing staff timely reviewed requests for health care services and timely completed face-to-face visits.
- In all clinics, staff properly sterilized or disinfected reusable medical equipment.
- Nurses employed appropriate administrative controls and followed proper protocols during the medication preparation process.
- LAC's main pharmacy followed general security, organization, and cleanliness management protocols, followed required medication error reporting protocols, and properly accounted for narcotic medications.
- The institution offered timely immunizations and colorectal cancer screenings to applicable patients.

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

- All providers, nursing staff, and the pharmacist in charge were current with their professional licenses; the pharmacy and authorized providers who prescribed controlled substances maintained current Drug Enforcement Agency registrations.
- All nursing staff hired within the most recent year received timely new employee orientation training, and nursing staff who administered medications possessed current clinical competency validations.

Program Weaknesses — Compliance

The institution received ratings of *inadequate*, scoring below 75 percent, in the following seven primary indicators: *Access to Care*, *Diagnostic Services*, *Health Information Management (Medical Records)*, *Health Care Environment*, *Inter- and Intra-System Transfers*, *Pharmacy and Medication Management*, and *Preventive Services*. The institution also received an *inadequate* score in the secondary indicator *Internal Monitoring, Quality Improvement, and Administrative Operations*. The following are some of the weaknesses identified by LAC's compliance scores on individual questions in all the primary health care indicators:

- Primary care providers did not conduct timely provider appointments for patients who suffered from chronic care conditions; for patients referred to a provider by nursing staff; or for patients who required a provider follow-up visit after receiving a specialty service, following a discharge from a community hospital, or following a provider sick call appointment.

- Health records staff did not always properly label or file health care documents into patients' electronic health records.

- Clinic exam rooms and common areas were often missing essential equipment and supplies, and emergency response bags did not always contain essential items. In many clinics, patients' auditory and visual privacy was compromised during exams and vital sign encounters, and patients' designated restrooms lacked hand hygiene supplies. Several clinic exam rooms were cramped or cluttered, or contained furniture in disrepair.

- For patients who transferred out of LAC, transfer packets did not include required medications and documentation; for patients who transferred with approved pending specialty service appointments, the institution did not identify the approved services on health care transfer forms.

- Nursing staff did not always timely deliver or administer prescribed medications to patients who returned from a community hospital, or to those who transferred to LAC from another institution or who were en route to another institution with a layover at LAC.

- The institution did not employ strong security controls over narcotic medications in clinical areas, and clinical staff did not always properly store non-narcotic medications.

- Nursing staff did not properly administer anti-tuberculosis medication to those who tested positive for tuberculosis, and patients who refused their medication did not receive follow-up counseling from a provider about the missed doses.

- Providers did not complete assessments at required intervals for patients admitted to the CTC.

- When patients transferred into LAC from other institutions with approved specialty service appointments, they often did not receive their services or received them late; when providers' specialty services requests were denied, the providers often failed to timely communicate those denials to the patients.

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

- Medical emergency response drill packages for the most recent quarter lacked required documentation, and drills did not include participation of both health care and custody staff.
- Clinical supervisors did not conduct sufficient periodic reviews of nursing staff.

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

LAC Executive Summary Table

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

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

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

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

Population-Based Metrics

In general, LAC performed well as measured by population-based metrics. In four of five comprehensive diabetes care measures, the institution matched or outperformed Medi-Cal and Kaiser Permanente, typically one of the highest scoring health organizations in California. For blood pressure control of diabetics, Kaiser outperformed LAC. In comparison to national organizations, LAC outperformed Medicaid, Medicare, and commercial entities in all five diabetic measures, but scored significantly lower than the United States Department of Veterans Affairs in dilated eye exams for diabetic patients.

The institution's scores were higher than or nearly the same as other State and national entities' scores with regard to immunization measures; LAC scored mid-range when compared to other entities for colorectal cancer screenings. However, for immunization and cancer screening measures, LAC routinely offered patients these preventive services, but many of them refused the offers; these refusals adversely affected the institution's scores.

Overall, LAC's performance indicated that its comprehensive diabetes care was above average and its immunization and colorectal cancer screening measures were average when compared to other State and national health care organizations. With respect to immunizations and cancer screenings, educating patients about refusals could improve LAC's scores in these measures.

INTRODUCTION

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

California State Prison, Los Angeles County (LAC) was the 26th medical inspection of Cycle 4. During the inspection process, the OIG assessed the delivery of medical care to patients for 12 primary clinical health care indicators and 2 secondary administrative health care indicators applicable to the institution. It is important to note that while the primary quality indicators represent the clinical care being provided by the institution at the time of the inspection, the secondary quality indicators are purely administrative and are not reflective of the actual clinical care provided.

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

ABOUT THE INSTITUTION

California State Prison, Los Angeles County (LAC), was constructed to meet the access requirements of the Americans with Disabilities Act (ADA) and has been designated to house security Levels I, III, and IV inmates. The housing of these inmates is accomplished on a minimum support facility and four 270-bed-design facilities. The institution provides productivity and self-improvement opportunities for inmates through academic classes, work programs, and religious and self-help groups. It also serves as a reentry hub with programs such as commercial plumbing, commercial painting, masonry, and computer literacy.

LAC runs eight medical clinics where staff members handle non-urgent requests for medical services. The institution also conducts patient screenings in its receiving and release clinical area, treats patients who require urgent or immediate care in its triage and treatment area (TTA), and treats patients who require inpatient care in its correctional treatment center (CTC). The CTC is a State-licensed facility where patients receive professionally supervised health care beyond that normally provided in the community on an outpatient basis. LAC also serves as a medical hub for enhanced outpatient programming (EOP) and EOP administrative segregation levels of healthcare. LAC is designated an "intermediate care prison"; these institutions are predominantly located in urban areas close to tertiary care centers and specialty care providers likely to be necessary for a population with moderately high medical needs.

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

Based on staffing data the OIG obtained from the institution, LAC's vacancy rate among medical managers, providers, nursing supervisors, and non-supervisory nurses was 23 percent in March 2016. LAC experienced the highest vacancy percentage among providers (27 percent) with three positions vacant and a total position authority for 11 providers. The institution also had a 23 percent vacancy rate among non-supervisory nurses, with 28.3 vacant positions and 4 nurses who were on long-term medical leave. Eighteen of the non-supervisory nurses were contracted staff hired through the nursing registry. The chief executive officer for health care services (CEO) reported that 10 medical staff members had been placed under CDCR disciplinary review during the prior 12-month period, but as of March 2016, 3 of those staff were no longer working at the institution; the remaining 7 continued to work in health care positions at LAC.

LAC Health Care Staffing Resources as of March 2016

	Management		Providers		Nursing Supervisors		Nursing Staff		Totals	
Description	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Authorized Positions	5	3%	11	7%	10.5	7%	120.7	82%	147.2	100%
Filled Positions	4	80%	8	73%	9	86%	92.4	77%	113.4	77%
Vacancies	1	20%	3	27%	1.5	14%	28.3	23%	33.8	23%
Recent Hires (within 12 months)	2	50%	0	0%	3	33%	28	30%	33	29%
Staff Utilized from Registry	0	0%	1	13%	0	0%	18	19%	19	17%
Redirected Staff (to Non-Patient Care Areas)	0	0%	0	0%	0	0%	0	0%	0	0%
Staff on Long-term Medical Leave	0	0%	0	0%	1	11%	4	4%	5	4%

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

As of March 21, 2016, the Master Registry for LAC showed that the institution had a total population of 3,586. Within that total population, 4.2 percent were designated as high medical risk, Priority 1 (High 1), and 11.3 percent were designated as high medical risk, Priority 2 (High 2). Patients' assigned risk levels are based on the complexity of their required medical care related to their specific diagnoses, frequency of higher levels of care, age, and abnormal labs and procedures. High 1 has at least two high-risk conditions; High 2 has only one. Patients at high medical risk are more susceptible to poor health outcomes than those at medium or low medical risk. Patients at high medical risk also typically require more health care services than do patients with lower assigned risk levels. The chart below illustrates the breakdown of the institution's medical risk levels at the start of the OIG medical inspection.

LAC Master Registry Data as of March 21, 2016

Medical Risk Level	# of Inmate-Patients	Percentage
High 1	150	4.2%
High 2	406	11.3%
Medium	1,801	50.2%
Low	1,229	34.3%
Total	**3,586**	**100.0%**

Commonly Used Abbreviations

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

OBJECTIVES, SCOPE, AND METHODOLOGY

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

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

The OIG rates each of the quality indicators applicable to the institution under inspection based on case reviews conducted by OIG clinicians and compliance tests conducted by OIG deputy inspectors general and registered nurses. The ratings may be derived from the case review results alone, the compliance test results alone, or a combination of both these information sources. For example, the ratings for the primary quality indicators *Quality of Nursing Performance* and *Quality of Provider Performance* are derived entirely from the case review results, while the ratings for the primary quality indicators *Health Care Environment* and *Preventive Services* are derived entirely from compliance test results. As another example, primary quality indicators such as *Diagnostic Services* and *Specialty Services* receive ratings derived from both sources. At LAC, 14 of the quality indicators were applicable, consisting of 12 primary clinical indicators and 2 secondary administrative indicators. Of the 12 primary indicators, 7 were rated by both case review clinicians and compliance inspectors, 3 were rated by case review clinicians only, and 2 were rated by compliance inspectors only; both secondary indicators were rated by compliance inspectors only.

Consistent with the OIG's agreement with the Receiver, this report only addresses the conditions found related to medical care criteria. The OIG does not review for efficiency and economy of

operations. Moreover, if the OIG learns of an inmate-patient needing immediate care, the OIG notifies the institution's 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 chief executive officer or to CCHCS. Because these matters involve confidential medical information protected by State and federal privacy laws, specific identifying details related to any such cases are not included in the OIG's public report.

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

CASE REVIEWS

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

PATIENT SELECTION FOR RETROSPECTIVE CASE REVIEWS

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

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

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

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

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

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

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

BENEFITS AND LIMITATIONS OF TARGETED SUBPOPULATION REVIEW

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

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

Nonetheless, the health care system's response to this subpopulation can be accurately evaluated and yields valuable systems information. In the above example, if the health care system is

providing appropriate diabetic monitoring, medication therapy, and specialty referrals for the high-risk patients reviewed, then it can be reasonably inferred that the health care system is also providing appropriate diabetic services to the entire diabetic subpopulation. However, if these same high-risk patients needing monitoring, medications, and referrals are generally not getting those services, it is likely that the health care system is not providing appropriate diabetic services to the greater diabetic subpopulation.

CASE REVIEWS SAMPLED

As indicated in *Appendix B, Table B–1: LAC Sample Sets*, the OIG clinicians evaluated medical charts for 70 unique inmate-patients. *Appendix B, Table B–4: LAC Case Review Sample Summary*, clarifies that both nurses and physicians reviewed charts for 17 of those patients, for 87 reviews in total. Physicians performed detailed reviews of 30 charts, and nurses performed detailed reviews of 18 charts, totaling 48 detailed reviews. For detailed case reviews, physicians or nurses looked at all encounters occurring in approximately six months of medical care. Nurses also performed a limited or focused review of medical records for an additional 39 inmate-patients. These generated 1,725 clinical events for review (*Appendix B, Table B–3: LAC Event–Program*). The inspection tool provides details on whether the encounter was adequate or had significant deficiencies, and identifies deficiencies by programs and processes to help the institution focus on improvement areas.

While the sample method specifically pulled only six chronic care patient records, i.e., three diabetes patients and three anticoagulation patients (*Appendix B, Table B–1: LAC Sample Sets*), the 70 unique inmate-patients sampled included patients with 216 chronic care diagnoses, including 10 additional patients with diabetes (for a total of 13) and one additional anticoagulation patient (for a total of four) (*Appendix B, Table B–2: LAC Chronic Care Diagnoses*). The OIG's sample selection tool allowed evaluation of many chronic care programs because the complex and high-risk patients selected from the different categories often had multiple medical problems. While the OIG did not evaluate every chronic disease or health care staff member, the overall operation of the institution's system and staff were assessed for adequacy. The OIG's case review methodology and sample size matched other qualitative research. The empirical findings, supported by expert statistical consultants, showed adequate conclusions after 10 to 15 charts had undergone full clinician review. In qualitative statistics, this phenomenon is known as "saturation." The OIG asserts that the physician sample size of 30 detailed reviews certainly far exceeds the saturation point necessary for an adequate qualitative review. With regard to reviewing charts from different providers, the case review is not intended to be a focused search for poorly performing providers; rather, it is focused on how the system cares for those patients who need care the most. Nonetheless, while not sampling cases by each provider at the institution, the OIG inspections adequately review most providers. Providers would only escape OIG case review if institutional management successfully mitigated patient risk by having the more poorly performing providers care for the less complicated, low-utilizing, and lower-risk patients. The OIG's clinicians concluded that the case review sample size was more than adequate to assess the quality of services provided.

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

COMPLIANCE TESTING

SAMPLING METHODS FOR CONDUCTING COMPLIANCE TESTING

From April to June 2016, deputy inspectors general and registered nurses attained answers to 108 objective medical inspection test (MIT) questions designed to assess the institution's compliance with critical policies and procedures applicable to the delivery of medical care. To conduct most tests, inspectors randomly selected samples of inmate-patients for whom the testing objectives were applicable and reviewed their electronic unit health records. In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed health records for 445 individual inmate-patients and analyzed specific transactions within their records for evidence that critical events occurred. Inspectors also reviewed management reports and meeting minutes to assess certain administrative operations. In addition, during the week of April 4, 2016, field inspectors conducted a detailed onsite inspection of LAC's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,359 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 LAC's plant infrastructure, protocols for tracking medical appeals and local operating procedures, and staffing resources.

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

SCORING OF COMPLIANCE TESTING RESULTS

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

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

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

After compiling the answers to the 108 questions, the OIG derived a score for each primary and secondary quality indicator identified above by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Based on those results, the OIG assigned a rating to each quality indicator of *proficient* (greater than 85 percent), *adequate* (between 75 percent and 85 percent), or *inadequate* (less than 75 percent).

DASHBOARD COMPARISONS

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

OVERALL QUALITY INDICATOR RATING FOR CASE REVIEWS AND COMPLIANCE TESTING

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

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

POPULATION-BASED METRICS

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

MEDICAL INSPECTION RESULTS

PRIMARY (CLINICAL) QUALITY INDICATORS OF HEALTH CARE

The primary quality indicators assess the clinical aspects of health care. As shown on the *Health Care Quality Indicators* table on page *ii* of this report, 12 of the OIG's primary indicators were applicable to LAC. Of those 12 indicators, 7 were rated by both the case review and compliance components of the inspection, 3 were rated by the case review component alone, and 2 were rated by the compliance component alone.

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

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

The OIG physicians rated the overall adequacy of care for each of the 30 detailed case reviews they conducted. Of these 30 cases, 28 were *adequate*, and 2 were *inadequate*. In the 1,725 events reviewed, there were 701 deficiencies, of which 46 were considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

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

There were no unsafe conditions or adverse events identified in the case reviews at LAC.

Summary of Compliance Results: The compliance component assessed 9 of the 12 primary (clinical) indicators applicable to LAC. Of these 9 indicators, OIG inspectors rated 2 *adequate*, and 7 *inadequate*. The results of those assessments are summarized within this section of the report. The test questions used to assess compliance for each indicator are detailed in *Appendix A*.

ACCESS TO CARE

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

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(72.2%)

Overall Rating:
Inadequate

In this indicator, the OIG case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance review resulting in an *inadequate* score. The OIG's internal review process considered those factors that led to both scores and ultimately rated this indicator *inadequate*, placing a heavier reliance on compliance testing. The case review assessments mainly focused on high-risk patients and targeted more recent patient appointments, but the compliance review randomly selected patients across various categories and evaluated the timeliness of appointments from two weeks to nine months prior to the inspection; this provided a more robust assessment of patients' access to medical care at LAC. In addition, similar to the compliance results, case review identified late appointments for the institution's new patient arrivals but reported those deficiencies in the *Inter- and Intra-System Transfers* indicator. As a result, the compliance review rating of *inadequate* was deemed a more appropriate reflection of the overall indicator rating.

Case Review Results

The OIG clinicians reviewed 627 outpatient provider and nursing encounters and identified 43 deficiencies relating to *Access to Care*. Only one deficiency was significant, case 11. This patient required monitoring and screening for cirrhosis. A follow-up visit ordered for this patient did not occur in two to three months as ordered. The patient was lost to follow-up for seven months, at which time the patient refused the visit. With the exception of case 11, LAC performed well with regard to *Access to Care*, and the case review rating was *adequate*.

Onsite Visit

During the OIG clinicians' onsite visit to the institution in June 2016, they learned of an ongoing backlog of patients waiting to be seen. The new medical leadership reported the backlog was due to the 30 to 40 percent provider vacancy that had occurred during the prior year, that the backlog was decreasing, and that LAC's provider vacancies were nearly filled.

Compliance Testing Results

The institution performed in the *inadequate* range in the *Access to Care* indicator, with a compliance score of 72.2 percent. The institution showed room for improvement in the following areas:

- Of the eight patients whom nursing staff referred to a provider and for whom the provider subsequently ordered a follow-up appointment, only four (50 percent) received their follow-up appointments timely. The remaining four patients received their follow-up appointments from 7 to 17 days late (MIT 1.006).

- Of the 30 sampled patients who had been discharged from a community hospital, 15 (50 percent) were timely offered a follow-up appointment with a provider and either received or refused it. Thirteen patients received appointments from one to 14 days late, and the two remaining patients did not receive a follow-up appointment at all (MIT 1.007).

- Of the 27 sampled patients who received a specialty service, 16 of them (59 percent) received a timely follow-up appointment with a provider. Eight patients received an appointment between 2 and 63 days late; three patients did not receive a follow-up visit (MIT 1.008).

- When the OIG reviewed recent appointments for 40 patients with chronic care conditions, only 25 of them (63 percent) received timely appointments. Thirteen patients received their appointments from 12 to 98 days late, while one was only two days late, and another was more than six months late (MIT 1.001).

- Among 11 sampled Health Care Services Request forms (CDCR Form 7362) on which nursing staff referred the patient for a provider appointment, seven patients (64 percent) received timely appointments. Four patients received their appointments from 3 to 29 days late (MIT 1.005).

- Provider appointments occurred timely for 16 of the 25 sampled patients who either transferred into LAC with a pre-existing need for a chronic care provider visit or received a new provider referral from the LAC screening nurse upon arrival (64 percent). Providers conducted three appointments from one to six days late, and six appointments 12 to 82 days late (MIT 1.002).

LAC received *proficient* scores of 100 percent in the following areas:

- Inspectors sampled 40 service request forms submitted by patients across all facility clinics. Nursing staff reviewed all the forms on the same day they were received and completed a face-to-face encounter with all 40 patients within one business day of reviewing the service request form (MIT 1.003, 1.004).

- Inmates had access to service request forms at all six housing units inspected (MIT 1.101).

Recommendations

No specific recommendations.

DIAGNOSTIC SERVICES

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(73.3%)

Overall Rating:
Inadequate

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

Case Review Results

The OIG clinicians reviewed 272 diagnostic events and found 115 deficiencies. The majority of these deficiencies related to health information management, i.e., diagnostic reports were missing from the health records or they were not reviewed and signed by a provider in a timely manner. Other deficiencies included diagnostic tests not being performed timely and incorrect tests being performed. In a small number of cases, abnormal results were not adequately addressed by the primary care providers. Due to the high number and patterns of deficiencies found, the case review rating for this indicator was *inadequate*.

Compliance Testing Results

The institution received an *inadequate* compliance score of 73.3 percent in the *Diagnostic Services* indicator, which encompasses radiology, laboratory, and pathology services. For clarity, each type of diagnostic service is discussed separately below:

Radiology Services

All ten of the radiology services sampled were timely performed (MIT 2.001). However, providers initialed and dated the radiology report, evidencing they reviewed the report within two business days of receipt, for only six of the ten patients (60 percent); providers reviewed four patients' reports between 2 and 13 days late (MIT 2.002). As a result, providers timely communicated the radiology results to only those six patients, communicating the results late to the remaining four patients (MIT 2.003).

Laboratory Services

Laboratory services were completed within the time frame specified in the provider's order for nine of ten patients sampled (90 percent); one patient received his service two days late (MIT 2.004). Providers timely reviewed the laboratory report results for nine of those ten patients (90 percent);

the provider reviewed one report nine days late (MIT 2.005). Providers timely communicated the test results to eight of the ten sampled patients (80 percent); for the remaining two patients, providers communicated results seven and nine days late (MIT 2.006).

Pathology Services

The institution received the final pathology report timely for only six of ten patients sampled (60 percent). The four untimely reports were from 4 to 13 days late (MIT 2.007). With regard to providers' review of pathology results, nine of the ten reviews were timely (90 percent); a provider reviewed one report four days late (MIT 2.008). Providers communicated pathology results timely to only three of the ten patients who received the service (30 percent). For six patients, the provider did not discuss the final pathology results with the patient within two business days of receipt of the test results; untimely communication was from 2 to 20 days late. For the remaining patient, the provider did not communicate the pathology results at all (MIT 2.009).

Recommendation

The OIG recommends that LAC's health care management improve flow processes regarding the ordering and reviewing of diagnostic tests.

EMERGENCY SERVICES

Case Review Rating:
Inadequate
Compliance Score:
Not Applicable

Overall Rating:
Inadequate

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

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

Case Review Results

The OIG clinicians reviewed 95 urgent/emergent events and found 100 deficiencies; 10 were significant deficiencies (cases 1, 3, 4, 5, 6, 16, 18, and 38, with some events having multiple deficiencies). The majority of the deficiencies were related to nursing care. The case review rating for this indicator was *inadequate.*

Provider Performance

Providers covering the TTA generally made appropriate triage decisions and sent patients to appropriate levels of care.

Nursing Performance

The majority of deficiencies found in emergency services related to untimely and inadequate nursing assessment, intervention, and documentation, as illustrated in the examples below:

- In case 1, a patient in the administrative segregation unit complained of severe chest pain. His pulse and breathing were rapid. The psychiatric technician (PT) failed to immediately request the TTA RN, but instead did so 15 minutes later. The nurse responded at an undocumented arrival time, but failed to immediately transport the patient to the TTA for nitroglycerin treatment. The patient received nitroglycerin after a delay of one hour and 16 minutes from initial symptoms. The OIG also identified a delay in treating the patient in case 18 with nitroglycerin.

- In case 3, the PT requested the TTA RN for a patient with chest pain. The RN failed to perform a thorough assessment, reassess blood pressure, assess this patient's significant risk

factors, document the time of response, or contact a provider. Two weeks later, the patient again complained of chest pain; his blood pressure was significantly elevated (159/111). The PT reported vital signs and requested the TTA RN. The RN did not respond for 25 minutes. The OIG found additional examples of incomplete nursing assessment in cases 2, 17, 19, 31, 38, and 41.

- In case 4, the PT contacted the TTA RN for a patient with chest pain. However, the PT failed to document the event. Similar deficiencies were also identified in cases 3, 15, and 38.

- In case 5, a medical alarm was activated for a patient with an altered level of consciousness. The LVN (first medical responder) arrived in the housing unit. The patient did not respond to words or touch stimulation. His breaths were shallow, and his pupils were nonreactive. Two liters of oxygen were administered to the patient, an RN was requested, and the patient was transported to the medical clinic. Upon the RN's arrival at the medical clinic, the patient's vital signs and oxygen saturation had not been assessed. Failure of an LVN to promptly assess vital signs was also identified in case 38.

- In case 16, the nurse failed to order a provider follow-up appointment after the patient was seen by nursing and the provider was contacted for seizure activity.

- In case 38, the patient presented to the medical clinic with dizziness, then complained of chest pain and vomited. The LVN requested assistance from the TTA RN. The RN did not respond for 26 minutes.

- In case 41, the TTA RN received a critical lab value (low blood count hemoglobin of 5.5). The RN failed to perform a face-to face assessment. Failure to perform face-to-face assessments was also identified in cases 4 and 38.

Emergency Medical Response Review Committee

The nursing instructor often completed the emergency medical response review. However, these events were not reviewed by the chief medical executive, as required by policy. Other deficiencies were also noted:

- Non-scheduled emergent transfers initiated from the CTC were not reviewed.

- In case 1, a nursing review was conducted. However, numerous deficiencies were not identified. Nursing's failure to identify deficiencies was also found in cases 2, 3, 5, 6, 16, 17, and 18.

- In case 6, the Emergency Medical Response Review Committee identified a delay in 9-1-1 activation, and indicated training would be conducted. Documentation of such training was not found.

Onsite Visit

During the onsite visit, the OIG clinicians confirmed emergency medications such as Narcan (treatment for narcotics overdose), nitroglycerin (treatment for chest pain), epinephrine (treatment for life-threatening allergic reactions), and glucagon (treatment for low blood sugar) were not available to first medical responders in the yards or in the administrative segregation unit. These medications were only available in the TTA.

- The OIG clinicians also learned the LVNs or RNs most often served as the medical first responders. However, in D yard (units 1 and 2) and in the administrative segregation unit, the medical needs were most often routed through PTs. During first watch, the TTA RN served as the first medical responder in all yards.

Conclusion

LAC performed poorly with regard to emergency services, mainly due to inadequate nursing care. The OIG rated the *Emergency Services* indicator *inadequate*.

Recommendations

The OIG recommends that the LAC nursing leadership implement strategies to:

- Audit and enforce complete, accurate, organized, and timely documentation of urgent/emergent care, compliant with documentation standards.

- Ensure patient complaints are assessed in a timely manner, regardless of the method they are initially reported, i.e., via medical alarm, in the pill line, or by custody staff.

- Implement a process to evaluate the timeliness and appropriateness of urgent/emergent complaints.

- Review the current emergency medical response review process and ensure deficiencies are adequately identified and addressed, and that all training is documented.

- Ensure all patients presenting with symptoms that may require emergency medications are promptly taken to an area where appropriate interventions can be promptly initiated.

HEALTH INFORMATION MANAGEMENT (MEDICAL RECORDS)

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(64.5%)

Overall Rating:
Inadequate

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

Case Review Results

The OIG clinicians found 154 deficiencies with LAC's health information management. Due to the high number and patterns of deficiencies found, case review rated the *Health Information Management* indicator *inadequate*.

Inter-Departmental Transmission

A few deficiencies related to orders not being carried through to various departments, such as incorrect labs being drawn and medication orders not being carried out.

Hospital Records

Hospital records were generally reviewed in a timely manner, though hospital discharge recommendations were not always carried out. This is discussed further in the Q*uality of Provider Performance* indicator.

Specialty Services

The majority of health information management deficiencies relating to specialty services were due to specialty reports not being reviewed and signed by a primary care provider in a timely manner, or specialty reports not being in the eUHR. Other deficiencies were due to patient health records not being available to specialists and a few illegible specialty consult notes.

Diagnostic Reports

Over half of the deficiencies noted in health information management related to diagnostic reports not being reviewed and signed in a timely manner or being missing from the health record altogether.

Urgent/Emergent Records

The few health information management deficiencies relating to urgent/emergent records were due to missing provider notes and inconsistent nursing documentation.

Scanning Performance

The few deficiencies relating to scanning performance were misfiled documents and various documents (specialty referrals, progress notes, provider orders, etc.) missing from the health records.

Legibility

A number of deficiencies were due to illegible nursing notes and signatures, especially in specialized medical housing. A few deficiencies were also due to provider signatures and portions of provider progress notes being illegible.

Miscellaneous

The use of legacy notes was found in several cases. These notes were cloned copies of prior notes with few changes made. In some of these cases, portions of the notes were misleading or confusing, as they had not been changed from prior visits. The use of legacy notes can cause confusion for subsequent providers, and creates a risk for harm to patients. This issue is also noted in the *Quality of Provider Performance* indicator.

Compliance Testing Results

LAC scored in the *inadequate* range in the *Health Information Management (Medical Records)* indicator, receiving a compliance score of 64.5 percent. LAC received *inadequate* scores in the following four areas:

- The institution scored zero in labeling and filing documents scanned into patients' eUHR; all errors were mislabeled documents, such as the scanning and mislabeling of a Patient Influenza Vaccine Documentation form (CDCR Form 7466) as a Refusal of Exam (CDCR Form 7225) (MIT 4.006).

- Only 10 of the 20 sampled medication administration records (MARs) were timely scanned into the patients' eUHR (50 percent); 10 MARs were scanned one or two days late (MIT 4.005).

- Institution staff timely scanned 10 of 20 sampled initial health screening forms and health care service request forms into patients' eUHRs within three calendar days of the patient encounter (50 percent). Ten documents were scanned one to three days late (MIT 4.001).

- The eUHR files for 21 of 30 sampled patients sent or admitted to the hospital were complete and reviewed by providers within three calendar days of discharge (70 percent). For five patients, the hospital discharge report did not include the admission or discharge date. For two other patients, there was no evidence providers reviewed the discharge report at all, and the provider reviewed the discharge summary report one day late for one other patient. For one final patient, there was no evidence the institution ever received the hospital discharge report (MIT 4.008).

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

- LAC scored 80 percent for the timely scanning of dictated or transcribed provider progress notes into patients' eUHR files. Twelve of 15 sampled documents were timely scanned within five calendar days; three documents were scanned from one to nine days late (MIT 4.002).

- Twenty-six of 32 samples of various medical documents such as hospital discharge reports, initial health screening forms, certain medication records, and specialty services reports (81 percent) showed compliance with clinical staff legibly documenting their names on the forms. Six of the samples did not include clinician name stamps, or the signatures were illegible (MIT 4.007).

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

- LAC staff timely scanned 18 of 20 sampled specialty service consultant reports into the patient's eUHR files (90 percent). The other two documents were scanned one and 63 days late (MIT 4.003).

- The institution timely scanned 19 of 20 sampled community hospital discharge reports or treatment records into patients' eUHRs (95 percent); one report was scanned one day late (MIT 4.004).

Recommendations

The OIG recommends that health care management implement the following actions:

- Implement processes to ensure pertinent patient records are available to specialists at the time of specialty consultations; ensure that providers request and retrieve dictated reports from specialty consultants if their hand-written notes are illegible.

- Prohibit the use of legacy notes.

HEALTH CARE ENVIRONMENT

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

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

Overall Rating:
Inadequate

Compliance Testing Results

LAC scored in the *inadequate* range in the *Health Care Environment* indicator, receiving a compliance score of 67.5 percent. Although the institution received a *proficient* score in 4 of the 11 applicable indicator test areas and an *adequate* score in one other test area, it received an *inadequate* score in six areas, as discussed below:

- Only 2 of the 11 clinics' common areas and exam rooms (18 percent) had all essential supplies and core medical equipment available for immediate and reliable use. The remaining nine clinics had one or more of the following deficiencies: exam rooms or clinic areas lacked biohazard waste receptacles or bags, nebulization units, hemoccult cards, sharps containers, an exam table, or a medication refrigerator; Snellen charts and distance markers were missing or incorrectly located; and an ultrasound machine in the specialty clinic was not functional (MIT 5.108).

- The OIG inspected various exam rooms in each of LAC's 11 clinics, observing patient encounters and interviewing clinical staff, to determine if appropriate space, configuration, supplies, and equipment allowed clinicians to perform a proper clinical exam. Exam rooms or treatment spaces were sufficient in 4 of the 11 clinics (36 percent); the remaining seven areas were not compliant for various reasons. Examples included clutter present in the exam room of one clinic (*Figure 1*);

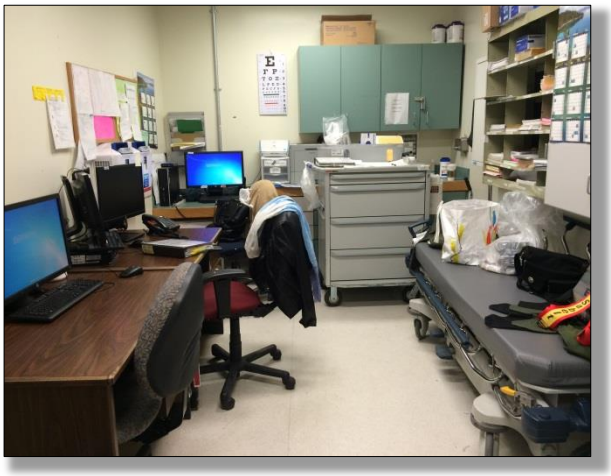

Figure 1: Clutter in exam room

exam tables or gurneys with ripped vinyl covering that could harbor infectious agents in four clinics; exam rooms that did not provide auditory or visual privacy for patients during clinical encounters in two clinics; and one clinic where the on-shift nurse did not have a dedicated exam room or computer terminal available. Also, poor placement of an exam table in one provider's room did not allow patients to lie in a fully extended position (*Figure 2*) (MIT 5.110).

Figure 2: Exam table that does not allow patients to extend fully

- Only 4 of the 11 clinics inspected had sufficient quantities of hand hygiene supplies in clinical areas (36 percent). In seven locations, the patients' designated bathroom had no antiseptic hand soap or disposable towels (MIT 5.103).

- Six of the 11 clinic areas observed (55 percent) had an environment conducive to providing medical services. Four clinic areas lacked adequate auditory privacy for patients during vital sign encounters—in each location the vital sign station was within audible and visual range of a holding cell or patient waiting area (*Figure 3*). Also, in the administrative segregation unit, the common area workspace was limited, and nursing staff had insufficient space to perform their medication preparation and administration duties (MIT 5.109).

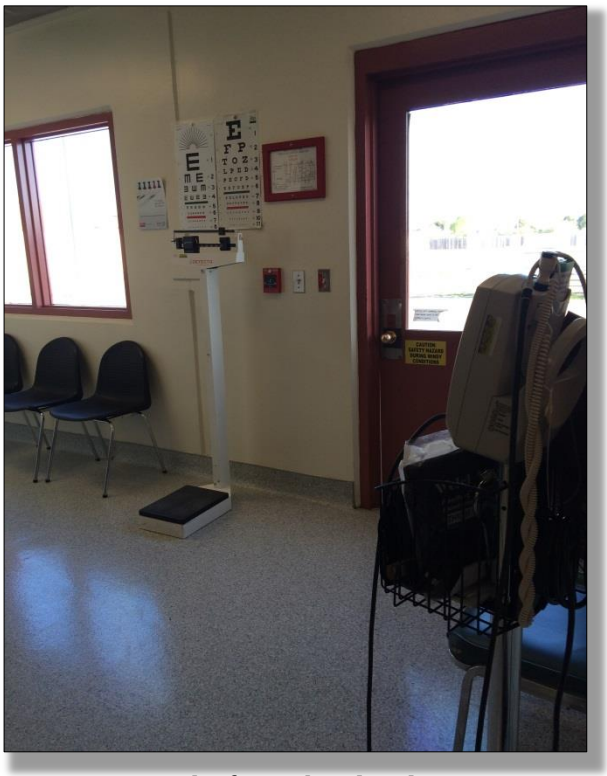

Figure 3: Lack of visual and auditory privacy at vital sign station

- At only five of the eight sampled clinical locations, staff inspected emergency response bags daily, inventoried them monthly, and ensured they contained all essential items (63 percent). In the minimum security facility clinic, the emergency response bag did not contain the required supply of glucose; the bag located in the TTA clinic was missing the required large-sized blood pressure cuff; and in a yard clinic, the bag contained an oxygen tank but did not have the necessary valve and regulator that should accompany it (*Figure 4*) (MIT 5.111).

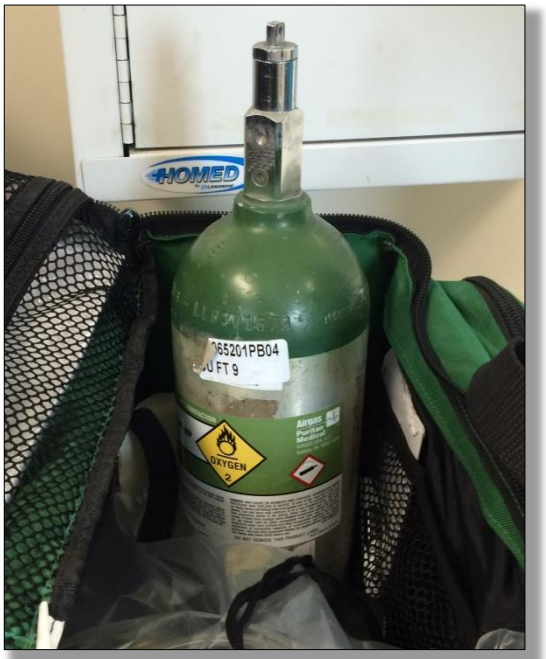

Figure 4: Oxygen tank without valve and regulator

- Eight of the 11 clinics (73 percent) followed adequate medical supply storage and management protocols. In three clinic areas, bulk medical supplies in storage rooms were not labeled for easy identification (*Figure 5*) (MIT 5.107).


Figure 5: Unlabeled medical supplies

LAC scored in the *adequate* range in the following test area:

- Nine of the 11 clinics inspected followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste (82 percent). OIG inspectors observed exam rooms in two clinics that did not have sharps containers (MIT 5.105).

The following four test areas received scores in the *proficient* range:

- OIG inspectors observed clinical encounters with patients in nine of LAC's clinics and found that clinicians followed good hand hygiene practices in eight of them (89 percent). In one of the yard clinics, not all nurses properly sanitized their hands prior to assessing patients through physical contact. In the same clinic, the phlebotomist utilized gloves during patient encounters, but did not wash her hands or use hand sanitizer between glove changes (MIT 5.104).

- Ten of the 11 clinics (91 percent) were appropriately disinfected, cleaned, and sanitary. In the administrative segregation unit clinic, inspectors observed accumulated grime and dust on the floor and corners of the staff restroom; additionally, OIG inspectors could not locate the most recent 30 days' cleaning logs for this same restroom, which indicated that cleaning crews did not regularly clean this area (MIT 5.101).

- Clinical health care staff at all ten applicable clinics ensured that reusable invasive and non-invasive medical equipment was properly sterilized and disinfected (MIT 5.102).

- All non-clinic bulk medical supply storage areas met the supply management process and support needs of the medical health care program (MIT 5.106).

Other Information Obtained from Non-Scored Results

The OIG gathered information to determine if LAC's physical infrastructure was maintained in a manner that supported health care management's ability to provide timely or adequate health care. This question was not scored. When OIG inspectors interviewed health care managers, they did not express concerns about the facility's infrastructure or its effect on staff's ability to provide adequate health care. At the time of the inspection, early April 2016, LAC had a master infrastructure project underway to remedy identified deficiencies in its existing health care components, including the following:

- Projects A, B, C: A new administrative segregation unit primary care clinic (completed January 2016), and two new primary care clinic complexes—one to serve patients in Facilities A and B, the other to serve patients in Facilities C and D. The projects were completed in June and July 2016.

- Project D: The addition and renovation of LAC's medication distribution rooms on four yards. The work was completed on the B, C, and D yards; completion of the A yard medication distribution room is expected to be completed in December 2016.

- Projects E and F: A new health care administration and health records building, and renovation of the central health services building. The health care administration and health records building was completed in April 2016; completion of the central health services building project is expected in April 2017.

- Project G: Proposed disability placement program accessibility improvements, expected to be completed in April 2017.

During the inspection, the CEO noted that the Facility B medical clinic was closed, and that medical, dental, and mental health services were temporarily operating out of the Facility B intake clinic/program office area. Irrespective of this repositioning of services, the CEO did not raise concerns about the adequacy of health care services at LAC (MIT 5.999).

Recommendation for CCHCS

- The OIG recommends that CCHCS develop a statewide policy to identify required core equipment and supplies for each type of clinical setting, including primary care clinics, specialty clinics, TTAs, R&Rs, and inpatient units.

Recommendations for LAC

The OIG recommends that LAC develop local operating procedures or provide training to ensure the following:

- All exam room and clinic areas maintain a full complement of core medical equipment that includes a nebulization unit, hemoccult cards, a biohazard waste receptacle or bags, sharps containers, an exam table, a medication refrigerator, and a Snellen chart with a distance marker appropriately located.

- Staff regularly monitor medical equipment items to ensure applicable equipment is in working order, repaired timely, and that torn areas on vinyl-covered exam tables are repaired or the tables are replaced.

INTER- AND INTRA-SYSTEM TRANSFERS

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(73.6%)

Overall Rating:
Inadequate

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

Case Review Results

The OIG clinicians reviewed 42 encounters relating to inter- and intra-system transfers, including information from both the sending and receiving institutions. Clinicians also reviewed 80 hospitalization-related events. Forty-four of these events were actual hospitalizations or emergency room visits, the majority of which resulted in a transfer back to the institution (other events resulted in transfers to other hospitals or institutions, or in patient deaths). The OIG identified 42 deficiencies, four of which were significant (cases 1, 3, 34, and 37). In general, the *Inter- and Intra-System Transfers* processes at LAC were *inadequate.*

Transfers In

Twelve deficiencies were found with patient's arriving at LAC. The receiving and release (R&R) nursing assessment was sometimes incomplete or lacked documentation. Appointments listed on the transfer form or initiated in the R&R were not always carried out. Some examples are listed below:

- In case 3, the newly arriving patient's blood sugar was severely elevated (472). The R&R nurse administered insulin, but failed to contact a provider. The nurse also failed to recheck the patient's blood sugar level after providing the insulin.

- In case 21, the patient arrived with a pending appointment for glaucoma treatment. This appointment did not occur.

- In case 32, weekly blood pressure checks were initiated in the R&R. However, there was no record in the eUHR that the weekly checks were performed.

- In case 33, the patient arrived with pending cardiology and nephrology appointments. These appointments did not occur in a timely manner.

Transfers Out

Incomplete Health Information Transfer forms (CDCR Form 7371) were identified in cases 1, 2, and 4. Transfer forms often lacked critical information:

- In case 34, the patient transferred out from the CTC to another institution. He had undergone eye surgery less than a month before. This information and pending nephrology and overdue ophthalmology appointments were not listed on the transfer form. Additionally, transferring a patient with an overdue ophthalmology appointment who had recently had eye surgery was inappropriate.

- In case 35, the patient had several chronic care diagnoses, was recently hospitalized, had two surgeries, and had a pending appointment for another surgery. His hemoglobin was low, and within two weeks decreased further. The nurse failed to initiate a medical hold. In addition, the recent hospitalization, surgeries, and lab results were not listed on the transfer form.

- In case 36, the information listed on the transfer form was inaccurate and incomplete. An abdominal ultrasound was listed as "pending," but it had actually already been completed a few days prior to transfer. A provider had reviewed this ultrasound and initiated a provider follow-up, but this was not listed. A pending esophageal gastroduodenoscopy (upper digestive tract imaging) with esophageal banding was also not listed.

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. At LAC, providers and nurses generally assessed patients returning from hospitals adequately and in a timely manner. On a few occasions, providers did not follow through with hospital discharge medications (and failed to document the rationale); medications were not always administered timely upon the patients' return from the hospital, and nursing assessment documentation was incomplete at times:

- In case 1, the patient returned from the hospital after treatment for a pulmonary embolism (blood clot). The nurse failed to identify the pain location and provide a complete assessment of causes and management of the pain, failed to initiate continuous oxygen monitoring and apply oxygen, failed to assess lung sounds, and failed to keep monitoring him until he was admitted to the CTC.

- In case 37, the provider failed to order the hospital-recommended antibiotic to a patient with a low white blood cell count and a fever.

Compliance Testing Results

The institution obtained an *inadequate* compliance score of 73.6 percent in the *Inter- and Intra-System Transfers* indicator. The institution scored in the *inadequate* range in the following three test areas:

- While conducting onsite testing, inspectors examined nine transfer packages of patients who were transferring out of the facility to determine whether they included required medications and support documentation; four of them were compliant (44 percent). Three transfer packages did not include one or more of the patient's prescribed medication, a fourth did not include the required medication reconciliation form, and a fifth transfer package included an outdated medication reconciliation form and medication no longer prescribed to the patient (MIT 6.101).

- Twelve of the 18 sampled patients who transferred into LAC (67 percent) had an existing medication order upon arrival and received their medication without interruption. The remaining six patients received their directly observed therapy (DOT) medication from one to three days late (MIT 6.003).

- Inspectors sampled 20 patients who transferred out of LAC to another CDCR institution to determine whether the institution listed their scheduled specialty service appointments on the Health Care Transfer Information form (CDCR form 7371). LAC nursing staff listed the patient's pending specialty service appointment for 14 of the 20 patients (70 percent) (MIT 6.004).

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

- Inspectors sampled 30 patients who transferred into LAC from other institutions to ensure that each patient received a timely health screening upon arrival at the institution. For 28 of them (93 percent), nursing staff completed an Initial Health Screening form (CDCR Form 7277) on the same day the patient arrived. For two patients, nursing staff did not answer all of the applicable questions on the form (MIT 6.001).

- A nurse properly completed the assessment and disposition section of the screening form for 28 of the 30 patients sampled (93 percent). The two exceptions were patients for whom the nurse did not properly sign and date the form to demonstrate completion of an assessment and disposition of the initial screening results (MIT 6.002).

Recommendation

The OIG recommends that nursing supervisors conduct additional training for their staff on transfer policies and procedures, and ensure nurses involved in these processes demonstrate ongoing competency.

PHARMACY AND MEDICATION MANAGEMENT

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(69.8%)

Overall Rating:
Inadequate

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

In this indicator, the OIG case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance review resulting in an *inadequate* score. The OIG's internal review process considered those factors that led to both scores and ultimately rated this indicator *inadequate,* relying more on the compliance testing results, which focus on quantitative rather than qualitative measures. For example, the compliance review found significant insufficiencies with LAC's ability to consistently provide medication to certain patient groups within required time frames. Also, the compliance review included an assessment of LAC's protocols and practices related to the storage, preparation, and administration of medications—areas not evaluated in the case review assessment. Since the compliance review included more robust sampling and testing, the inspection team considered this indicator *inadequate* overall.

Case Review Results

In the majority of cases, patients received their medications timely and as prescribed. There were occasional occurrences of chronic care medications not being renewed timely, and chronic care medications, antibiotics, and chemotherapy not being administered timely. In case 10, for example, the reason for the frequent nitroglycerin for chest pain refills should have been explored. In case 19, a CTC patient's rescue inhaler for asthma was inappropriately ordered as nurse-administered, rather than keep-on-person (KOP).

Onsite Visit

During the OIG clinician visit, the CTC supervisor confirmed that rescue inhalers were kept with patients' nurse-administered medications. This inappropriate practice was discussed with the medical leadership.

Conclusion

The OIG rated the case review portion of *Pharmacy and Medication Management* performance *adequate*.

Compliance Testing Results

The institution received an *inadequate* compliance score of 69.8 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

In this sub-indicator, the institution received an average score of 71.0 percent, showing room for improvement in the following areas:

- Medication administration record (MAR) evidence showed that nursing staff administered prescribed medications to only four of the ten patients who, during the sample test period, were en route from one institution to another and who had a temporary layover at LAC (40 percent). Three patients missed doses of one or more medications; one of those patients and three others did not receive their medication orders at all (MIT 7.006).

- Only 18 of 30 patients sampled who had returned from a community hospital (60 percent) timely received their hospital discharge medications. For the remaining 12 patients, inspectors identified the following deficiencies (MIT 7.003):

    - Eight patients received one or more of their KOP or DOT medications one to two days late. One of those patients was offered his DOT medication one day late, but he refused it.

    - For two patients, the administering nurse did not indicate the delivery date of the patients' KOP medication on their MAR; therefore, OIG inspectors could not determine if the medication was delivered timely to the patient.

    - Inspectors did not find the monthly MAR in one patient's eUHR to evidence when the patient first received one of his DOT medications. Even though the MAR for the following month showed that he continued to receive the medication, it was unclear when the medication was started.

    - One patient received one DOT medication one day late, and for the same patient, there was no evidence he received his 10-day antibiotics prescription at all.

- Nursing staff timely dispensed long-term chronic care medications to 23 of the 32 patients sampled, scoring 72 percent on this test. Five patients who required a referral to the

prescriber for medication follow-up counseling because they refused or were "no-shows" did not receive a provider appointment. For two of those same patients and for four other patients, inspectors were unable to locate eUHR evidence that the patients received refills for one or more of their KOP medications (MIT 7.001).

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

- LAC ensured that 28 of 30 patients sampled (93 percent) received their medications without interruption when they transferred from one housing unit to another. Two patients did not receive their prescribed medication at the next dosing interval following the transfer (MIT 7.005).

- Thirty-six of the 40 patients sampled (90 percent) timely received their new medication orders. One patient received his medication one day late, and another, 46 days late. For a third patient, inspectors could not locate the monthly MAR in the patient's eUHR to verify that he received one newly ordered KOP medication. For the fourth patient, the administering nurse did not indicate the delivery date of the patient's KOP medication; therefore, OIG inspectors could not determine if the medication was delivered timely (MIT 7.002).

Observed Medication Practices and Storage Controls

In this sub-indicator, the institution received a score of 60.9 percent and showed need for improvement in the following areas:

- The institution properly stored non-narcotic medications that required refrigeration at only 2 of the 11 applicable clinics and medication line locations, receiving a score of 18 percent. One or more of the following deficiencies were observed: staff did not follow a standard system to store non-refrigerated medications pending return to the pharmacy (six locations); batteries were stored inside refrigerators (five locations) (*Figure 6*); and a medication was not labeled with the date it was opened (one location). OIG inspectors also tested daily refrigerator and freezer temperature logs over a 60-day period and found refrigerator temperatures that were below the acceptable range three times at one medication line and 25 times at one clinic (MIT 7.103).

Figure 6: Batteries stored inside medication refrigerator

- The institution employed strong medication security controls over narcotic medications in only three of the eight applicable clinics and medication line locations where narcotics were stored (38 percent). At five medication line locations, a review of the narcotics logbook showed that while physical inventories were routinely performed between nursing shifts, a second nurse did not always counter-sign the logbook certifying the reconciliation of narcotics pill totals. At three of those same locations, a second nurse did not always counter-sign the logbook certifying the incidence of narcotics waste; OIG inspectors documented that the failure to counter-sign for narcotics waste occurred on 20 occasions in a 30-day period at one location (MIT 7.101).

- When observing the medication distribution process at seven medication line locations, inspectors found that four locations were compliant with appropriate administrative controls and protocols (57 percent). Two of the outdoor medication locations did not have adequate overhang or shade protection to shield patients from extreme heat or inclement weather while waiting to receive their medication (*Figure 7*). At a third location, a medication nurse distributed the incorrect quantity of medication tablets to the patient; the patient informed the nurse of the error and the correct quantity was given. During the same observation, the nurse failed to crush and float the medication tablets as prescribed (MIT 7.106).

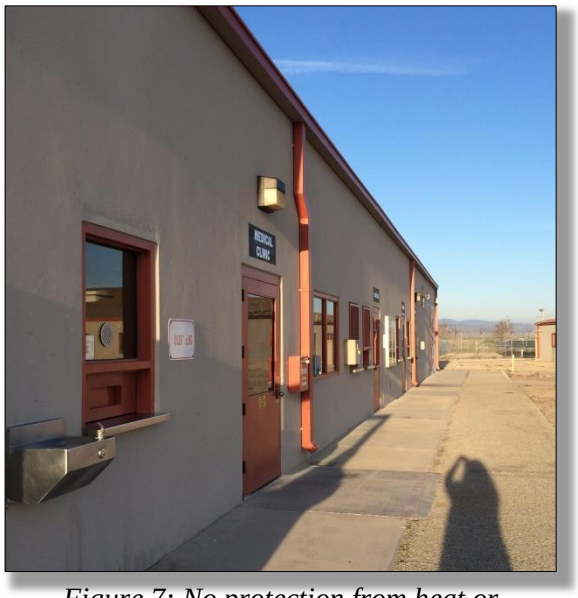

Figure 7: No protection from heat or inclement weather for patients waiting at medication line window

- LAC properly stored non-narcotic medications that did not require refrigeration at 12 of the 18 applicable clinics and medication line storage locations sampled (67 percent). Deficiencies included one or more of the following: medications were not labeled with the date they were opened (three locations); a bottle of aspirin had expired more than three months prior to the OIG's inspection (one location); staff did not follow a standard system to store non-refrigerated medications pending return to the pharmacy (three locations); and external medications were not stored separately from internal medications (two locations) (MIT 7.102).

LAC performed well in the following two areas of this sub-indicator:

- Clinical staff employed appropriate administrative controls and followed proper protocols during medication preparation at all seven applicable medication line locations observed (MIT 7.105).

- Nursing staff were compliant with proper hand hygiene contamination control protocols at six of seven medication line locations (86 percent). In one of the medication lines, not all nurses sanitized their hands prior to initially putting on gloves, nor did they sanitize their hands after removing gloves (MIT 7.104).

Pharmacy Protocols

In this sub-indicator, the institution received an average score of 79.3 percent among scores received at the institution's main pharmacy. The institution performed proficiently in the following tests within this sub-indicator:

- In its main pharmacy, LAC followed general security, organization, and cleanliness management protocols; properly stored refrigerated or frozen medication; and properly accounted for narcotic medications (MIT 7.107, 7.109, 7.110).

- The institution's pharmacist in charge (PIC) followed required protocols for 29 of the 30 medication error reports and related monthly statistical reports reviewed (97 percent). For one error, the PIC did not identify the follow-up review date; as a result, OIG inspectors could not determine if the PIC timely completed the follow-up report (MIT 7.111).

The institution showed room for improvement in the following area:

- In its main pharmacy, LAC did not properly store non-refrigerated medications, scoring zero on this test. While all medication should be stored off the ground and in a clean and organized manner, a box of sodium chloride was stored on the floor where it could potentially be exposed to excessive moisture (MIT 7.108).

Non-Scored Tests

- In addition to testing reported medication errors, OIG inspectors follow up on any significant medication errors found during the case reviews or compliance testing to determine if the errors were properly identified and reported. These findings are not scored. The OIG found two significant medication errors at LAC; one patient missed several doses of his ordered chronic care seizure medication, and a second patient returned to LAC from a community hospital and never received his ordered antibiotics. Based on further review, the OIG concluded that both patients' missed medications likely contributed to their hospitalization; according to CCHCS policy, a medication error resulting in the need for additional treatment with another drug or hospitalization shall be reported to CCHCS as a severity Level 4 medication error. When the OIG followed up with the CEO and the PIC to obtain the medication error reporting documents for each patient's hospitalization, the CEO confirmed that LAC clinical staff had not completed the proper documents to identify and report either incident as resulting from a medication error (MIT 7.998).

- The OIG tested patients housed in isolation units to determine if they had immediate access to their prescribed KOP rescue inhalers and nitroglycerin medications. None of the six applicable patients interviewed indicated they had possession of their rescue medications; all six patients had been without their rescue inhaler on their person from one week to one year. Patients provided many reasons why the medication was not in their possession, including that it was lost or not provided following transfer to the isolation unit; one patient indicated he did not possess his inhaler because he did not agree with the provider's assessment that he needed one. Upon the OIG's notification to the institution regarding this deficiency, LAC immediately reissued the medication to five of the six patients; for one patient, the institution delivered the replacement medication to the patient seven days after inspectors notified the CEO that the medication was lost (MIT 7.999).

Recommendations

No specific recommendations.

PREVENTIVE SERVICES

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

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(72.7%)

Overall Rating:
Inadequate

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

Compliance Testing Results

The institution performed in the *inadequate* range in the *Preventive Services* indicator, with a compliance score of 72.7 percent. LAC received *inadequate* scores in the three areas below:

- Inspectors reviewed the records of 20 patients who received tuberculosis (TB) medications and found that clinical staff properly completed the required TB monitoring assessment for only six patients (30 percent). For 11 patients, the institution did not separately scan the monitoring forms into the patients' electronic health record; for one of those patients and three other patients, the institution failed to perform all required monitoring during the three-month review period (MIT 9.002).

- LAC scored 50 percent for timely administration of TB medications. Of the 20 patients sampled, only ten received all required doses of TB medication for the specified test period. Inspectors noted nine exceptions for one or more of the following reasons: the patient did not receive counseling from a provider about missed medication doses when the patient either refused the medication or was a "no-show" to the medication line, the nurse failed to document whether the medication was administered or not, the patient received one or more unscheduled doses of medication, or the patient's MAR was not found in the eUHR (MIT 9.001).

- Although the institution timely conducted annual TB screenings within the prior year for all 30 sampled patients, nursing staff conducted those screenings adequately for only 21 of those patients (70 percent). Nurses properly screened only 9 of the 15 patients classified as Code 22 (requiring a TB skin test in addition to a signs and symptoms check); for three patients, an LVN, rather than an RN, public health nurse, or primary care provider, read the skin test results; for three other patients, the nurse did not document the administration or read time of the test, or the times were illegible, so the OIG could not determine if the test was read timely. Nurses properly screened 12 of 15 sampled Code 34 patients (subject only

to an annual signs and symptoms check); for one patient, the nurse failed to document a complete review of the patient's signs and symptoms, and for a two additional patients, the nurse did not complete the history section of the Tuberculin Testing/Evaluation Report (CDCR Form 7331) (MIT 9.003).

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

- All 30 sampled patients timely received or were offered influenza vaccinations during the most recent influenza season (MIT 9.004).

- The institution offered colorectal cancer screenings to 38 of 40 sampled patients subject to the annual screening requirement (95 percent). For two patients, there was no evidence in the eUHR that health care staff offered a colorectal cancer screening within the previous 12 months, or that the patient had a normal colonoscopy within the last ten years (MIT 9.005).

- The OIG tested whether patients who suffered from a chronic care condition were offered vaccinations for influenza, pneumonia, and hepatitis. Among the 22 sampled patients with applicable chronic conditions, 20 patients (91 percent) were timely offered the vaccinations. Inspectors found no evidence that one patient received or refused his hepatitis A immunization, or was otherwise immune to hepatitis A, and no evidence that another patient received or refused his pneumococcal immunization within the last five years (MIT 9.008).

Recommendations

No specific recommendations.

QUALITY OF NURSING PERFORMANCE

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

Overall Rating:
Adequate

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

Case Review Results

The OIG nursing clinicians rated the *Quality of Nursing Performance* at LAC *adequate*. The OIG clinicians reviewed 215 outpatient nursing encounters and identified 77 deficiencies. While the majority of deficiencies were minor, there were concerns in the areas of documentation, assessment, and intervention, such as in the following examples:

- In case 10, when the patient presented with elevated blood pressure on two separate occasions (193/95 and 198/99), the pill line LVNs failed to reassess his blood pressure and contact an RN or provider. When this same patient submitted a sick call request for a nitroglycerin refill, the LVN documented "nitro too early to refill." The LVN failed to consult the RN and initiate an urgent nurse appointment regarding medication frequency and increasing chest pain. When this patient was seen by a nurse for hypertension, asthma, and a chronic pain follow-up, the nurse failed to review his blood pressure logs and to assess his nitroglycerin and rescue inhaler use.

Failure to perform wound care was identified in cases 10, 19, and the following:

- In case 12, the wound care was not completed daily as ordered.

Failure to perform same-day assessments was identified in cases 1, 5, 36, and the following:

- In case 19, the patient was seen in the medical clinic with a fast heart rate (138 beats per minute), and a low oxygen saturation (90 to 91%). The provider was contacted and a community hospital admission was initiated. The LVN inappropriately advised the patient to return to his housing unit, where he waited unmonitored for almost three hours until the admission was arranged.

- In case 62, the patient was seen for sick call, complaining of irregular heartbeats and chest pain. The nurse failed to perform a same-day assessment of symptom frequency, duration and associated activity, chest pain severity, and medication compliance, and failed to contact a provider.

Onsite Visit

The OIG clinicians learned that the chief nurse executive (CNE) and supervising registered nurse (SRN III) were both in "acting" positions. At the time of the OIG clinicians visit, the CNE had been in this role for approximately one month and the SRN III for approximately four months. Discussions with nursing staff indicated the new nursing leadership was adjusting well.

Recommendations

No specific recommendations.

QUALITY OF PROVIDER PERFORMANCE

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

Case Review Rating:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

Case Review Results

The OIG clinicians reviewed 536 medical provider encounters and identified 106 deficiencies related to provider performance. Fifteen were significant deficiencies that placed patients at increased risk for harm (five in case 37; two in cases 1, 11, and 12; and one each in cases 16, 19, 28, and 30). Although the care provided by LAC medical providers was occasionally suboptimal, it was appropriate overall. The OIG rated the *Quality of Provider Performance* at LAC *adequate.*

Assessment and Decision-Making

Eighteen deficiencies related to provider assessments and decision-making. Three cases involved inappropriate follow-up orders: failing to order a provider follow-up after a hospital ER visit (case 1); failing to order a provider follow-up visit after the provider was contacted for seizure activity (case 16); and an inappropriately lengthy follow-up interval after starting a patient on new medications (case 28).

- In case 11, an esophageal gastroduodenoscopy (upper digestive tract imaging) was not ordered despite the specialist's recommendations.

Review of Records

Twenty-seven deficiencies related to records not being adequately reviewed. This resulted in labs and hospital and specialty recommendations not being appropriately addressed. The most serious of these deficiencies were the following:

- In case 1, the provider failed to note hospital recommendations regarding medications. The provider inappropriately renewed the patient's blood pressure medications and failed to renew a chronic anti-fungal medication. This was eventually remedied a week later.

- In case 37, the provider failed to note hospital discharge recommendations for a patient with a low white blood cell count and fever of uncertain origin. The provider failed to prescribe the recommended antibiotics.

Emergency Care

The quality of emergency care by providers was generally adequate.

Chronic Care

The quality of chronic care by providers, while overall adequate, was suboptimal at times. In cases 3, 37, and 40, the patients' chronic conditions were not always addressed in a timely manner. Fortunately, their conditions were stable. In cases 14 and 23, the provider inappropriately referred the patient to an endocrinologist without first attempting to control the patient's diabetes. In cases 24 and 37, the interventions ordered for diabetes were questionable.

Specialty Services

LAC providers generally requested specialty services appropriately, but there were a few deficiencies. As noted above, there were instances when specialty recommendations were not adequately reviewed. In cases 19 and 29, inappropriate requests resulted in portable catheter placements being delayed. In cases 26, 30, 33, 38, and 41, referrals should have been submitted as "urgent" rather than "routine."

Health Information Management

In cases 10, 11, 37, and 40, provider documentation was inadequate. In cases 11, 12, 14, and 23, while providers' progress notes documented the intent to order diagnostic tests and specialty and provider follow-ups, they failed to actually order them on the order forms. The use of legacy notes was found in cases 12, 13, 19, 28, and 38. This is further discussed in the *Health Information Management* indicator.

Onsite Inspection

During the onsite visit, the OIG clinicians learned that there had been a recent change in medical leadership at LAC, including both the chief medical executive (CME) and chief physician and surgeon (CP&S) positions. The CME and CP&S were systematically reviewing and implementing statewide and local operating procedures to ensure compliance. They also reported making changes to various committees and meetings, which included more open and inclusive provider meetings and medical authorization review committee meetings. The CME and CP&S reported that the changes were positive, which the OIG confirmed during provider interviews. Medical leadership anticipated overall improvements in the medical care over the next year.

LAC providers were generally content with their work and felt they had adequate time and the tools necessary to provide appropriate medical care. Providers reported they had good working relationships with clinic and custody staff. Several providers reported ongoing issues with obtaining radiology reports via the eUHR and Synapse (software programming used by CCHCS for radiology reports). This problem was usually circumvented by calling the radiology department at LAC and having the reports emailed or faxed to the clinics.

The providers felt well supported by their new leadership, and many mentioned the competency and collegiality of their colleagues.

Provider meetings occurred at the start of each weekday. Discussions included patients addressed by the on-call provider overnight, TTA patients transported in and out of the facility, medication issues, and staffing issues. Challenging cases and specialty referrals were also discussed.

The OIG clinicians also observed the morning huddle meetings for two different yards. The issues discussed were comprehensive and pertinent to each yard and followed the outline CCHCS provided to all institutions.

Pharmacy and Medication Management

While pharmacy and medication management by providers was adequate overall, it was suboptimal at times. As noted above, there were several occasions in which hospital discharge medications were not followed (cases 1, 10, and 37). In cases 10, 14, 21, 23, and 37, medications were either not stopped or not started in a timely manner.

Conclusion

After taking all factors into consideration, the OIG rated LAC provider performance *adequate.*

Recommendations

The OIG recommends that LAC management require providers do the following:

- Thoroughly review medical records, including prior progress notes, diagnostic reports, and hospital and specialty reports to ensure thorough and appropriate care and follow-up.
- Review the CCHCS care guides for diabetes management.

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

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

Case Review Rating:
Adequate
Compliance Score:
Adequate
(78.0%)

Overall Rating:
Adequate

Case Review Results

At the time of the OIG inspection in June 2016, the CTC at LAC consisted of four medical beds and 12 mental health crisis beds. The OIG clinicians reviewed 293 provider and nursing encounters relating to the CTC in eight CTC cases. Throughout the inspection, the OIG identified a total of 146 deficiencies related to *Specialized Medical Housing*, including two significant deficiencies.

Provider Performance

Provider performance as it related to *Specialized Medical Housing* was *adequate*. Of the 141 provider encounters reviewed, the OIG identified 21 deficiencies, with two significant deficiencies in case 37. The patient in case 37 had diabetes. It was unclear why the provider drastically reduced the patient's insulin dose. Fortunately, the patient was on regular glucose monitoring with an order for additional insulin if needed. In addition, the provider missed two medication changes for antibiotics and blood thinners that the community hospital had advised at the time of the patient's discharge. Minor deficiencies included the lack of continuity of care and the failure of various providers to review records adequately.

During the onsite visit, the OIG clinicians learned LAC had already recently assigned one provider to consistently cover the CTC beds (medical and mental health) for more continuity of care. This provider also had fewer patients in the yard than other providers.

Nursing Performance

All of the 86 nursing CTC deficiencies were minor in nature. However, the OIG had concerns about nursing documentation, assessments, and interventions. Nursing documentation was frequently illegible (also discussed in the *Health Information Management* indicator), and assessments were often incomplete.

- In case 16, the patient was admitted to the CTC after irrigation and debridement of an infected arm at a local hospital. He also had a peripherally inserted central catheter (PICC) line in place. The admitting nurse failed to review the hospital's discharge recommendations and failed to assess circulation, sensation, and temperature of the affected extremity. Additionally, the PICC line was not assessed.

- In case 19, the patient often displayed signs of dehydration (increased heart rate and dry skin). The nurse failed to assess the patient's fluid intake and output. On several occasions, the nurses failed to promptly initiate oxygen when indicated.

- In case 40, the patient was admitted to the CTC with a surgical wound. The nurse failed to assess the wound and obtain wound care orders, and the wound documentation was incomplete.

- In case 38, the patient was on continuous oxygen, which can dry out and irritate the nose and other respiratory passages. The nurse failed to request humidified oxygen when the nurse noted dried blood in the patient's mouth.

Conclusion

The providers' and nurses' performance within LAC's *Specialized Medical Housing* was satisfactory overall, although the OIG noted a number of nursing deficiencies related to documentation and assessments. Fortunately, they were minor deficiencies, not likely to put patients at increased risk of harm. Case review rated *Specialized Medical Housing* at LAC *adequate.*

Compliance Testing Results

The institution received an *adequate* score of 78.0 percent in the *Specialized Medical Housing* indicator, which focused on the institution's CTC. As detailed below, LAC received a *proficient* score in the following four tests:

- Providers completed a history and physical for all ten patients admitted to the CTC within 72 hours of their admission (MIT 13.003).

- All sampled call buttons in CTC patient rooms were working properly. According to staff interviews, custody officers and clinicians were able to efficiently respond and access patients' rooms in about two minutes when an emergent event occurred (MIT 13.101).

- For nine of ten patients admitted to the CTC (90 percent), nursing staff timely completed an initial assessment on the day of admission. For one patient, inspectors could not locate a nurse's assessment in the patient's electronic health record (MIT 13.001).

- Providers evaluated nine of the ten sampled patients within 24 hours of their admission to the CTC (90 percent). For one patient, the provider completed the evaluation approximately three hours late (MIT 13.002).

The institution scored in the *inadequate* range in the following test:

- Providers completed their subjective, objective, assessment, plan, and education (SOAPE) notes at three-day intervals, as required in the CTC, for only one of the ten applicable patients (10 percent). For the remaining nine patients, providers failed to complete one or more of the SOAPE notes during the patients' stay, failed to complete a SOAPE note timely, or failed to provide sufficient documentation to yield a comprehensive SOAPE note (MIT 13.004).

Recommendations

No specific recommendations.

SPECIALTY SERVICES

Case Review Rating:
Adequate
Compliance Score:
Adequate
(76.8%)

Overall Rating:
Adequate

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

Case Review Results

The OIG clinicians reviewed 391 events related to *Specialty Services*, about half of which were specialty consultations and procedures. Other events related to provider and nursing follow-up visits and orders after specialty consultations and procedures. There were 89 deficiencies in this category, with 10 significant deficiencies (cases 11, 12, 19, 29, 30, and 37, with some cases having multiple deficiencies).The OIG clinicians concluded specialty services at LAC were borderline *adequate.*

Access to Specialty Services

While urgent and routine specialty services were generally timely and adequate, some minor delays occurred, as well as some dropped referrals, which required resubmitting requests.

Nursing Performance

- In case 30, a surgical specialist saw the patient via telemedicine. The telemedicine nurse failed to perform a thorough pre-visit review. The surgeon thought the patient had undergone orbital floor reconstruction (repair of a facial bone) the week prior when, in fact, he had undergone eye surgery.

- In case 37, the patient continued to be transported to offsite specialty appointments via a community ambulance even though his condition had improved significantly enough that State vehicle transport would have sufficed.

- In case 16, 40, and 41, the specialty services and telemedicine nurses failed to ensure pertinent records were available to specialists.

Provider Performance

Provider performance as it related to *Specialty Services* was adequate, though at times there were deficiencies. These included specialty recommendations not being followed and the rationale not being noted, poor coordination of cancer treatments, intended referrals noted on progress notes not being ordered on order forms, and referrals not being ordered appropriately. These issues are also discussed in the *Quality of Provider Performance* indicator. In case 12, the provider noted the plan was for follow-ups with rheumatology and ophthalmology, but the visits were not ordered. In cases 19, 29, and 37, the poor coordination of cancer treatments included delayed portable catheter placement and delayed administration of prednisone (steroid) per the chemotherapy protocol. In cases 14 and 23, patients were referred to diabetes specialists prematurely without the provider adequately attempting to control the patients' diabetes.

Health Information Management

Health information management deficiencies related to specialty services included specialty reports not being found in the eUHR, specialty reports not being timely reviewed and signed by the provider, and patient health records and diagnostic reports not being available to specialists.

Onsite Inspection

The OIG clinicians learned the specialty services and telemedicine nurses were responsible for ensuring pertinent medical records were available to the specialist. The medical records department ensured offsite specialist records were received, and the utilization management nurse ensured community hospital inpatient records were received. The utilization management nurse also assisted in coordinating specialty services for patients housed in the CTC.

Compliance Testing Results

The institution received an *adequate* compliance score of 76.8 percent in the *Specialty Services* indicator, scoring within the *proficient* range in four of the seven test areas:

- All 15 patients sampled either received or refused their routine specialty services appointment within 90 calendar days of the provider's order (MIT 14.003).

- For 18 of 20 patients sampled (90 percent), denials of provider specialty services requests occurred within the required time frame; untimely denials were one and five days late (MIT 14.006).

- Among 15 patients sampled who received routine specialty services, providers timely received and reviewed 13 of the specialists' reports (87 percent). For one patient, the provider reviewed the report 65 days late; for a second patient, the report was not received at all (MIT 14.004).

- For 13 of the 15 patients sampled (87 percent), their high-priority specialty services appointment occurred within 14 days of the provider's order. One patient received his specialty appointment three days late, while another patient's appointment occurred 54 days late (MIT 14.001).

The institution scored in the *adequate* range in the test below:

- Providers timely received and reviewed the specialists' reports for 10 of the 13 sampled patients (77 percent) who received high-priority specialty services. For two patients, the provider reviewed the reports 4 and 12 days late; for the remaining patient, the specialty service report was received one day late (MIT 14.002).

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

- When an institution approves or schedules a patient for specialty services appointments and then transfers the patient to another institution, policy requires that the receiving institution ensure a patient's appointment occurs timely. At LAC, only 9 of the 19 sampled patients (47 percent) received their specialty services appointment within the required action period. Inspectors identified the following exceptions (MIT 14.005):
    - Four patients received their appointment from 27 to 212 days after the date the appointment should have occurred.
    - Three patients did not receive their appointments at all.
    - Two patients each had two pending appointments. One received his appointments 17 and 23 days late; the other patient received one appointment 73 days late and did not receive his other appointment at all.
    - For one patient, a provider determined his condition did not indicate an impending need for the specialty service, but the provider made this determination 36 days after the appointment should have occurred.
- Providers timely informed patients of the denial status for requested specialty services for 10 of the 20 denials sampled (50 percent). Providers informed three patients of the specialty service denial 11, 114, and 180 days late. For seven other patients, inspectors did not find any evidence that the provider ever discussed the denial (MIT 14.007).

Recommendations

The OIG recommends that health care management review existing processes and provide training to providers to ensure the following:

- Provider referrals are appropriately ordered.

- Providers thoroughly review specialty reports and recommendations and, when recommendations are not implemented, document the rationale.

- Processes are in place to ensure pertinent patient records are available to specialists at the time of specialty consultations.

- Providers request and retrieve dictated reports from specialty consultants when handwritten notes are illegible.

SECONDARY (ADMINISTRATIVE) QUALITY INDICATORS OF HEALTH CARE

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

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

INTERNAL MONITORING, QUALITY IMPROVEMENT, AND ADMINISTRATIVE OPERATIONS

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(69.6%)

Overall Rating:
Inadequate

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

Compliance Testing Results

The institution scored in the *inadequate* range in this indicator, receiving a compliance score of 69.6 percent. The institution showed room for improvement in the following two test areas:

- Inspectors reviewed the summary reports and related documentation for three medical emergency response drills conducted in the prior quarter. For all three drills, four or more required documents were not completed; in two of the three drills, either health care or custody staff did not participate in the drill. Therefore, the institution received a score of zero on this test (MIT 15.101).

- LAC improved or reached targeted performance objectives for only one of the five quality improvement initiatives identified in its 2015 Performance Improvement Work Plan, resulting in a score of 20 percent. For the other four initiatives, the institution did not update the work plan to identify the status of its performance measures, which was needed to assess whether the institution made program improvements (MIT 15.005).

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

- The OIG reviewed data to determine if LAC timely processed at least 95 percent of its monthly inmate medical appeals during the 12-month period ending February 2016. The institution timely processed the appeals during 9 of those 12 months (75 percent). During two months, LAC reported that approximately 6 percent of its medical appeals were overdue; during another month, LAC reported that 8 percent of its medical appeals were overdue (MIT 15.001).

- The institution's local governing body (LGB) met at least quarterly over the last 12 months, but the committee chairperson timely approved the meeting minutes for only three of the four quarterly meetings, resulting in a score of 75 percent on this test (MIT 15.006).

- The OIG reviewed the institution's Quality Management Committee (QMC) meeting minutes for a recent six-month period. For five of the six months (83 percent), the QMC evaluated program performance and took action when improvement opportunities were identified. The QMC did not conduct a meeting during one of the months (MIT 15.003).

- The OIG inspected documentation for 12 emergency medical response incidents reviewed by LAC's Emergency Medical Response Review Committee (EMRRC) during the prior six-month period; 10 of the 12 incident packages (83 percent) complied with policy. For two incident packages, the required EMRRC Event Checklist forms were not completed (MIT 15.007).

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

- Inspectors sampled ten second-level medical appeals and found that the institution's responses addressed all of the patients' appealed issues (MIT 15.102).

- The institution took adequate steps to ensure the accuracy of its Dashboard data reporting (MIT 15.004).

- Medical staff timely submitted the Initial Inmate Death Report (CDCR Form 7229A) to CCHCS's Death Review Unit for nine of the ten applicable deaths that occurred at LAC in the prior 12-month period (90 percent). One report was not initialed by either the CEO or CME prior to being submitted to the Death Review Unit (MIT 15.103).

Other Information Obtained from Non-Scored Areas

- The OIG gathered non-scored data regarding the completion of death review reports by CCHCS' Death Review Committee (DRC). During the OIG's review period, CCHCS made revisions to its death review summary procedure resulting in changes to the required death review completion and reporting time frames; this change was effective November 2015. As a result, the information is presented in two parts below (MIT 15.996):

    - Prior to November 1, 2015, the DRC was required to complete a death review summary report within 30 business days of the death and submit it to the institution's CEO within five additional business days. The DRC both timely completed its reports and timely notified the CEO for only one of the six sampled deaths. For one patient death, the DRC completed its death review summary 12 days late (or 55 calendar days after the death); CCHCS did not timely submit this report, nor the reports for two additional patients, to the institution's CEO. The CEO was notified of the results for these three deaths from 7

to 24 days late (or 57 to 74 days after the deaths). For the remaining two patient deaths, which occurred in June and August 2015, the DRC had not completed its summary report at the time of the OIG's review, and both reports were overdue.

  - As of November 1, 2015, the CCHCS Death Review Committee is required to complete a death review summary report within 60 calendar days from the date of death for any unexpected death (Level 1), or within 30 calendar days from the date of death for any expected death (Level 2). CCHCS is also required to submit the death review summary report to the institution's CEO within seven calendar days following completion of the report. The OIG determined that the DRC failed both to complete its reports timely and to notify the CEO timely for all four of the sampled deaths. In all four instances, which occurred between November 2015 and February 2016, the death review reports had yet to be completed; at the time of the OIG's review, all four reports were overdue (MIT 15.996).

- Inspectors met with the institution's CEO to inquire about LAC's protocols for tracking medical appeals. According to the CEO, LAC's appeal coordinator provided management staff with a weekly appeals report. The institution also received a monthly report from CCHCS headquarters. The reports served as management tools for tracking open appeals by subject type (medical, mental health, dental, etc.) and date of resolution. Inclusive descriptions of the issues and metric data provided management the ability to identify trends, resolve issues, and plan for the improvement of future outcomes. When medical appeals presented potential problem areas associated with medical staff, it was common for the CEO to meet with applicable management staff to evaluate concerns and, if warranted, to identify resolutions. As an example, health care management staff had recently acted in coordination with custody staff to investigate multiple appeals and complaints against a medical provider. The situation required close monitoring by the CEO; the institution implemented progressive disciplinary actions in response to the findings (MIT 15.997).

- The OIG gathered non-scored data regarding the institution's practices for implementing local operating procedures (LOPs). The data indicated that LAC had an effective process in place for developing LOPs. According to the institution's health program manager, LOPs were developed from medical provider input and comment. Each of the institution's providers and the institution's health program specialist were responsible for the analysis, modification, or development of LOPs based on revisions to statewide policy and procedure. In cases when an LOP did not yet exist, the CEO, CME, and CNE decided whether a statewide policy and procedure could stand alone or if an LOP was required. Once an LOP was developed or the content was revised, it went to a subcommittee for approval. Following subcommittee approval, the LOP was sent to the local governing body for final approval. Once authorized, the LOP was emailed to providers and placed on a shared drive for staff reference. At the time of the OIG's inspection, LAC had implemented 47 of the 49 applicable stakeholder-recommended LOPs (96 percent) (MIT 15.998).

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

Recommendations

No specific recommendations.

JOB PERFORMANCE, TRAINING, LICENSING, AND CERTIFICATIONS

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

Case Review Rating:
Not Applicable
Compliance Score:
Proficient
(86.8%)

Overall Rating:
Proficient

Compliance Testing Results

The institution received a *proficient* compliance score of 86.8 percent in the *Job Performance, Training, Licensing, and Certifications* indicator. LAC scored in the *proficient* range in the following tests, including scores of 100 percent in five of the six tests below:

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

- All ten of the 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 16.102, 16.107).

- The institution's pharmacy and providers who prescribed controlled substances were current with their Drug Enforcement Agency registrations (MIT 16.106).

- The institution performed complete structured clinical performance appraisals for seven of eight applicable primary care providers (88 percent). The CP&S did not have the 360 Degree Evaluation completed by the CEO or CME (MIT 16.103).

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

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

- Inspectors examined records to determine if supervising nurses completed evaluations of nursing staff. Only two of the five sampled nurses (40 percent) had received sufficiently completed reviews. The nursing supervisor who performed the reviews failed to complete the required number of monthly reviews for three nurses; also, for two of these nurses, evaluations did not include a discussion of the areas in need of improvement nor aspects of their performance done well (MIT 16.101).

Recommendations

No specific recommendations.

POPULATION-BASED METRICS

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

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

Methodology

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

Comparison of Population-Based Metrics

For California State Prison, Los Angeles County, nine HEDIS measures were selected and are listed in the following *LAC 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. LAC outperformed or closely matched other entities in three of the five measures; this included its close monitoring of diabetic patients, its low percentage of patients considered to be under poor control, and its high percentage of patients under good control. The institution scored lower than some entities in blood pressure control and conducting dilated eye exams for diabetic patients.

When compared statewide, LAC outperformed Medi-Cal in all five diabetic measures selected. The institution also outperformed or matched Kaiser Permanente in four of the five measures, scoring lower than Kaiser in diabetic blood pressure control. When compared nationally, LAC outperformed Medicaid, Medicare, and commercial entities (based on data obtained from health maintenance organizations) in each of the five measures. LAC either outperformed or performed similarly to the U.S. Department of Veterans Affairs (VA) in three measures, but scored lower than the VA in conducting diabetic eye exams. The VA offered no comparable data for one measure.

Immunizations

Comparative data for immunizations was only fully available for the VA and partially available for Kaiser Permanente, Medicare, and commercial entities. With respect to administering influenza shots to younger adults, LAC performed better than Kaiser and commercial entities and only slightly lower than the VA. For adults aged 65 and older, the institution scored higher than Medicare and closely matched the VA. With regard to the administration of pneumococcal immunizations, LAC outperformed both Medicare and the VA. For all immunization measures, test data showed that LAC had offered these preventive services to all but one of the patients sampled, but many patients refused the offers; these refusals adversely affected the institution's scores.

Cancer Screening

With respect to colorectal cancer screenings, LAC outperformed commercial entities and Medicare, but scored lower than Kaiser and the VA; data for Medi-Cal and Medicaid was unavailable. Similar to the results for immunizations, LAC's cancer screening scores were largely affected by patient refusals.

Summary

LAC's population-based metrics performance reflected an adequate chronic care program, corroborated by the institution's *adequate* ratings in the *Quality of Provider Care* and the *Quality of Nursing Care* indicators. The institution either outperformed or closely matched other State entities in all but one of five comprehensive diabetes care measures, and displayed similar performance when compared to national entities. The institution also outperformed or matched other State and national entities in immunization measures; for cancer screenings, LAC's score was average when compared to other entities reporting data. Regarding the immunization and cancer screening measures, the institution may improve its scores by educating patients regarding their refusals of these preventive services.

LAC Results Compared to State and National HEDIS Scores

Clinical Measures	California				National			
	LAC Cycle 4 Results [1]	HEDIS Medi-Cal 2015 [2]	Kaiser (No.CA) HEDIS Scores 2015 [3]	Kaiser (So.CA) HEDIS Scores 2015 [3]	HEDIS Medicaid 2015 [4]	HEDIS Com-mercial 2015 [4]	HEDIS Medicare 2015 [4]	VA Average 2014 [5]
Comprehensive Diabetes Care								
HbA1c Testing (Monitoring)	**97%**	86%	95%	94%	86%	91%	93%	99%
Poor HbA1c Control (>9.0%) [6,7]	**13%**	39%	18%	24%	44%	31%	25%	19%
HbA1c Control (<8.0%) [6]	**72%**	49%	70%	62%	47%	58%	65%	-
Blood Pressure Control (<140/90)	**75%**	63%	84%	85%	62%	65%	65%	78%
Eye Exams	**81%**	53%	69%	81%	54%	56%	69%	90%
Immunizations								
Influenza Shots - Adults (18–64)	**56%**	-	54%	55%	-	50%	-	58%
Influenza Shots - Adults (65+)	**75%**	-	-	-	-	-	72%	76%
Immunizations: Pneumococcal	**94%**	-	-	-	-	-	70%	93%
Cancer Screening								
Colorectal Cancer Screening	**76%**	-	80%	82%	-	64%	67%	82%

1. Unless otherwise stated, data was collected in March 2016 by reviewing medical records from a sample of LAC's population of applicable inmate-patients. These random statistical sample sizes were based on a 95 percent confidence level with a 15 percent maximum margin of error.
2. HEDIS Medi-Cal data was obtained from the California Department of Health Care Services *2015 HEDIS Aggregate Report for Medi-Cal Managed Care*.
3. Data was obtained from Kaiser Permanente's November 2015 reports for the Northern and Southern California regions.
4. National HEDIS data for Medicaid, commercial plans, and Medicare was obtained from the 2015 *State of Health Care Quality Report*, available on the NCQA website: www.ncqa.org. The results for commercial plans were based on data received from various health maintenance organizations.
5. The Department of Veterans Affairs (VA) data was obtained from the VA's website, www.va.gov. For the Immunizations: Pneumococcal measure only, the data was obtained from the *VHA Facility Quality and Safety Report - Fiscal Year 2012 Data*.
6. For this indicator, the entire applicable LAC 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

California State Prison, Los Angeles County Range of Summary Scores: 64.53%–86.77%	
Indicator	**Compliance Score (Yes %)**
Access to Care	72.16%
Diagnostic Services	73.33%
Emergency Services	Not Applicable
Health Information Management (Medical Records)	64.53%
Health Care Environment	67.48%
Inter- and Intra-System Transfers	73.56%
Pharmacy and Medication Management	69.82%
Prenatal and Post-Delivery Services	Not Applicable
Preventive Services	72.65%
Quality of Nursing Performance	Not Applicable
Quality of Provider Performance	Not Applicable
Reception Center Arrivals	Not Applicable
Specialized Medical Housing (OHU, CTC, SNF, Hospice)	78.00%
Specialty Services	76.80%
Internal Monitoring, Quality Improvement, and Administrative Operations	69.63%
Job Performance, Training, Licensing, and Certifications	86.77%

Reference Number	*Access to Care*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
1.001	**Chronic care follow-up appointments:** Was the inmate-patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter?	25	15	40	62.50%	0
1.002	**For endorsed inmate-patients received from another CDCR institution:** If the nurse referred the inmate-patient to a provider during the initial health screening, was the inmate-patient seen within the required time frame?	16	9	25	64.00%	5
1.003	**Clinical appointments:** Did a registered nurse review the inmate-patient's request for service the same day it was received?	40	0	40	100.00%	0
1.004	**Clinical appointments:** Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed?	40	0	40	100.00%	0
1.005	**Clinical appointments:** If the registered nurse determined a referral to a primary care provider was necessary, was the inmate-patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter?	7	4	11	63.64%	29
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?	4	4	8	50.00%	32
1.007	**Upon the inmate-patient's discharge from the community hospital:** Did the inmate-patient receive a follow-up appointment within the required time frame?	15	15	30	50.00%	0
1.008	**Specialty service follow-up appointments:** Do specialty service primary care physician follow-up visits occur within required time frames?	16	11	27	59.26%	3
1.101	**Clinical appointments:** Do inmate-patients have a standardized process to obtain and submit health care services request forms?	6	0	6	100.00%	0
Overall percentage:					**72.16%**	

Reference Number	*Diagnostic Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
2.001	**Radiology:** Was the radiology service provided within the time frame specified in the provider's order?	10	0	10	100.00%	0
2.002	**Radiology:** Did the primary care provider review and initial the diagnostic report within specified time frames?	6	4	10	60.00%	0
2.003	**Radiology:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	6	4	10	60.00%	0
2.004	**Laboratory:** Was the laboratory service provided within the time frame specified in the provider's order?	9	1	10	90.00%	0
2.005	**Laboratory:** Did the primary care provider review and initial the diagnostic report within specified time frames?	9	1	10	90.00%	0
2.006	**Laboratory:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	8	2	10	80.00%	0
2.007	**Pathology:** Did the institution receive the final diagnostic report within the required time frames?	6	4	10	60.00%	0
2.008	**Pathology:** Did the primary care provider review and initial the diagnostic report within specified time frames?	9	1	10	90.00%	0
2.009	**Pathology:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	3	7	10	30.00%	0
Overall percentage:					**73.33%**	

Emergency Services	Scored Answers
Assesses reaction times and responses to emergency situations.	**Not Applicable**

Reference Number	*Health Information Management (Medical Records)*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated progress notes, initial health screening forms, and health care service request forms scanned into the eUHR within three calendar days of the inmate-patient encounter date?	10	10	20	50.00%	0
4.002	Are dictated / transcribed documents scanned into the eUHR within five calendar days of the inmate-patient encounter date?	12	3	15	80.00%	0
4.003	Are specialty documents scanned into the eUHR within the required time frame?	18	2	20	90.00%	0
4.004	Are community hospital discharge documents scanned into the eUHR within three calendar days of the inmate-patient date of hospital discharge?	19	1	20	95.00%	0
4.005	Are medication administration records (MARs) scanned into the eUHR within the required time frames?	10	10	20	50.00%	0
4.006	During the eUHR review, did the OIG find that documents were correctly labeled and included in the correct inmate-patient's file?	0	12	12	0.00%	0
4.007	Did clinical staff legibly sign health care records, when required?	26	6	32	81.25%	0
4.008	**For inmate-patients discharged from a community hospital:** Did the preliminary hospital discharge report include key elements and did a PCP review the report within three calendar days of discharge?	21	9	30	70.00%	0
Overall percentage:					**64.53%**	

Reference Number	*Health Care Environment*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
5.101	**Infection Control:** Are clinical health care areas appropriately disinfected, cleaned and sanitary?	10	1	11	90.91%	0
5.102	**Infection control:** Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	10	0	10	100.00%	1
5.103	**Infection Control:** Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	4	7	11	36.36%	0
5.104	**Infection control:** Does clinical health care staff adhere to universal hand hygiene precautions?	8	1	9	88.89%	2
5.105	**Infection control:** Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	9	2	11	81.82%	0
5.106	**Warehouse, Conex and other non-clinic storage areas:** Does the medical supply management process adequately support the needs of the medical health care program?	1	0	1	100.00%	0
5.107	**Clinical areas:** Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	8	3	11	72.73%	0
5.108	**Clinical areas:** Do clinic common areas and exam rooms have essential core medical equipment and supplies?	2	9	11	18.18%	0
5.109	**Clinical areas:** Do clinic common areas have an adequate environment conducive to providing medical services?	6	5	11	54.55%	0
5.110	**Clinical areas:** Do clinic exam rooms have an adequate environment conducive to providing medical services?	4	7	11	36.36%	0
5.111	**Emergency response bags:** Are TTA and clinic emergency medical response bags inspected daily and inventoried monthly, and do they contain essential items?	5	3	8	62.50%	3
5.999	**For Information Purposes Only:** Does the institution's health care management believe that all clinical areas have physical plant infrastructures sufficient to provide adequate health care services?	Information Only				
Overall percentage:					**67.48%**	

Reference Number	*Inter- and Intra-System Transfers*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
6.001	**For endorsed inmate-patients received from another CDCR institution or COCF:** Did nursing staff complete the initial health screening and answer all screening questions on the same day the inmate-patient arrived at the institution?	28	2	30	93.33%	0
6.002	**For endorsed inmate-patients received from another CDCR institution or COCF:** When required, did the RN complete the assessment and disposition section of the health screening form; refer the inmate-patient to the TTA, if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening?	28	2	30	93.33%	0
6.003	**For endorsed inmate-patients received from another CDCR institution or COCF:** If the inmate-patient had an existing medication order upon arrival, were medications administered or delivered without interruption?	12	6	18	66.67%	12
6.004	**For inmate-patients transferred out of the facility:** Were scheduled specialty service appointments identified on the Health Care Transfer Information Form 7371?	14	6	20	70.00%	0
6.101	**For inmate-patients transferred out of the facility:** Do medication transfer packages include required medications along with the corresponding Medication Administration Record (MAR) and Medication Reconciliation?	4	5	9	44.44%	0
Overall percentage:					**73.56%**	

Reference Number	*Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.001	Did the inmate-patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows?	23	9	32	71.88%	8
7.002	Did health care staff administer or deliver new order prescription medications to the inmate-patient within the required time frames?	36	4	40	90.00%	0
7.003	**Upon the inmate-patient's discharge from a community hospital:** Were all medications ordered by the institution's primary care provider administered or delivered to the inmate-patient within one calendar day of return?	18	12	30	60.00%	0
7.004	**For inmate-patients received from a county jail:** Were all medications ordered by the institution's reception center provider administered or delivered to the inmate-patient within the required time frames?	Not Applicable				
7.005	**Upon the inmate-patient's transfer from one housing unit to another:** Were medications continued without interruption?	28	2	30	93.33%	0
7.006	**For inmate-patients en route who lay over at the institution:** If the temporarily housed inmate-patient had an existing medication order, were medications administered or delivered without interruption?	4	6	10	40.00%	0
7.101	**All clinical and medication line storage areas for narcotic medications:** Does the institution employ strong medication security controls over narcotic medications assigned to its clinical areas?	3	5	8	37.50%	10
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?	12	6	18	66.67%	0
7.103	**All clinical and medication line storage areas for non-narcotic medications:** Does the institution properly store non-narcotic medications that require refrigeration in assigned clinical areas?	2	9	11	18.18%	7
7.104	**Medication preparation and administration areas:** Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes?	6	1	7	85.71%	11
7.105	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when preparing medications for inmate-patients?	7	0	7	100.00%	11
7.106	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when distributing medications to inmate-patients?	4	3	7	57.14%	11

7.107	**Pharmacy:** Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and satellite pharmacies?	1	0	1	100.00%	0
7.108	**Pharmacy:** Does the institution's pharmacy properly store non-refrigerated medications?	0	1	1	0.00%	0
7.109	**Pharmacy:** Does the institution's pharmacy properly store refrigerated or frozen medications?	1	0	1	100.00%	0
7.110	**Pharmacy:** Does the institution's pharmacy properly account for narcotic medications?	1	0	1	100.00%	0
7.111	**Pharmacy:** Does the institution follow key medication error reporting protocols?	29	1	30	96.67%	0
7.998	**For Information Purposes Only:** During eUHR compliance testing and case reviews, did the OIG find that medication errors were properly identified and reported by the institution?	Information Only				
7.999	**For Information Purposes Only:** Do inmate-patients in isolation housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications?	Information Only				
Overall percentage:					**69.82%**	

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

Reference Number	*Preventive Services*	Scored Answers				
		Yes	**No**	**Yes + No**	**Yes %**	**N/A**
9.001	**Inmate-patients prescribed TB medications:** Did the institution administer the medication to the inmate-patient as prescribed?	10	10	20	50.00%	0
9.002	**Inmate-patients prescribed TB medications:** Did the institution monitor the inmate-patient monthly for the most recent three months he or she was on the medication?	6	14	20	30.00%	0
9.003	**Annual TB Screening:** Was the inmate-patient screened for TB within the last year?	21	9	30	70.00%	0
9.004	Were all inmate-patients offered an influenza vaccination for the most recent influenza season?	30	0	30	100.00%	0
9.005	**All inmate-patients from the age of 50 through the age of 75:** Was the inmate-patient offered colorectal cancer screening?	38	2	40	95.00%	0
9.006	**Female inmate-patients from the age of 50 through the age of 74:** Was the inmate-patient offered a mammogram in compliance with policy?	Not Applicable				
9.007	**Female inmate-patients from the age of 21 through the age of 65:** Was the inmate-patient offered a pap smear in compliance with policy?	Not Applicable				
9.008	Are required immunizations being offered for chronic care inmate-patients?	20	2	22	90.91%	18
9.009	Are inmate-patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	Not Applicable				
Overall percentage:					**72.65%**	

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

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

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

Reference Number	*Specialized Medical Housing (OHU, CTC, SNF, Hospice)*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	**For all higher-level care facilities:** Did the registered nurse complete an initial assessment of the inmate-patient on the day of admission, or within eight hours of admission to CMF's Hospice?	9	1	10	90.00%	0
13.002	**For OHU, CTC, & SNF only:** Did the primary care provider for OHU or attending physician for a CTC & SNF evaluate the inmate-patient within 24 hours of admission?	9	1	10	90.00%	0
13.003	**For OHU, CTC, & SNF only:** Was a written history and physical examination completed within 72 hours of admission?	10	0	10	100.00%	0
13.004	**For all higher-level care facilities:** Did the primary care provider complete the Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes on the inmate-patient at the minimum intervals required for the type of facility where the inmate-patient was treated?	1	9	10	10.00%	0
13.101	**For OHU and CTC Only:** Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter inmate-patient's cells?	1	0	1	100.00%	0
Overall percentage:					**78.00%**	

Reference Number	*Specialty Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	Did the inmate-patient receive the high-priority specialty service within 14 calendar days of the PCP order?	13	2	15	86.67%	0
14.002	Did the PCP review the high priority specialty service consultant report within the required time frame?	10	3	13	76.92%	2
14.003	Did the inmate-patient receive the routine specialty service within 90 calendar days of the PCP order?	15	0	15	100.00%	0
14.004	Did the PCP review the routine specialty service consultant report within the required time frame?	13	2	15	86.67%	0
14.005	**For endorsed inmate-patients received from another CDCR institution:** If the inmate-patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames?	9	10	19	47.37%	1
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	18	2	20	90.00%	0
14.007	Following the denial of a request for specialty services, was the inmate-patient informed of the denial within the required time frame?	10	10	20	50.00%	0
Overall percentage:					**76.80%**	

Reference Number	*Internal Monitoring, Quality Improvement, and Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.001	Did the institution promptly process inmate medical appeals during the most recent 12 months?	9	3	12	75.00%	0
15.002	Does the institution follow adverse/sentinel event reporting requirements?	Not Applicable				
15.003	Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified?	5	1	6	83.33%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	1	0	1	100.00%	0
15.005	For each initiative in the Performance Improvement Work Plan (PIWP), has the institution performance improved or reached the targeted performance objective(s)?	1	4	5	20.00%	0
15.006	**For institutions with licensed care facilities:** Does the Local Governing Body (LGB), or its equivalent, meet quarterly and exercise its overall responsibilities for the quality management of patient health care?	3	1	4	75.00%	0
15.007	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	10	2	12	83.33%	0
15.101	Did the institution complete a medical emergency response drill for each watch and include participation of health care and custody staff during the most recent full quarter?	0	3	3	0.00%	0
15.102	Did the institution's second level medical appeal response address all of the inmate-patient's appealed issues?	10	0	10	100.00%	0
15.103	Did the institution's medical staff review and submit the initial inmate death report to the Death Review Unit in a timely manner?	9	1	10	90.00%	0
15.996	**For Information Purposes Only:** Did the CCHCS Death Review Committee submit its inmate death review summary to the institution timely?	Information Only				
15.997	**For Information Purposes Only:** Identify the institution's protocols for tracking medical appeals.	Information Only				
15.998	**For Information Purposes Only:** Identify the institution's protocols for implementing health care local operating procedures.	Information Only				
15.999	**For Information Purposes Only:** Identify the institution's health care staffing resources.	Information Only				
Overall percentage:					**69.63%**	

Reference Number	*Job Performance, Training, Licensing, and Certifications*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
16.001	Do all providers maintain a current medical license?	11	0	11	100.00%	0
16.101	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	2	3	5	40.00%	0
16.102	Are nursing staff who administer medications current on their clinical competency validation?	10	0	10	100.00%	0
16.103	Are structured clinical performance appraisals completed timely?	7	1	8	87.50%	1
16.104	Are staff current with required medical emergency response certifications?	2	1	3	66.67%	0
16.105	Are nursing staff and the Pharmacist-in-Charge current with their professional licenses and certifications?	5	0	5	100.00%	1
16.106	Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	1	0	1	100.00%	0
16.107	Are nursing staff current with required new employee orientation?	1	0	1	100.00%	0
Overall percentage:					**86.77%**	

APPENDIX B — CLINICAL DATA

Table B-1: LAC Sample Sets	
Sample Set	**Total**
Anticoagulation	3
Death Review/Sentinel Events	4
Diabetes	3
Emergency Services – CPR	4
Emergency Services – Non-CPR	5
High Risk	5
Hospitalization	5
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	30
Specialty Services	5
	70

Table B-2: LAC Chronic Care Diagnoses	
Diagnosis	**Total**
Anemia	6
Anticoagulation	4
Arthritis/Degenerative Joint Disease	4
Asthma	12
COPD	6
Cancer	10
Cardiovascular Disease	4
Chronic Kidney Disease	6
Chronic Pain	14
Cirrhosis/End-Stage Liver Disease	6
Coccidioidomycosis	2
DVT/PE	2
Diabetes	13
Gastroesophageal Reflux Disease	20
Hepatitis C	24
Hyperlipidemia	14
Hypertension	33
Mental Health	17
Migraine Headaches	2
Rheumatological Disease	2
Seizure Disorder	11
Sleep Apnea	1
Thyroid Disease	3
	216

Table B-3: LAC Event - Program	
Program	**Total**
Diagnostic Services	272
Emergency Care	95
Hospitalization	80
Intra-System Transfers In	27
Intra-System Transfers Out	15
Not Specified	2
Outpatient Care	525
Specialized Medical Housing	318
Specialty Services	391
	1,725

Table B-4: LAC Case Review Sample Summary	
	Total
MD Reviews, Detailed	30
MD Reviews, Focused	0
RN Reviews, Detailed	18
RN Reviews, Focused	39
Total Reviews	87
Total Unique Cases	70
Overlapping Reviews (MD & RN)	17

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

California State Prison, Los Angeles County			
Quality Indicator	**Sample Category (number of samples)**	**Data Source**	**Filters**
Access to Care			
MIT 1.001	Chronic Care Patients (40)	Master Registry	• Chronic care conditions (at least one condition per inmate-patient—any risk level) • **Randomize**
MIT 1.002	Nursing Referrals (30)	OIG Q: 6.001	• See ***Intra-system Transfers***
MITs 1.003-006	Nursing Sick Call (5 per clinic) 40	MedSATS	• Clinic (each clinic tested) • Appointment date (2–9 months) • **Randomize**
MIT 1.007	Returns from Community Hospital (30)	OIG Q: 4.008	• See ***Health Information Management (Medical Records)*** (returns from community hospital)
MIT 1.008	Specialty Services Follow-up (30)	OIG Q: 14.001 & 14.003	• See ***Specialty Services***
MIT 1.101	Availability of Health Care Services Request Forms (6)	OIG onsite review	• Randomly select one housing unit from each yard
Diagnostic Services			
MITs 2.001–003	Radiology (10)	Radiology Logs	• Appointment date (90 days–9 months) • **Randomize** • Abnormal
MITs 2.004–006	Laboratory (10)	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • **Randomize** • Abnormal
MITs 2.007–009	Pathology (10)	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • **Randomize**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Health Information Management (Medical Records)			
MIT 4.001	Timely Scanning (20)	OIG Qs: 1.001, 1.002, & 1.004	• Non-dictated documents • 1st 10 IPs MIT 1.001, 1st 5 IPs MITs 1.002, 1.004
MIT 4.002	(15)	OIG Q: 1.001	• Dictated documents • First 20 IPs selected
MIT 4.003	(20)	OIG Qs: 14.002 & 14.004	• Specialty documents • First 10 IPs for each question
MIT 4.004	(20)	OIG Q: 4.008	• Community hospital discharge documents • First 20 IPs selected
MIT 4.005	(20)	OIG Q: 7.001	• MARs • First 20 IPs selected
MIT 4.006	(12)	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (12 or more = No)
MIT 4.007	Legible Signatures & Review (32)	OIG Qs: 4.008, 6.001, 6.002, 7.001, 12.001, 12.002 & 14.002	• First 8 IPs sampled • One source document per IP
MIT 4.008	Returns From Community Hospital (30)	Inpatient claims data	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • **Randomize** (each month individually) • First 5 inmate-patients from each of the 6 months (if not 5 in a month, supplement from another, as needed)
Health Care Environment			
MIT 5.101-105 5.107-111	Clinical Areas (11)	OIG inspector onsite review	• Identify and inspect all onsite clinical areas.
Inter- and Intra-System Transfers			
MIT 6.001-003	Intra-System Transfers (30)	SOMS	• Arrival date (3–9 months) • Arrived from (another CDCR facility) • Rx count • **Randomize**
MIT 6.004	Specialty Services Send-Outs (20)	MedSATS	• Date of transfer (3–9 months) • **Randomize**
MIT 6.101	Transfers Out (9)	OIG inspector onsite review	• R&R IP transfers with medication

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Pharmacy and Medication Management			
MIT 7.001	Chronic Care Medication (40)	OIG Q: 1.001	*See* ***Access to Care*** • At least one condition per inmate-patient—any risk level • **Randomize**
MIT 7.002	New Medication Orders (40)	Master Registry	• Rx count • **Randomize** • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns from Community Hospital (30)	OIG Q: 4.008	• See ***Health Information Management (Medical Records)*** *(returns from community hospital)*
MIT 7.004	RC Arrivals – Medication Orders *N/A at this institution*	OIG Q: 12.001	• See ***Reception Center Arrivals***
MIT 7.005	Intra-Facility Moves (30)	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • **Randomize**
MIT 7.006	En Route (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 (30)	Monthly medication error reports	• All monthly statistic reports with Level 4 or higher • Select a total of 5 months
MIT 7.999	Isolation Unit KOP Medications (20)	Onsite active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in isolation units
Prenatal and Post-Delivery Services			
MIT 8.001-007	Recent Deliveries *N/A at this institution*	OB Roster	• Delivery date (2–12 months) • **Most recent** deliveries (within date range)
	Pregnant Arrivals *N/A at this institution*	OB Roster	• Arrival date (2–12 months) • **Earliest** arrivals (within date range)

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Preventive Services			
MITs 9.001–002	TB Medications (20)	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • **Randomize**
MIT 9.003	TB Code 22, Annual TST (15)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (22) • **Randomize**
	TB Code 34, Annual Screening (15)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (34) • **Randomize**
MIT 9.004	Influenza Vaccinations (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • **Randomize** • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening (40)	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 (40)	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • **Randomize** • Condition must require vaccination(s)
MIT 9.009	Valley Fever (number will vary) *N/A at this institution*	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • **All**

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

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Internal Monitoring, Quality Improvement, & Administrative Operations			
MIT 15.001	Medical Appeals (all)	Monthly medical appeals reports	• Medical appeals (12 months)
MIT 15.002	Adverse/Sentinel Events *N/A at this institution*	Adverse/sentinel events report	• Adverse/sentinel events (2–8 months)
MITs 15.003–004	QMC Meetings (6)	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.005	Performance Improvement Work Plans (PIWP) (5)	Institution PIWP	• PIWP with updates (12 months) • Medical initiatives
MIT 15.006	LGB (4)	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.007	EMRRC (12)	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.101	Medical Emergency Response Drills (3)	Onsite summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	2nd Level Medical Appeals (10)	Onsite list of appeals/closed appeals files	• Medical appeals denied (6 months)
MIT 15.103	Death Reports (10)	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.996	Death Review Committee (10)	OIG summary log - deaths	• Between 35 business days & 12 months prior • CCHCS death reviews
MIT 15.998	Local Operating Procedures (LOPs) (all)	Institution LOPs	• All LOPs

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Job Performance, Training, Licensing, and Certifications			
MIT 16.001	Provider licenses (11)	Current provider listing (at start of inspection)	• Review all
MIT 16.101	RN Review Evaluations (5)	Onsite supervisor periodic RN reviews	• RNs who worked in clinic or emergency setting six or more days in sampled month • **Randomize**
MIT 16.102	Nursing Staff Validations (10)	Onsite nursing education files	• On duty one or more years • Nurse administers medications • **Randomize**
MIT 16.103	Provider Annual Evaluation Packets (9)	OIG Q:16.001	• All required performance evaluation documents

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

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

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

December 30, 2016

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

Dear Mr. Barton:

The purpose of this letter is to inform you that the Office of the Receiver has reviewed the draft report of the Office of the Inspector General (OIG) Medical Inspection Results for California State Prison, Los Angeles County (LAC) conducted from April 2016 to June 2016. California Correctional Health Care Services (CCHCS) acknowledges all OIG findings.

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

Sincerely,

Janet Lewis

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

cc: Clark Kelso, Receiver
Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Richard Kirkland, Chief Deputy Receiver
Roy Wesley, Chief Deputy Inspector General, OIG
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