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Inspector General

Office of the Inspector General

Mule Creek State Prison
Medical Inspection Results
Cycle 5

July 2018

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

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FOREWORD

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

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

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

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

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EXECUTIVE SUMMARY

The OIG completed the Cycle 5 medical inspection of Mule Creek State Prison (MCSP) in July 2018. The vast majority of our inspection findings were based on MCSP's health care delivery between November 2016 and July 2017. Our policy compliance inspectors performed an onsite inspection in July 2017. After reviewing the institution's health care delivery, our case review clinicians performed an onsite inspection in January 2018.

OVERALL RATING:

INADEQUATE

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

Our clinician team reviewed 66 cases that contained 1,459 patient-related events. Our compliance team tested 89 policy questions by observing MCSP's processes and examining 404 patient records and 1,148 data points. We distilled the results from both the case review and compliance testing into 13 health care indicators, and have listed the individual indicators and ratings applicable for this institution in the *MCSP Executive Summary Table* on the following page. Our experts made a considered and measured opinion that the overall quality of health care at MCSP was ***inadequate***.

MCSP Executive Summary Table

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

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

Expert Clinician Case Review Results

Our clinicians reviewed the care of patients with high medical needs and included a review of more than 1,459 patient care events.[1] The vast majority of our case reviews covered the period between November 2016 and July 2017. Of the 13 indicators applicable to MCSP, 10 were rated by clinician case review; all 10 were *inadequate.* When determining the overall adequacy of care, we paid particular attention to the clinical nursing and provider quality indicators, as adequate health care staff can sometimes overcome suboptimal processes and programs. However, the opposite is not true; inadequate health care staff cannot provide adequate care, even though the established processes and programs may be adequate. We identify inadequate medical care based on the risk of significant harm to the patient, not the actual outcome.

MCSP had a severe physician shortage during the case review period. However, at the time of the onsite inspection, MCSP had recently hired five registry (temporary) physicians and two physician transfers from another institution. MCSP also hired an additional physician who was working part-time. This report does not reflect any benefit resulting from MCSP's improved provider staffing because MCSP hired the additional staff after the case review period concluded.

Program Strengths — Clinical

- MCSP nurses felt supported by their supervisors and the chief nurse executive. They reported good morale during the onsite inspection.

- MCSP providers reported improved morale compared to Cycle 4. The providers attributed the improvement to increased provider staffing and the hiring of a chief executive officer (CEO) and chief medical executive (CME).

Program Weaknesses – Clinical

- MCSP's laboratory department often did not perform tests that providers ordered.

- MCSP anticoagulation performance worsened compared to Cycle 4. Without a centralized anticoagulation program, individual providers did not monitor anticoagulation levels closely. Some patients experienced dangerously low anticoagulation levels for extended periods.

- Emergency care at MCSP was extremely poor. In the case reviews, first medical responders failed to respond to the scene of an emergency or perform necessary stabilizing interventions. Providers repeatedly failed to document their TTA assessments and decision making. Providers did not evaluate patients in the TTA when they should have and

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

inappropriately discharged patients back to general housing. These patients were unstable and later required hospitalizations.

- MCSP could not meet its population's demand for medical services, and access to medical care continued to be a problem as it was in Cycle 4. Provider follow-ups regularly occurred late. At the onsite inspection, severe backlogs of provider appointments corroborated the case review findings. The introduction of the new electronic health record system (EHRS), which was unfamiliar to the staff and required extensive training, further exacerbated these backlogs when it was introduced at the end of October 2017.

- Newly arrived patients from other CDCR institutions did not receive timely provider appointments.

- MCSP could not ensure continuity of care for patients returning from outside hospitals.

- Nurses' performance was poor in multiple areas. Nursing problems were widespread, and included poor assessment, intervention, wound care, documentation, sick call, and care management.

- The institution did not adequately provide patients with specialty services. When specialists requested follow-up appointments, they often occurred late or not at all. Nurses often failed to communicate specialists' recommendations to primary care providers. Providers sometimes ordered specialty services with inappropriate priority, resulting in dangerous delays. Providers also did not consistently review the specialty reports.

- MCSP providers consistently failed to make sound assessments or accurate diagnoses. Poor assessments and misdiagnoses frequently occurred throughout the case reviews.

- MCSP providers often failed to review their patients' medical records sufficiently. This was in part due to understaffing at MCSP, which created a heavier workload for providers.

- MCSP lacked stable medical leadership to oversee and guide provider care during the case review period. The institution hired the current CEO and CME in May 2017, which was near the end of the OIG's case review period.

Compliance Testing Results

Of the 13 health care indicators applicable to MCSP, our compliance inspectors[2] evaluated ten. Of these, two were *proficient*, four were *adequate*, and four were *inadequate*. The vast majority of our compliance testing was of medical care that occurred between November 2016 and July 2017. There were 89 individual compliance questions within those 10 indicators, generating 1,148 data points that tested MCSP's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[3] *Appendix A — Compliance Test Results* provides detail for the 89 questions.

Program Strengths — Compliance

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

- MCSP's main and satellite pharmacies maintained security and cleanliness management protocols, stored medications safely and maintained proper control of narcotic medications.
- The medical warehouse managed the medical supply process properly and supported the needs of the health care program.
- The institution offered and provided preventive medical services to its patients, including health screenings, immunizations, and monitoring of patients taking tuberculosis medications.
- MCSP did very well with certain aspects of the inter- and intra-facility transfer process, including initial health screenings and uninterrupted delivery of patients' previously ordered medications.

Program Weaknesses — Compliance

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

- Several MCSP medication administration areas did not properly store nonrefrigerated, non-narcotic medications.
- Medication nurses did not monitor patients appropriately when their patients swallowed direct observation therapy medications.

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

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

- Medication nurses did not follow proper hand hygiene protocols when administering medications.
- MCSP did not perform well at ensuring that ordered specialty services were either timely provided or appropriately denied to patients.
- Providers did not review diagnostic reports timely.

Recommendations

- The CEO should rectify the EMRRC review process because the committee failed to identify problems with MCSP's emergency response as well as with the care provided by the TTA providers and nurses. The institution needs a properly functioning EMRRC to identify and correct its various lapses in emergency care.

- The CEO should develop effective methods for evaluating the quality of its providers and nurses because of the poor performance of the medical staff in our review. MCSP's development of reliable and accurate methods to assess provider and nurse performance should form the bases for subsequent quality improvement in these areas.

- The CEO should identify and correct several of its specialty services processes because of the institution's problems with providing specialty appointments for patients with urgent referrals, for newly arrived patients with pending referrals, or for patients who need specialty follow-up appointments.

- The CEO should isolate and fix those laboratory processes that resulted in the high, recurring rate of non-completion of laboratory tests we identified in this cycle.

- The CEO should analyze and adjust many of its pharmacy and nursing processes to correct the problems we found with medication administration and medication continuity.

- The CEO should create an institution-wide anticoagulation management system to help track, monitor, and intervene for patients taking anticoagulation medications because the individual providers were unable to do so independently.

Population-Based Metrics

MCSP outperformed all statewide and national health plans in three of five measures of comprehensive diabetes care, which included HbA1c (a test that measures a patient's average glucose level over the past three months) monitoring and both measures of HbA1c control. However, MCSP trailed all other health plans in providing diabetic eye exams and performed lower than two other health care plans in controlling diabetic blood pressure.

For immunization measures, MCSP outperformed all the other health plans in administering influenza vaccines for the adult population 18 to 64 years old but trailed all other health plans in administering influenza vaccines to the population over 64 years old. MCSP also had the second lowest score for colorectal cancer screening.

INTRODUCTION

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

Mule Creek State Prison (MCSP) was the 20th medical inspection of Cycle 5. During the inspection process, the OIG assessed the delivery of medical care to patients using the primary clinical health care indicators applicable to the institution. The *Administrative Operations* indicator is secondary because it does not reflect the actual clinical care provided.

ABOUT THE INSTITUTION

Mule Creek State Prison (MCSP) opened in 1987 and is located in Ione, in Amador County. In 2005, MCSP became the state's only prison exclusively for sensitive needs yard (SNY) inmates. SNY inmates are segregated from general population inmates for their own safety. Many SNY inmates are gang dropouts, informants, sex offenders, or former law enforcement officers. MCSP maintains three SNYs and a minimum support facility.

The institution operates six clinics where staff members handle non-urgent requests for medical services, including five facility clinics and a specialty clinic. MCSP also conducts health screenings in its receiving and release clinical area (R&R), treats patients requiring urgent or emergent care in its triage and treatment area (TTA), and treats patients in need of inpatient health services in its correctional treatment center (CTC). MCSP has been designated as an "intermediate" care institution; these institutions are predominantly located in or near urban areas, close to tertiary care centers and specialty care providers for the most cost-effective care.

MCSP received an initial accreditation from the Commission on Accreditation for Corrections, a professional peer review process based on national standards set by the American Correctional Association (ACA), on August 12, 2013. The institution received reaccreditation from the ACA on August 8, 2016.

Based on staffing data the OIG obtained from the institution, MCSP's vacancy rate among medical managers, primary care providers, supervisors, and rank-and-file nurses was 6 percent in July 2017, with the highest vacancy percentages among nursing supervisors. At the time of the OIG's inspection, there were three staff nurses on extended leave. Also of note is the fact that 28 percent of the medical staff was hired within the twelve months preceding the OIG's inspection. Lastly, the CEO reported that in July 2017, there were eight medical staff members under CDCR disciplinary review currently working at the institution.

MCSP Health Care Staffing Resources as of July 2017

	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff		Totals	
Description	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Authorized Positions	5	3%	16	11%	16.2	11%	112.1	75%	149.3	100%
Filled Positions	5	100%	13.25	83%	13	80%	109	97%	140.25	94%
Vacancies	0	0%	2.75	17%	3.2	20%	3.1	3%	9.05	6%
Recent Hires (within 12 months)	3	60%	1	8%	1	8%	34	31%	39	28%
Staff Utilized from Registry	0	0%	4.25	32%	0	0%	2	2%	6.25	4%
Redirected Staff (to Non-Patient Care Areas)	0	0%	0	0%	0	0%	0	0%	0	0%
Staff on Extended Leave	0	0%	0	0%	0	0%	3	3%	3	2%

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

As of July 10, 2017, the Master Registry for MCSP showed that the institution had a total population of 3,621. Within that total population, 14.4 percent were designated as high medical risk, Priority 1 (High 1), and 31.3 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 laboratory results and procedures. High 1 has at least two high-risk conditions; High 2 has only one. Patients at high medical risk are more susceptible to poor health outcomes than those at medium or low medical risk. Patients at high medical risk also typically require more health care services than do patients with lower assigned risk levels. The chart below illustrates the breakdown of the institution's medical risk levels at the start of the OIG medical inspection.

MCSP Master Registry Data as of July 10, 2017

Medical Risk Level	# of Patients	Percentage
High 1	521	14.4%
High 2	1,132	31.3%
Medium	1,461	40.3%
Low	507	14.0%
Total	**3,621**	**100.0%**

OBJECTIVES, SCOPE, AND METHODOLOGY

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

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

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

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

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

CASE REVIEWS

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

Exhibit 1. Case Review Definitions

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

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

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

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

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

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

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

Patient Selection for Retrospective Case Reviews

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

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

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

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

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

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

3. Patient cases generated during death reviews, sentinel events (unexpected occurrences involving death or serious injury, or risk thereof), and hospitalizations are more likely to comprise high-risk patients.

Benefits and Limitations of Targeted Subpopulation Review

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

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

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

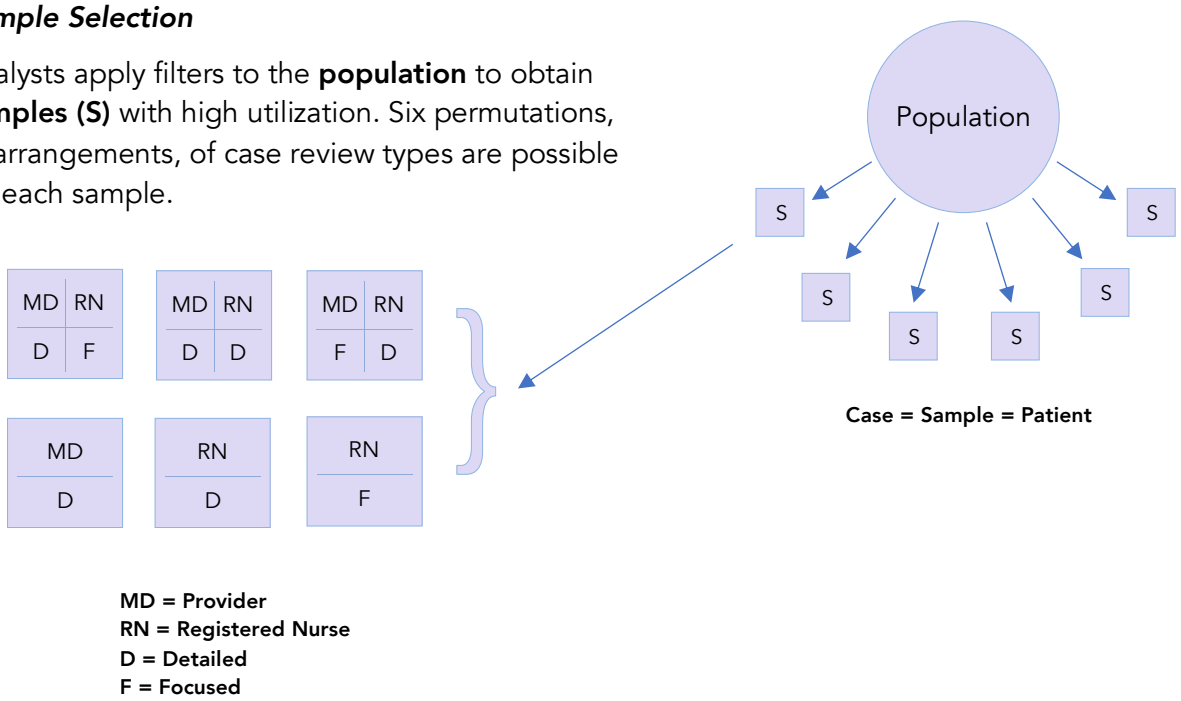
Case Review Sampling Methodology

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

Chart 1. Case Review Sample Selection

Sample Selection

Analysts apply filters to the **population** to obtain **samples (S)** with high utilization. Six permutations, or arrangements, of case review types are possible for each sample.



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

Breadth of Case Reviews

As indicated in *Appendix B, Table B-1: MCSP Sample Sets*, the OIG clinicians evaluated medical cases for 66 unique cases. *Appendix B, Table B-4: MCSP Case Review Sample Summary* clarifies that both nurses and physicians reviewed 17 of those cases, for 83 case reviews in total. Physicians performed detailed reviews of 25 cases, and nurses performed detailed reviews of 16 cases, totaling 41 detailed case reviews. Nurses and physicians also performed a limited or

focused review of an additional 42 cases. These generated 1,459 clinical events for review (*Appendix B, Table B-3: MCSP Event – Program*).

While the sample method specifically pulled only 6 chronic care cases, i.e., 3 diabetes cases and 3 anticoagulation cases (*Appendix B, Table B-1: MCSP Sample Sets*), the 66 unique cases sampled included 279 chronic care diagnoses, including 18 additional cases with diabetes (for a total of 21), and 6 additional cases receiving anticoagulation (for a total of 10) (*Appendix B, Table B-2: MCSP Chronic Care Diagnoses*). The OIG's sample selection tool allowed evaluation of many chronic care programs because the complex and high-risk patients selected from the different categories often had multiple medical problems. While the OIG did not evaluate every chronic disease or health care staff member, the OIG did assess for adequacy the overall operation of the institution's system and staff.

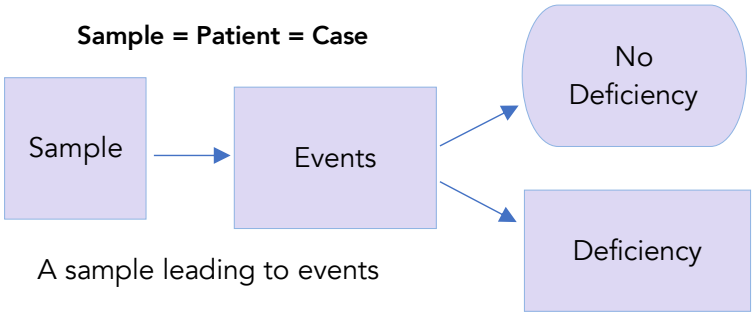
Case Review Testing Methodology

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

Chart 2. Case Review Testing and Deficiencies

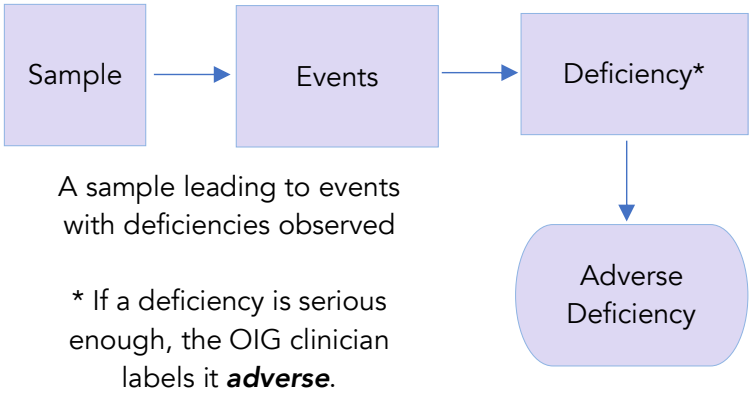
Case Review Testing

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



Deficiencies

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



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

Additionally, the OIG physicians also rate each of the detailed physician cases for adequacy based on whether the institution met the patient's medical needs and if it placed the patient at significant risk of harm. The cumulative analysis of these cases gives the OIG clinicians

additional perspective to help determine whether the institution is providing adequate medical services or not.[4]

Based on the collective results of clinicians' case reviews, the OIG clinicians rated each quality indicator *proficient* (excellent), *adequate* (passing), or *inadequate* (failing). A separate confidential *MCSP Supplemental Medical Inspection Results: Individual Case Review Summaries* report details the case reviews the OIG clinicians conducted and is available to specific stakeholders. For further details regarding the sampling methodologies and counts, see *Appendix B — Clinical Data, Table B-1; Table B-2; Table B-3;* and *Table B-4*.

COMPLIANCE TESTING

Sampling Methods for Conducting Compliance Testing

Our registered nurse inspectors obtained answers to 89 objective medical inspection test (MIT) questions designed to assess the institution's compliance with critical policies and procedures applicable to the delivery of medical care. To conduct most tests, inspectors randomly selected samples of patients for whom the testing objectives were applicable and reviewed their electronic medical records. In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed medical records for 404 individual patients and analyzed specific transactions within their records for evidence that critical events occurred. Inspectors also reviewed management reports and meeting minutes to assess certain administrative operations. In addition, during the week of July 24, 2017, field registered nurse inspectors conducted a detailed onsite inspection of MCSP's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,147 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 MCSP'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*.

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

Scoring of Compliance Testing Results

After compiling the answers to the 89 questions for the 10 applicable indicators, the OIG derived a score for each quality indicator by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Based on those results, the OIG assigned a rating to each quality indicator of *proficient* (greater than 85 percent), *adequate* (between 75 percent and 85 percent), or *inadequate* (less than 75 percent).

OVERALL QUALITY INDICATOR RATING FOR CASE REVIEWS AND COMPLIANCE TESTING

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

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

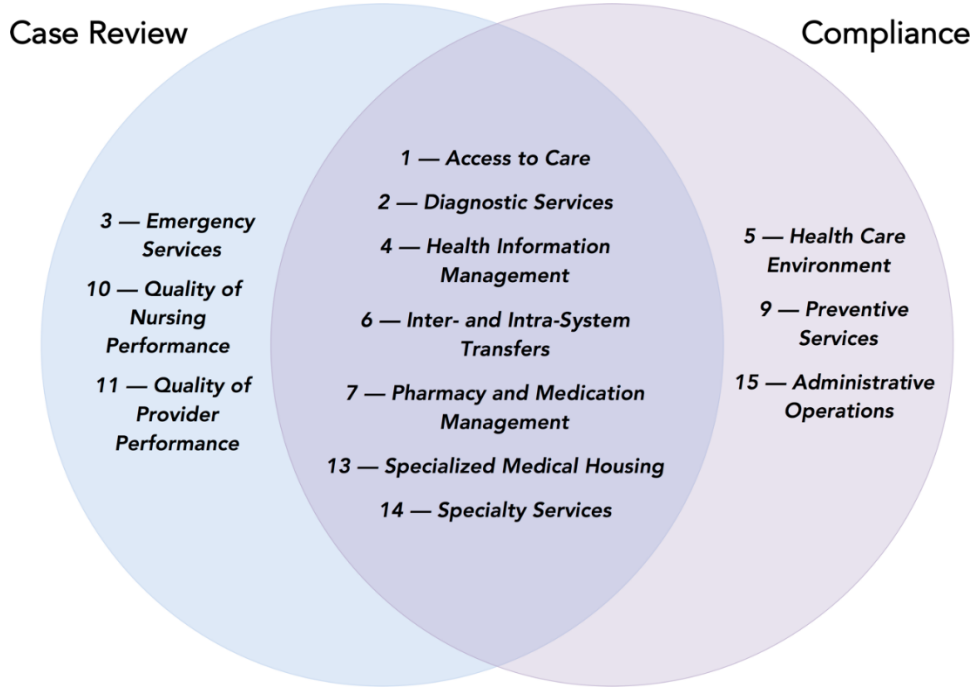
POPULATION-BASED METRICS

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

MEDICAL INSPECTION RESULTS

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

Chart 3. Inspection Indicator Review Distribution



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

Summary of Case Review Results: The clinical case review component assessed 10 of the 13 indicators applicable to MCSP. Of these 10 indicators, OIG clinicians rated all 10 *inadequate*.

The OIG physicians rated the overall adequacy of care for each of the 25 detailed case reviews they conducted. Of these 25 cases, 17 were *adequate*, and 8 were *inadequate*. In the 1,459 events reviewed, there were 503 deficiencies, of which 138 were considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

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

- In case 1, the pulmonologist (lung specialist) recommended an urgent lung biopsy after the patient's scans revealed a mass that may have been cancer. The mass was too small for the radiologist to biopsy. The radiologist instead recommended a surgical biopsy, but the biopsy did not occur until three months later. This was a significant delay in the patient's diagnosis and treatment of potential lung cancer.

- In case 8, the patient had worsening anemia. Although the provider reviewed the laboratory results, the provider did not address the patient's anemia immediately. The same provider later saw the patient for follow-up but again failed to address the anemia. Due to the provider's oversight and failure to review the records thoroughly, no one rechecked the patient's blood counts; his blood counts decreased to a critically low level, resulting in the patient's need for hospitalization and blood transfusions.

- In case 17, the patient had many TTA visits for hematuria (blood in urine), but a provider never evaluated the patient. Instead, MCSP staff sent the patient back to general housing repeatedly without appropriate intervention. Providers should have considered cancer as a probable reason for the patient's hematuria because the patient had also lost more than 40 pounds of weight. On several occasions, providers ordered scans for the patient with a routine priority. These routine orders were inappropriate because of the patient's elevated risk of cancer. As a result, the diagnosis of the bladder tumor was significantly delayed. The providers' failure to evaluate his hematuria promptly allowed his bladder tumor to progress without treatment or intervention.

- In case 23, the patient had been receiving intravenous medication for inflammatory bowel disease every eight weeks before his transfer to MCSP. When the patient arrived at MCSP, the scheduler failed to schedule the patient for his next medication dose. A provider then inappropriately submitted a referral for this medication with routine priority; routine priority services can take as long as three months to complete. The provider should have requested this referral with urgent priority to avoid delaying the patient's medication further. Due to the failure of the scheduler and the inappropriate referral submitted by the provider, the

patient required two hospitalizations for exacerbations of his inflammatory bowel disease. MCSP might have prevented these hospitalizations if the patient had received his intravenous medication in a timely manner.

- In case 25, the patient had several episodes of severe hypoglycemia (low blood sugar), which placed him at risk for seizures or loss of consciousness. The provider failed to promptly address the patient's hypoglycemia after his blood sugar became severely low a second time. Furthermore, the provider did not give the patient sugar tablets to prevent further episodes of hypoglycemia.

- Also, in case 25, the provider was concerned about the possibility of a blood clot after the patient developed swelling and discoloration of his right thigh. Although the provider appropriately ordered an urgent ultrasound scan, the provider failed to start the patient on a blood thinner while waiting for the ultrasound to be completed. This failure significantly increased the patient's risk of developing cardiac arrest, stroke, or a pulmonary embolism (a blood clot in the lung).

Summary of Compliance Results: The compliance component assessed 10 of the 13 indicators applicable to MCSP. Of these 10 indicators, OIG inspectors rated two *proficient*, four *adequate,* and four *inadequate*. The test questions used to assess compliance for each indicator are detailed in *Appendix A*.

1 — *ACCESS TO CARE*

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

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(69.4%)
Overall Rating:
Inadequate

Case Review Results

The OIG clinicians reviewed 592 provider, nursing, specialty, and outside hospital encounters, and identified 67 deficiencies relating to access to care. Of the 67 deficiencies, 33 were significant. Poor health care access affected nearly all aspects of health care delivery at MCSP. The case review rating for this indicator was *inadequate*.

Provider-to-Provider Follow-up Appointments

When providers order follow-up appointments, the failure to follow those orders can result in lapses in care. MCSP demonstrated modest improvement with provider-ordered follow-up appointments since Cycle 4, but serious delays were still present in Cycle 5. These deficiencies occurred in 10 out of 27 applicable cases. In most of these cases, the follow-up appointments were late or did not occur. In some of these cases, the delays occurred several times. These deficiencies occurred in cases 1, 10, 13, 18, 19, 22, 24, and the following:

- In case 16, the patient had a critical laboratory result, which showed his diabetes was out of control. The provider ordered several close follow-up appointments to address the patient's diabetes, but none of those appointments occurred. These errors resulted in a significant lapse in the patient's medical care.

- In case 20, the patient had a productive cough and shortness of breath that required close monitoring by the provider. The provider ordered multiple close follow-up appointments, none of which occurred for more than a month. These were all significant delays.

- In case 28, the provider requested a close follow-up after the patient underwent an urgent computerized tomography (CT) scan of his chest. This follow-up never occurred. This error was a significant lapse in the patient's medical care because he had a chest mass that required close monitoring.

RN Sick Call Access

MCSP had room for improvement in RN sick call access. The OIG clinicians reviewed 123 sick call encounters, 43 of which required a RN evaluation. Though most sick call requests resulted in timely nursing face-to-face evaluation for patients, there were problems in this area in 3 of the 43 applicable cases reviewed. RN sick call appointments did not occur timely or at all in case 55 and the following:

- In case 17, the patient reported a 47-pound weight loss despite consuming an excessive amount of food. According to policy, the nurse should have seen the patient the next business day, but instead saw the patient four days late. On another occasion, the patient reported dizziness, lightheadedness, and pain when urinating. The sick call nurse did not see the patient at all.

- In case 18, the patient had problems walking and requested a medical note excusing him from work until he saw the doctor. The sick call nurse did not see the patient.

RN-to-Provider Referrals

MCSP clinic nurses rarely referred patients to a provider. Of the 123 sick call encounters, there were only seven events in five cases in which the nurse referred the patient to the provider. In two of the five cases, there were severe delays:

- In case 16, the nurse gave wound care and medication counseling, and also obtained an electrocardiogram (test to measure the heart's electrical activity). The nurse made a seven-day provider follow-up referral, but the appointment occurred 21 days late.

- In case 20, the patient needed a disability evaluation. The nurse made a routine referral to the provider (within 14 days), but the appointment occurred 68 days late.

Provider Follow-Up after Specialty Service

MCSP often failed to provide patients with a provider follow-up after specialty services appointments. The OIG clinicians reviewed 135 diagnostic and consultative specialty services and found many instances of delayed follow-ups, with several follow-ups that did not occur. This pattern of delayed follow-ups markedly increased the risk for lapses in patient care. The OIG identified this type of deficiency in 11 out of 21 applicable cases (cases 1, 13, 16, 19, 20, 23, 25, 27, 28, and the following):

- In case 8, the patient returned from an ophthalmology consultation appointment, and the follow-up appointment with the provider occurred ten days late.

- In case 24, the patient returned to MCSP after an urgent ultrasound. Because of the urgency, the follow-up provider appointment should have occurred within three days, but it occurred in six days, or three days late.

- On another occasion in case 24, the patient returned from seeing the ear, nose, and throat specialist (ENT). The nurse intended for the patient to follow up with his provider within 5 days, but the appointment occurred in 16 days, or 11 days late.

Intra-System Transfers

MCSP had serious problems ensuring an appropriate transition of care for patients arriving from other CDCR institutions. The OIG clinicians reviewed seven transfer-in patients and found problems in five of those cases. These problems are further discussed in the *Inter- and Intra-System Transfers* indicator.

- In case 9, the high-risk patient with multiple chronic care problems transferred into MCSP. The provider appointment should have occurred within seven days, but it occurred 16 days late.

- In case 24, another high-risk patient with multiple chronic care conditions transferred into MCSP. He also needed a seven-day provider appointment, but it occurred 15 days late.

- In case 29, another high-risk patient transferred into MCSP and should have been evaluated by a provider within seven days of arrival. This appointment occurred 20 days late.

- In case 31, the patient with chronic medical conditions arrived at MSCP, but the initial provider appointment for newly arrived patients did not occur at all. He was not seen by a provider until the nursing staff happened to notice his non-compliance with medications and made another provider referral.

Follow-up after Hospitalization

Compared to Cycle 4, MCSP continued to have difficulty ensuring their patients followed up with their provider after returning from an outside hospital or emergency department. This problem occurred in 3 of 16 applicable cases (cases 1, 28, and below). The OIG also discusses these problems in the *Inter- and Intra-System Transfers* quality indicator.

- In case 21, the provider ordered a follow-up appointment after the patient returned from an outside emergency department, but the appointment never occurred. This was a significant lapse because patients returning from the outside hospital or an emergency department usually have acute medical issues that require close provider monitoring.

Urgent/Emergent Care

MCSP usually scheduled provider follow-ups correctly after patients returned from the triage and treatment area (TTA). The OIG clinicians reviewed 45 TTA encounters, 16 of which required a PCP follow-up. All the provider follow-up appointments occurred correctly, except in cases 1 and 36.

Specialized Medical Housing

MCSP showed vast improvement with provider access during and after admission to the correctional treatment center (CTC) since Cycle 4. Providers made rounds to see patients in the CTC at appropriate intervals. The OIG clinicians reviewed three CTC admissions with 89 CTC provider encounters. There was only one instance (case 64) when a provider did not perform CTC rounds within the every 3-day policy requirement.

Specialty Access

MCSP usually provided initial access to specialists within acceptable time frames. However, there were numerous problems with the specialty follow-up appointments. Access to specialty services is discussed further in the *Specialty Services* indicator.

Clinician Onsite Inspection

Problems with access to care were primarily due to a lack of provider availability, which was a problem that continued from Cycle 4. This problem is further discussed in the *Quality of Provider Performance* indicator. Of the 16 provider positions available at MCSP, five were vacant during the review period. The lack of providers posed significant challenges for the institution to provide access to care. The result was a tremendous backlog of provider appointments in all five yards. At the time of the onsite inspection, Yard A had a backlog of 100 appointments; Yard B, more than 200; Yard C, more than 100; Yard D, more than 400; and Yard E, more than 170. The clinic schedulers attributed the backlog to provider vacancies.

Of note, the schedulers were appropriately prioritizing appointments that were overdue as well as those that were for offsite returns. Also, the schedulers attempted to decrease the backlogs in each yard by "bundling" several appointments into one appointment in their attempts to increase provider efficiency. Compared to Cycle 4, these scheduling practices were an improvement, as the OIG did not observe these in the prior inspection.

Another reason for the significant backlog of patients was that MCSP began the transition to the electronic health record system (EHRS) in October 2017. As a result, MCSP scheduled fewer appointments for each provider because the providers were still learning and adapting to this new system. Most of the providers started with four appointments per day, but schedulers had gradually increased the number of appointments to eight or nine patients by the time of the onsite inspection.

Since Cycle 4, MCSP gave their providers recruitment and retention bonuses in June 2017 in an attempt to improve its provider staffing. MCSP leadership believed that the bonuses would aid in the institution's ability to recruit new providers as well as to retain current medical staff. At the time of the onsite inspection, two providers had recently transferred to MCSP from other CDCR institutions. MCSP also hired one additional part-time provider and five temporary physicians.

In Cycle 4, the OIG clinicians identified a lack of clinic space at multiple yards. Without enough functional space, providers were unable to meet their patients' demands for medical services. However, MCSP had since expanded its existing clinics via the CCHCS Health Care Facilities Improvement Project (HCFIP). MCSP leadership believed that these newly expanded clinics would be ready for use in March 2018. In addition, MCSP built a new triage and treatment area (TTA), which it planned to open in February 2018.

Case Review Conclusion

MCSP continued to have problems with providing adequate access to care. The OIG identified these issues in Cycle 4 and found that many of the same issues were ongoing during this inspection. MCSP continued to have problems with provider follow-ups. There was a significant backlog of patients in each yard. However, MCSP recently took steps to improve access to care. The institution recruited new providers, which should help with reducing the appointment backlogs. Although the implementation of the new EHRS exacerbated the backlogs, MCSP providers became more comfortable with the new system and started to see more patients. In addition, MCSP expanded its existing clinic space and constructed a new TTA. While the OIG clinicians recognized MCSP's ongoing efforts to improve access to care, many of these efforts occurred after the case review period and were not reflected in this report. During the review period, the *Access to Care* indicator was *inadequate*.

Compliance Testing Results

The institution performed in the *inadequate* range with a compliance score of 69.4 percent for the *Access to Care* indicator. The OIG inspectors found room for improvement in the following four tests:

- Among 25 patients sampled who transferred into MCSP from other institutions and were referred to a provider based on nursing staff's initial health care screening, only five (20.0 percent) were seen timely. For the other 20 patients, the appointments were held three to 59 days late (MIT 1.002).

- Only 8 of 16 sampled patients who received a high-priority or routine specialty service (50.0 percent) also received a timely follow-up appointment with a provider. Of those eight patients who did not receive a timely follow-up appointment, four patients' high-priority specialty service follow-up appointments were 11 to 64 days late, and the other four patients' routine specialty service follow-up appointments were 5 to 38 days late (MIT 1.008).

- Among six Health Care Services Request forms (CDCR Form 7362) sampled on which nursing staff referred the patient for a provider appointment, four patients (66.7 percent) received a timely appointment. One patient received his appointment one day late, and for the other patient, there was no evidence that he received a provider visit at all (MIT 1.005).

- Inspectors sampled 25 patients who suffered from one or more chronic care conditions; only 17 patients timely received their provider-ordered follow-up appointments (68.0 percent). Five patients received their follow-up appointments between 21 and 154 days late; and for three patients, the follow-up appointments occurred between 201 and 313 days late, which was beyond the maximum allowable follow-up interval of 180 days for diabetic and hypertensive chronic care conditions (MIT 1.001).

Two tests received scores in the *adequate* range:

- Patients had access to health care services request forms at five of six housing units inspected (83.3 percent). One inspected housing unit did not have a supply of the forms available for patients' use (MIT 1.101).

- Out of the 25 sampled patients, 21 who were discharged from a community hospital (84.0 percent) received a timely provider follow-up appointment upon their return to MCSP. Four patients received their follow-up appointments two to ten days late (MIT 1.007).

The following two tests earned scores in the *proficient* range:

- For 30 of the 35 patients sampled who submitted a CDCR Form 7362 (85.7 percent), nursing staff completed a face-to-face encounter with the patient within one business day of reviewing the service request form. For the other five patients, the nurse conducted the visit between one and eight days late (MIT 1.004).

- Inspectors sampled 35 CDCR Form 7362s submitted by patients across all facility clinics. Nursing staff reviewed 34 of the service request forms on the same day they were received (97.1 percent); one request form was reviewed one day late (MIT 1.003).

2 — *DIAGNOSTIC SERVICES*

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(70.0%)
Overall Rating:
Inadequate

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

Case Review Results

The OIG clinicians reviewed 276 diagnostic events and found 86 deficiencies, of which 23 were significant. Of those 86 deficiencies, 43 were related to health information management, and 18 occurred when staff did not complete the required tests. The case review rating for this indicator was *inadequate*.

Test Completion

In Cycle 4, MCSP performed most diagnostic tests appropriately. In this inspection, the institution often failed to perform diagnostic tests ordered by providers. Staff often obtained diagnostic tests late or failed to complete them at all. The failure to complete a diagnostic test is a serious deficiency that can lead to lapses in medical care. Providers ordered laboratory tests that were not completed in cases 1, 10, 12, 15, 16, 17, 23, 25, 27, and in the following:

- In case 11, laboratory staff failed to complete an INR test (laboratory test to monitor blood-thinner levels) despite the provider having ordered monthly tests for the patient. The patient already had a low INR level and, therefore, he required close monitoring. Because MCSP did not perform the test, the provider remained unaware of the patient's low blood-thinner levels for 50 days. This error significantly increased the patient's risk of developing blood clots in the legs or the lungs since the patient had a history of prior blood clots.

- Later in case 11, laboratory staff again failed to perform the patient's INR test the provider ordered. This error was significant as the patient's INR remained low, thereby increasing his risk for developing additional blood clots.

Laboratory tests were performed late in cases 1, 8, 11, and in the following:

- In case 10, staff performed an INR test more than two weeks late. This was a significant delay because the patient's blood-thinner levels remained low for more than two weeks, which increased his risk of developing a stroke from his irregular heart rhythm.

Staff completed most diagnostic imaging scans promptly, except in the following:

- In case 25, the provider ordered a bladder ultrasound for the patient within 30 days due to an episode of hematuria (blood in the urine). However, MCSP performed the test two weeks late. As a result, there was a delay in the medical care for the patient's hematuria.

Health Information Management

For diagnostic report management, MCSP usually performed acceptably, but intermittently displayed the following deficiencies:

- MCSP failed to retrieve or scan diagnostic reports in cases 8, 17, and 20. This failure increased the risk of patient harm because the pertinent information would be unavailable to subsequent providers.

- Staff scanned laboratory and diagnostic reports into the electronic medical record late in cases 1, 3, 14, 15, and 17. Most of the delays resulted from MCSP staff failing to timely retrieve and scan these reports into the electronic medical record.

- Diagnostic and laboratory reports that providers had illegibly signed, or that were missing a provider signature or date were found in cases 8, 17, 18, 19, 25, 26, and 28.

MCSP misfiled or mislabeled laboratory reports in cases 1, 7, 10, 17, and the following case:

- In case 16, medical records staff misfiled another patient's laboratory result under the wrong patient's name. This was significant as both patients had laboratory results for diabetes. Due to this filing error, any provider that reviewed the electronic record could have easily used the wrong laboratory results to guide this patient's diabetic care.

Clinician Onsite Inspection

The OIG clinicians expressed concern regarding the high, recurring rate of non-completion of laboratory tests in Cycle 5, which was a new finding compared to Cycle 4. During the onsite inspection, the OIG clinicians learned that there had been no laboratory supervisor until MCSP hired one in May 2017. The hiring of the laboratory supervisor occurred towards the end of the OIG case review period. The OIG clinicians believe that the absence of leadership and supervision in the laboratory department explained why the institution's performance in this indicator regressed in Cycle 5. The new laboratory supervisor found numerous unprocessed

laboratory requests filed away in miscellaneous folders. Furthermore, the laboratory supervisor reported that MCSP had only recently fully staffed this department.

The OIG clinicians also learned that all providers at MCSP had direct access to the radiology images or could view them through the new electronic health record system (EHRS). Therefore, access to diagnostic reports and images were not an issue at MCSP.

Case Review Conclusion

MCSP performed poorly in most aspects of diagnostic services that related to laboratory services during this review period. In Cycle 5, there was a high, recurring rate of non-completed laboratory orders. The OIG clinicians believe this decline in performance was primarily due to the absence of a laboratory supervisor and understaffing in the laboratory department. In addition, MCSP had intermittent failures in retrieving and scanning laboratory reports into the electronic medical record. Although MCSP hired a new supervisor and additional technicians for the laboratory department, the changes occurred too late to be reflected in the OIG Cycle 5 medical inspection. The OIG clinicians rated this indicator *inadequate*.

Compliance Testing Results

The institution received an *inadequate* compliance score of 70.0 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

- Radiology services were timely performed for all ten patients sampled at MCSP (MIT 2.001). MCSP scored zero in the timely review of the corresponding radiology services reports; the reports were not found in the electronic medical records and did not evidence provider review with initials and date (MIT 2.002). Providers timely communicated the diagnostic results to all ten sampled patients (MIT 2.003).

Laboratory Services

- Nine of ten sampled patients (90.0 percent) received their provider-ordered laboratory services timely; one laboratory test was performed seven days late (MIT 2.004). The institution's providers then reviewed seven of the ten resulting laboratory reports within the required time frame (70.0 percent). One report was reviewed seven days late, and for the other two reports, there was no evidence the provider reviewed the reports (MIT 2.005). Finally, providers timely communicated the results to nine of the ten patients (90.0 percent); one patient's results were communicated seven days late (MIT 2.006).

Pathology Services

- Clinicians at MCSP timely received the final pathology report for seven of ten patients sampled (70.0 percent). The three untimely reports were received between 5 and 30 days late (MIT 2.007). Providers timely reviewed the pathology results for four of ten patients (40.0 percent). For five patients, there was no evidence found that the provider reviewed the pathology reports, and for one patient, the provider documented evidence of review one day late (MIT 2.008). Additionally, providers timely communicated the final pathology results to seven of the ten patients sampled (70.0 percent). Results were communicated one to five days late for three patients (MIT 2.009).

3 — *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 21 cases in which patients required urgent or emergent care. These cases yielded 47 urgent/emergent events and 60 deficiencies in various aspects of emergency care. Fifteen deficiencies were significant. The case review rating of the *Emergency Services* indicator at MCSP was *inadequate*.

Delays in Emergency Care

MCSP staff often failed to provide timely emergent care.

- In case 3, the patient had multiple stab wounds to the upper back and shoulder and had a possible punctured lung. There was a 20-minute delay in calling 9-1-1. Upon the patient's arrival at the TTA, emergency medical services determined the patient needed an airlift to the hospital. There was a second delay during which the paramedics waited for custody staff to arrange a different transport team for the airlift.

- In case 5, custody staff found the patient lying face down with blood clots coming out of his mouth. Custody staff failed to start CPR, causing an eight-minute delay. Although the TTA nurse started CPR immediately upon arrival on the scene, the EMS paramedics were unable to resuscitate the patient and pronounced him dead.

Provider Performance

MCSP emergency care provider performance was extremely poor. The OIG clinicians identified a pattern whereby the MCSP providers consistently failed to record their TTA assessments and decision-making. Providers often failed to evaluate these potentially unstable patients. Instead,

MCSP staff inappropriately discharged these patients back to their housing units with many of the patients later requiring hospitalizations. In the 46 TTA encounters reviewed, 32 provider errors occurred. The following are just a few of the examples found during this case review:

- In case 1, the on-call provider failed on several separate occasions to return to the institution to evaluate the patient's complaints of bloody urine. Due to these failures, the patient later required hospitalization for a severe urinary tract infection. If the on-call provider had returned to the institution once to evaluate the patient, the provider might have prevented this hospitalization.

- In case 2, the patient presented to the TTA for severe shortness of breath. The first TTA provider failed to record a progress note explaining why the patient did not need an urgent ambulance transfer to the hospital. A different provider later examined the patient and upgraded the transfer to an emergent ambulance transfer. This delay in emergently transferring the patient to the hospital increased his risk of respiratory failure.

- In case 11, the patient presented to the TTA for a headache and facial numbness. The patient had an increased risk of stroke because this patient was taking estrogen (a female hormone that can increase the risk of stroke). The provider should have instructed the TTA nurse to assess the patient's neurological status or should have returned to the institution to perform an in-person neurological exam.

- In case 17, the patient was in the TTA for recurrent blood and clots in his urine. The on-call provider not only failed to record a telephone provider note but also failed to return to the institution to examine the patient. Instead, the provider discharged the patient back to his regular housing unit. This was a significant lapse in medical care as the patient continued to have bloody urine with significant weight loss and received no provider assessment or intervention.

- In case 23, the patient was lightheaded, dizzy, and confused upon arrival at the TTA. The on-call provider failed to return to the institution to examine the patient for a possible stroke. Also, the provider failed to record a progress note explaining why the potentially unstable patient was discharged back to general housing.

- In case 26, the provider failed to record a progress note when the elderly patient visited the TTA with a right elbow injury, hypotension (abnormally low blood pressure), and a fall. The provider should have performed a neurological exam to evaluate the patient for a possible stroke or head or neck injury. This was a significant lapse in medical care; the TTA nurse evaluated the patient and discharged him back to general housing without a physician evaluation, even though the visit occurred during regular work hours when physicians were readily available.

- In case 26, the same provider again did not properly examine the patient before sending him to an outside emergency department (ED), even though the TTA visit occurred

during regular work hours. The provider transferred the patient to the ED with a diagnosis of possible congestive heart failure and shortness of breath. When the patient arrived at the ED, he denied any symptoms of shortness of breath or chest pain. The patient further reported he was not sure why he had even been transferred to the outside ED. His chest x-ray and the ED physician's exam did not show any signs of congestive heart failure. This could have been a preventable ED transfer if the provider had performed a proper evaluation in the TTA.

Nursing Performance

The nurses at MCSP provided poor on-scene emergency response care. First medical responders should provide critical life-saving medical interventions based on accurate assessments of the patients' conditions before transporting their patients to the TTA. At MCSP, the first medical responders often failed to evaluate patients with urgent/emergent conditions or failed to provide any care before the patient's arrival in the TTA. In the cases that follow, MCSP first medical responders did not even respond to the scene to assess and transport high-risk patients to the TTA:

- In case 1, the patient had two emergency response encounters: one for shortness of breath, and the other for bloody urine and bladder distention. On both occasions, the first medical responder failed to assess the patient's condition or provide any nursing interventions.

- In case 3, the patient with multiple stab wounds to his back walked himself to the outpatient clinic. The licensed vocational nurse (LVN) bandaged his wounds in the clinic but failed to activate the institution's emergency response system. The patient had a possible punctured lung, but the LVN sent him to the TTA via wheelchair, failed to call 9-1-1, and did not accompany or monitor the patient as he went to the TTA. There was no evidence that a first medical responder examined the patient.

- In case 8, the patient had signs of severe cardiac or pulmonary illness. The patient had a decreased level of consciousness, hot moist skin, blue fingers and toes, fever, and urinary incontinence. The first medical responder did not evaluate the patient or accompany him to the TTA. There was no evidence that a first medical responder examined the patient. After the patient arrived in the TTA, staff sent the patient to the hospital, where hospital doctors diagnosed him with a dangerous heart rhythm, lung fluid and inflammation, and a severe blood infection.

- In case 17, a LVN notified the TTA nurse about the patient's dizziness, pain with urination, and bloody urine. No first medical responder assessed the patient. Instead, the patient walked to the TTA, unaccompanied and unmonitored by medical staff. TTA staff found that the patient had urinary retention and sent the patient to the hospital for further evaluation.

TTA nurses also did not assess their patients sufficiently to determine if their patients required intervention or if the interventions provided were effective.

- In case 9, the first medical responder arrived on the scene to assess the patient with difficulty breathing, moist skin, dilated and sluggish pupils, weak pulse, and insufficient verbal responses. The first medical responder did not check the patient's oxygen levels or his blood pressure and did not give supplementary oxygen to support his breathing. The first medical responder noted that emergency medical response equipment was not available at the scene. The patient had a cardiac arrest shortly after arriving in the TTA and died despite CPR and other interventions.
- In case 36, TTA staff assessed the patient with asthma for shortness of breath and wheezing. The patient received one dose of steroid medication in the TTA to treat his condition. The TTA RN did not check the patient's vital signs or respiratory status before discharging him from the TTA.

Emergency Medical Response Review Committee

The Emergency Medical Response Review Committee (EMRRC) reviewed the emergency medical response cases. However, the EMRRC failed to identify the lack of first medical response in any of the cases listed in this indicator except case 1.

Clinician Onsite Inspection

MCSP had two TTAs; one served the recently opened "infill-complex," and the other served the main facility. One nursing supervisor managed both TTAs. The TTA nurses assessed patients who transferred out to or returned from hospitals and emergency departments. The TTA expanded its services to include weekend coverage of sick call requests.

Case Review Conclusion

The MCSP *Emergency Services* indicator was *inadequate* due to poor provider and nursing performance, delays in emergency care, the lack of first medical responders for patients with urgent/emergent needs, and the unavailability of appropriate emergency medical equipment and supplies at the scene of the emergency. Many of the patients reviewed had potentially serious medical conditions, and first medical responders should have assessed them while at the scene and should have monitored and escorted the patients to the TTA.

4 — *HEALTH INFORMATION MANAGEMENT*

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(68.0%)
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 medical record; whether the various medical records (internal and external, e.g., hospital and specialty reports and progress notes) are obtained and scanned timely into the patient's electronic medical record; whether records routed to clinicians include legible signatures or stamps; and whether hospital discharge reports include key elements and are timely reviewed by providers.

Case Review Results

The OIG clinicians reviewed 1,459 events and found 153 deficiencies related to health information management. Of those 153 deficiencies, 13 were significant. The case review rating for this indicator was *inadequate*.

Interdepartmental Transmission

The OIG clinicians identified a recurring pattern in which the nurses failed to communicate vital information to the providers. These errors involving interdepartmental transmission occurred in cases 1, 2, 9, 19, and the following:

- In case 17, the patient had recurrent hematuria (blood in the urine). The urologist recommended a cystoscopy (test using a camera to view the interior of the bladder). However, the nurse did not record the patient's refusal of the test on a refusal form. The nurse also failed to notify the provider of this refusal. These errors may have contributed to the delay in diagnosing the patient's bladder tumor.

- In case 23, the patient had multiple flare-ups of his Crohn's Disease (inflammatory bowel disorder), which required two separate hospitalizations. After the patient returned from his first hospitalization, the TTA nurse failed to inform the on-call physician of the hospital's recommendations for steroid medications. He was supposed to receive oral steroid medications when he arrived at MCSP. This transmission error contributed to the poor care the patient received for his Crohn's Disease.

Hospital Records

MCSP performed well with the retrieval of emergency department physician reports and hospital discharge summaries. The OIG clinicians reviewed 11 emergency department events and 16 community hospital events. MCSP retrieved and scanned all emergency department reports and

discharge summaries into the electronic medical record promptly. Although the institution retrieved the hospital records, the providers performed poorly with reviewing and signing those offsite records. This problem occurred in cases 1, 3, 12, 19, and 26.

Specialty Services

MCSP managed specialty services reports poorly. Although MCSP was better able to retrieve specialty reports compared to Cycle 4, there were still significant problems with the review and scanning of those reports. MCSP continued to scan most specialty reports into the electronic medical record without ensuring that the providers had first reviewed them. These findings are discussed in detail in the *Specialty Services* indicator.

Diagnostic Reports

MCSP performed insufficiently with diagnostic report processing. These findings are discussed in the *Diagnostic Services* indicator.

Urgent/Emergent Records

MCSP providers continued to perform poorly in recording TTA encounters with patients, regardless of whether the encounter occurred during regular work hours or the after-hours on-call period. These findings are discussed further in the *Emergency Services* and the *Quality of Provider Performance* indicators.

Nurses did not document the nursing care provided to patients before sending them to the TTA for urgent/emergent care. This was especially true of nursing staff in the clinics who sent patients to the TTA. The lack of nursing documentation resulted in incomplete patient information about their presenting condition or the treatment rendered. The *Emergency Services* indicator discusses additional information about these findings.

Scanning Performance

The OIG clinicians identified mistakes in the document scanning process as either mislabeled, misfiled documents (filed in the wrong record) or incorrectly dated. Erroneously scanned documents can create lapses in care by hindering the providers' ability to find relevant clinical information. As in Cycle 4, MCSP continued to perform poorly in this area. Case reviewers found mislabeled documents in the electronic medical record in cases 7, 8, 10, 16, 17, 21, and 24. Misfiled documents were scanned in cases 16, 17, and 21. Documents with incorrect dates were scanned in cases 1, 2, 8, 10, 16, 20, 22, 23, 24, 25, and 26. MCSP scanned documents without a signature or with a signature but no date in cases 12, 13, 16, and 24. Although scanning accuracy and completeness were lacking, scanning times for most documents were generally good.

Many health documents were missing from the medical records. Missing documents included most first medical responder nursing notes, a health care services request form, a telemedicine nurse progress note, a provider progress note, medication administration records, provider

orders, TTA flowsheets, and diagnostic reports. Missing documents occurred in cases 8, 18, 19, 22, 27, 64, and 66.

Documentation Quality and Legibility

Provider documentation was good except for one provider. This provider failed to document thought processes and reasoning in the progress notes, which at times resulted in poor care. Since most of the providers either typed their progress notes or occasionally used the dictation service, the OIG clinicians had few concerns with legibility. Illegible signatures and dates occurred in cases 8, 10, 13, 17, 24, and 28.

Clinician Onsite Inspection

The OIG clinicians observed clinical information transmission during the morning huddles. Also, the OIG clinicians interviewed various health care staff regarding how they handled information, especially when clinical care occurred outside the clinic or after hours. The OIG clinicians found that the process used by MCSP to transmit information was appropriate. MCSP care teams distributed and discussed important after-hours clinical information using a standard huddle report agenda.

The OIG clinicians also discovered many of the MCSP providers maintained open lines of communication with their local hospitals and many of the local specialists. This flow of information mitigated some of MCSP's problems with reviewing hospital records and retrieving specialty reports.

Case Review Conclusion

MCSP had difficulty with document retrieval in Cycle 4, which resulted in missing documents throughout all clinical areas. In Cycle 5, MCSP made improvements in specialty report retrieval and demonstrated satisfactory performance in the retrieval of hospital reports. Despite these improvements, MCSP demonstrated continued problems with the transmission of information between various departments, reviewing and signing hospital discharge summaries and specialty reports. Diagnostic report handling was also poor. MCSP providers often did not record their TTA encounters. Documents were missing, and scanning was inaccurate and incomplete. Therefore, MCSP's *Health Information Management* indicator was *inadequate*.

Compliance Testing Results

The institution scored in the *inadequate* range with a compliance score of 68.0 percent in the *Health Information Management* indicator. The following tests showed areas for improvement:

- The institution scored zero for the labeling and filing of electronic medical record documents. For this test, the OIG bases its score on an allowable maximum of 24 mislabeled or misfiled documents. When there are 24 or more mislabeled or misfiled documents, the resulting score is zero (MIT 4.006).

- Among 25 sampled patients admitted to a community hospital and then returned to the institution, MCSP's providers timely reviewed only 15 patients' corresponding hospital discharge reports within three calendar days of the patient's discharge (60.0 percent). For the other ten sampled patients, providers did not review the discharge reports timely; nine reports were reviewed one to five days late, and one report was reviewed 12 days late (MIT 4.007).

- MCSP medical records staff timely scanned medication administration records (MARs) into 13 of 20 sampled patients' electronic medical records (65.0 percent). Seven MARs were scanned between one and three days late (MIT 4.005).

Three tests received scores in the *adequate* range:

- MCSP staff scanned 13 of 16 specialty service consultant reports sampled into the patient's electronic medical record within five calendar days (81.3 percent). However, two high priority specialty service reports were scanned 23 days late; one routine priority specialty service report was scanned two days late (MIT 4.003).

- MCSP's medical records staff timely scanned miscellaneous non-dictated documents such as provider progress notes, nursing initial health screening forms, and patient requests for health care services. Specifically, 17 of the 20 applicable documents sampled (85.0 percent) were timely scanned into the patient's electronic medical record within three calendar days of the patient's encounter. Non-dictated documents for three patients were scanned one to 11 days late (MIT 4.001).

- The medical records staff at MCSP timely scanned community hospital discharge reports or treatment records into patients' medical records for 17 of the 20 sampled reports (85.0 percent); three reports were scanned one day late (MIT 4.004).

One test received a score of *proficient*:

- MCSP scored 100 percent for the timely scanning of dictated or transcribed provider progress notes into patients' electronic medical records (MIT 4.002).

5 — *HEALTH CARE ENVIRONMENT*

Case Review Rating:
Not Applicable
Compliance Score:
Adequate
(81.9%)
Overall Rating:
Adequate

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

Compliance Testing Results

The institution received an *adequate* compliance score of 81.9 percent in the *Health Care Environment* indicator. Scores were in the *proficient* range in the following seven tests:

- The non-clinic bulk medical supply storage areas met the supply management process and support needs of the health care program, earning MCSP a score of 100 percent on this test (MIT 5.106).
- Health care staff at all 14 clinics followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste (MIT 5.105).
- Clinical health care staff at 13 of 14 applicable clinics (92.9 percent) ensured that reusable invasive and non-invasive medical equipment was properly sterilized or disinfected. One clinic did not maintain a medical equipment sterilization log (MIT 5.102).
- Clinic common areas at 13 of the 14 clinics (92.9 percent) had environments conducive to providing medical services. The location of vital signs station in one clinic compromised patients' auditory privacy (MIT 5.109).
- Of the 14 clinics examined, 12 (85.7 percent) were appropriately disinfected, cleaned, and sanitized; the remaining two clinics had one or more problem areas: cleaning logs were not maintained, and accumulated dirt was visible on cracked floors (MIT 5.101).
- When inspectors examined MCSP's 14 clinics to verify that adequate hygiene supplies were available, and sinks were operable, 12 clinics (85.7 percent) complied. Two clinics' patient restrooms did not have sufficient quantities of hygiene supplies such as antiseptic soap and disposable hand towels (MIT 5.103).

- Among the 14 clinics, 12 (85.7 percent) followed adequate medical supply storage and management protocols. Medical supplies in one clinic were not clearly identifiable. In another clinic, medical supplies were stored directly on the floor (MIT 5.107).

One test received a score in the *adequate* range:

- Clinic common areas and exam rooms were sometimes missing core equipment or other essential supplies necessary to conduct comprehensive exams. As a result, 11 of the 14 clinics were compliant (78.6 percent). Equipment and supply deficiencies included two clinics without exam table disposable paper and one clinic with a non-operational ophthalmoscope (MIT 5.108).

Three tests showed areas in which the institution may improve:

- Ten of the 14 clinic exam rooms observed (71.4 percent) had appropriate space, configuration, supplies, and equipment to allow clinicians to perform proper clinical examinations. In four clinics, one or more deficiencies were identified: exam tables had torn vinyl covers; clinicians had impeded access to the exam table; patients were unable to lie fully extended on the exam table due to physical obstructions, and the exam room did not have adequate space to perform a patient examination (*Figure 1*) (MIT 5.110).

Figure 1: Physical obstructions impeding a patient's ability to lie fully extended on the exam table.

- OIG inspectors observed clinician encounters with patients in 14 clinics. Clinicians followed good hand hygiene practices in only ten of these (71.4 percent). At four clinic locations, clinicians failed to wash their hands before or after patient contact or before applying gloves (MIT 5.104).

- Inspectors examined emergency response bags to determine if they were inspected daily and inventoried monthly and whether they contained all essential items. Emergency response bags were compliant in only 4 of the 11 applicable clinical locations where they were stored (36.4 percent). In seven locations, the EMRB log was missing one or more entry evidencing staff verified the bag's compartments were sealed and intact (MIT 5.111)

Non-Scored Results

- The OIG gathered information to determine if the institution's physical infrastructure was maintained in a manner that supported health care management's ability to provide timely or adequate health care. When OIG inspectors interviewed health care managers, they did not identify any significant concerns. At the time of the OIG's medical inspection, MCSP had several significant infrastructure projects underway, which included increasing clinic space at three yards, expanding medication distribution areas, remodeling the TTA, and remodeling a specialty clinic. These projects started in the summer of 2016; the institution estimates that these projects will be completed by the end of fall 2017 (MIT 5.999).

6 — *INTER- AND INTRA-SYSTEM TRANSFERS*

Case Review Rating:
Inadequate
Compliance Score:
Proficient
(87.4%)
Overall Rating:
Inadequate

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

In this indicator, the OIG's case review and compliance review process yielded different results, with the case reviewers assigning an *inadequate* rating and the compliance testing resulting in an *proficient* score. The OIG's internal review process considered those factors that led to both results. MCSP did not schedule newly arrived patients to see their primary care providers within appropriate time frames. Additionally, MCSP did not consistently ensure continuity of care for patients returning from the hospital. These factors increased the risk of harm and resulted in the *inadequate* rating for this indicator.

Case Review Results

The OIG clinicians reviewed 39 inter- and intra-system transfer events, including information from both the sending and receiving institutions. These included 26 hospitalizations and outside emergency room events that resulted in transfers back to the institution. There were 21 deficiencies, 8 of which were significant. The transfer process was inadequate, as there were significant problems with access to provider appointments for patients transferring into MCSP from other institutions.

Transfers In

The OIG clinicians reviewed seven patients who transferred into MCSP from other CDCR institutions. The nurses in the receiving and release clinic (R&R) used a template form to order referrals to providers, nurse care managers, mental health, dental services, and other services as needed. Significant delays occurred in timely scheduling patients for provider appointments in the following cases:

- In case 9, the seven-day appointment with the medical provider was delayed by 16 days. This was a significant delay for a patient with multiple chronic conditions.

- In case 24, a significant delay in access to a medical provider occurred for the patient with multiple chronic conditions. The seven-day referral to the medical provider did not occur until 22 days after the patient's arrival at MCSP, and the five-day appointment with the nurse care manager was delayed by an additional two days.

- In case 29, the initial evaluation was delayed by 20 days for a patient with multiple chronic conditions including heart disease, diabetes, chronic kidney disease, and arthritis.

- In case 30, a pending follow-up oncology appointment scheduled by the sending institution did not occur timely. Two months after the patient arrived at MCSP, the provider placed another request for oncology services, but the follow-up oncology appointment did not occur until five months after the patient arrived at MCSP. The delay could have negatively affected this patient's cancer treatment.

- In case 31, the nurse care manager assessed the newly arrived patient with multiple chronic conditions including uncontrolled diabetes. The nurse care manager did not check the patient's most recent abnormal laboratory results, blood sugar levels, or the patient's compliance with medications. The nurse contacted the medical provider but did not communicate the patient's out-of-control diabetic condition. The provider then ordered a lengthy 90-day provider follow-up. The nurse should have informed the provider of the patient's poorly controlled diabetes and questioned the lengthy appointment for the newly arrived patient.

Transfers Out

The OIG clinicians reviewed four patients who transferred out of MCSP and found no deficiencies. All four patients departed MCSP and were directly admitted to an outside hospital at the time of transfer. After hospital discharge, the patients were transferred to correctional treatment centers (CTCs) at other institutions due to their medical needs. The R&R nurses documented and communicated the patients' significant medical and mental health conditions, diagnostic laboratory findings, durable medical equipment (DME) items, and upcoming appointments with the receiving institutions.

Hospitalizations

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

OIG clinicians reviewed 26 events in which patients returned to MCSP from a community hospital or emergency department. There were 13 deficiencies, 3 of which were significant. The delays in the medical provider follow-up appointments and post-hospital medication administration issues occurred in cases 17, 28, and the following two cases:

- In case 1, the five-day medical provider follow-up was three days late after the patient returned from the hospital for hematuria (blood in urine) and urinary retention. This was a significant delay because the patient required close follow-up monitoring after hospital discharge.

- Also in case 1, the patient returned to MCSP, and the hospital physician recommended to stop the metformin medication (diabetes medication). The TTA nurse did not communicate the discontinued medication order to the medication nurse. Subsequently, the patient received the metformin medication. This error placed the patient at increased risk for medication side effects.

- In case 23, the patient returned to MCSP after a hospitalization for a severe episode of Crohn's Disease (inflammatory bowel disorder). The TTA nurse did not inform the provider about the hospital discharge recommendations for prednisone (a steroid medication to reduce inflammation). Fortunately, a nurse assessed the patient the following day and corrected the error.

Clinician Onsite Inspection

MCSP had two separate R&R clinics, one for the recently opened infill-complex and the other for the main facility. One nursing supervisor managed both clinics. Each clinic had adequate space to provide patient screening and physical assessment. R&R nurses processed patients returning from specialty appointments, whereas TTA nurses processed patients returning from a hospital discharge or hospital emergency room. The R&R nurses reviewed consultation reports from the specialists, and the specialty nurses scheduled the onsite or offsite follow-up appointments. During the review period, R&R nurses used the transfer screening form for patient assessment and the order template to make follow-up referrals. By the time of the onsite inspection, MCSP no longer used these forms due to the transition to the EHRS in October 2017.

Case Review Conclusion

The *Intra-Inter-System Transfer* indicator rating was *inadequate* due to MCSP's deficient performance with providing timely provider appointments for newly arrived patients at MCSP. Additionally, nursing staff did not sufficiently coordinate the patients' care upon their return from the hospital. These problems included serious medication administration errors that placed patients at increased risk of harm as well as delayed provider follow-up.

Compliance Testing Results

The institution received a *proficient* score of 87.4 percent in this indicator. Three tests received scores in the *proficient* range:

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

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

- Of the 25 sampled patients who transferred into MCSP, 15 had an existing medication order that required nursing staff to issue or administer medications upon arrival. All 15 applicable patients received their medications timely (MIT 6.003).

The institution can improve in the following areas:

- Among 20 sampled patients who transferred out of MCSP to other CDCR institutions, only 13 had their scheduled specialty service appointments properly included on the health care transfer form (65.0 percent). For the remaining seven patients, one or more pending specialty service appointments were not documented on the transfer forms (MIT 6.004).

- The OIG tested 25 patients who transferred into MCSP from other CDCR institutions to determine whether they received a complete initial health screening assessment from nursing staff on their day of arrival. MCSP received a score of 72.0 percent on this test because nursing staff timely completed the assessment for only 18 of the sampled patients. For five patients, nurses neglected to answer one or more of the screening form questions; and for two patients, there was no evidence that the initial health screening was completed (MIT 6.001).

7 — *PHARMACY AND MEDICATION MANAGEMENT*

Case Review Rating:
Inadequate
Compliance Score:
Adequate
(77.3%)
Overall Rating:
Inadequate

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

In this indicator, the OIG's case review and compliance review process yielded different results, with the case reviewers assigning an *inadequate* rating and the compliance testing resulting in an *adequate* score. The OIG's internal review process considered those factors that led to both results. MCSP had difficulty maintaining appropriate medication continuity for patients with chronic conditions and for those returning from a hospital. There were errors and delays in administering critically important medications. Because these errors placed patients at risk of harm, the OIG clinicians rated this indicator *inadequate*.

Case Review Results

The OIG clinicians evaluated 83 events related to medications and found 11 deficiencies, 8 of which were significant. Significant deficiencies occurred in cases 1, 8, 18, 19, and 23. The OIG identified breaks in medication continuity, nursing medication administration errors, and pharmacy dispensing errors. The case review rating for this indicator was *inadequate*.

Medication Continuity

Case reviewers found that chronic care medication continuity was acceptable. Patients did not receive needed medications in the following case:

- In case 18, the patient did not receive a 30-day supply of simvastatin (cholesterol medication) for an entire month. This break in medication continuity placed this patient at risk of increased cholesterol and heart disease.

Medication Administration

Although nurses at MCSP generally administered medications timely and notified providers when a patient was non-compliant with his medications, the following medication administration deficiencies occurred:

- In case 1, the patient returned to MCSP after a hospitalization and there were changes to his medications. The TTA nurse did not communicate the medication changes to the medication nurse, and the medication nurse did not review the patient's current medication list after hospital discharge. Subsequently, the patient received medication that the hospital physician had stopped. This error placed the patient at risk for adverse medication side effects. This case is also discussed in the *Inter- and Intra-System Transfers* indicator.

- In case 1, the patient had pneumonia. The provider extended the antibiotic medication for an additional five days. The pharmacy delivered the medication two days later, resulting in a two-day gap in antibiotic treatment. The nurse should have prevented this lapse in medication continuity by administering the medication from the Omnicell (medication delivery cabinet).

- In case 8, the provider stopped a higher dose of prednisone (a steroid to reduce inflammation) and prescribed a lower dose of the medication. Instead, the nurse gave the patient both the discontinued higher dose as well as the new lower dose of prednisone. This error increased the risk of medication overdose and adverse side effects.

Pharmacy Errors

Issues in the pharmacy delivery system at MCSP contributed to both gaps in treatment and errors in medication administration, as illustrated in the following cases:

- In case 2, the pharmacy filled the 30-day supply of tamsulosin (prostate medication) twice in the same month, resulting in duplicate delivery within an 11-day period.

- In case 19, the patient returned to MCSP after a hospitalization and the provider decreased the dose of the blood pressure medication. The pharmacy dispensed the old, higher dose instead of the newly ordered, lower dose. The medication nurse did not review the medication administration record before giving the patient the incorrect KOP medication.

- In case 23, the patient was on a tapered dose of prednisone for increased Crohn's Disease (inflammatory bowel disorder) symptoms. The pharmacy did not account for the prednisone doses administered to the patient in the TTA and dispensed two extra doses.

Clinician Onsite Inspection

MCSP had two independent pharmacies, one serving the infill-complex and the other serving the main facility. The OIG clinicians interviewed various pharmacy and nursing staff during the onsite inspection. The nurses viewed the implementation of the new electronic medical records system as a positive change for improving communication between providers, nurses, and the pharmacy.

Case Review Conclusion

MCSP performed poorly with ensuring accurate medication administration due to nursing and pharmacy errors. Therefore, the *Pharmacy and Medication Management* indicator at MCSP was *inadequate*.

Compliance Testing Results

The institution received an *adequate* score of 77.3 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 *adequate* score of 75.1 percent. Three tests earned scores in the *proficient* range:

- Nursing staff administered medications without interruption to the three applicable patients who were en route from one institution to another and had a temporary layover at MCSP, resulting in a score of 100 percent (MIT 7.006).

- MCSP timely administered or delivered new medication orders to 23 of the 25 patients sampled (92.0 percent). One patient received his medication one day earlier than the specified provider's order, and for the other patient, there was no evidence in the electronic medical record that the medication was timely administered (MIT 7.002).

- MCSP ensured that 23 of 25 patients sampled who transferred from one housing unit to another (92.0 percent) received their medications without interruption. Two patients did not receive one dose of their medications at the next dosing interval after the transfer occurred (MIT 7.005).

Two tests showed room for improvement:

- Among 21 applicable patients, 10 (47.6 percent) timely received chronic care medications. Eight patients did not receive their KOP medications per CCHCS policy requirement; two patients missed one or more doses of their direct-observation-therapy (DOT) medications

and did not receive provider counseling, and there was no evidence that one patient received or refused his medication (MIT 7.001).

- Clinical staff timely provided new and previously prescribed medications to 11 of 25 sampled patients who had been discharged from a community hospital and returned to the institution (44.0 percent). Twelve patients received provider ordered medications one to three days late. For two patients, providers did not order new medications by the required time after patients' arrival from community hospital (MIT 7.003).

Observed Medication Practices and Storage Controls

The institution scored 62.9 percent in this sub-indicator, with the following tests scoring in the *inadequate* range:

- Only one of eight inspected medication preparation and administration areas demonstrated appropriate administrative controls and protocols (12.5 percent). At seven locations, one or more of the following deficiencies were observed: patients waiting to receive their medications did not have sufficient outdoor cover to protect them from heat or inclement weather; medication nurses did not always ensure patients swallowed DOT medications; and medication nurses did not appropriately administer medication as ordered by the provider (MIT 7.106).

- Inspectors observed the medication preparation and administration processes at eight applicable medication line locations. Nursing staff was compliant regarding proper hand hygiene and contamination control protocols at only three locations (37.5 percent). At five locations, not all nursing staff washed or sanitized their hands before re-gloving (MIT 7.104).

- MCSP safely stored non-refrigerated, non-narcotic medications in 8 of the 13 applicable clinic and medication line storage locations (61.5 percent). In five locations, one or more of the following deficiencies were observed: medication cabinets were unlocked; multi-use medication was not labeled with the date it was opened, and medication was stored beyond its expiration date (MIT 7.102).

One test received a score in the *adequate* range:

- Refrigerated, non-narcotic medications were safely stored in 9 of 12 clinics and medication line storage locations (75.0 percent). At three locations, deficiencies were found related to refrigerator temperatures not being kept within the acceptable range (MIT 7.103).

Two tests received scores in the *proficient* range:

- The OIG interviewed nursing staff and inspected narcotics storage areas at 11 applicable clinic and pill line locations to assess narcotics security controls. Nursing staff had strong medication security controls over narcotic medications at ten locations (90.9 percent). For one clinic, the narcotics logbook showed that on multiple occasions that a controlled substance inventory was not performed by two licensed nursing staff (MIT 7.101).

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

Pharmacy Protocols

MCSP scored 96.8 percent in this sub-indicator, with the following tests earning *proficient* scores:

- In its main pharmacy, the institution followed general security, organization, and cleanliness management protocols; safely stored and monitored both refrigerated and non-refrigerated non-narcotic medications; and the main pharmacy maintained adequate controls over and properly accounted for narcotic medications (MIT 7.107, 7.108, 7.109, 7.110).

One test received an *adequate* score:

- The institution's pharmacist in charge (PIC) followed required protocols for 21 of the 25 medication error reports and monthly statistical reports reviewed (84.0 percent). For four medication error reports, there was a lack of evidence provided that the PIC received a timely notification (MIT 7.111).

Non-Scored Tests

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

- The OIG tested patients in isolation units to determine if they had immediate access to their prescribed KOP rescue inhaler. Inspectors interviewed all five of MCSP's applicable inmates, and all of them indicated that they had their KOP rescue medications (MIT 7.999).

8 — *PRENATAL AND POST-DELIVERY SERVICES*

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

MCSP does not have female patients; therefore, this indicator does not apply.

Case Review Rating:
Not Applicable
Compliance Score:
Not Applicable

Overall Rating:
Not Applicable

9 — *PREVENTIVE SERVICES*

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

Case Review Rating:
Not Applicable
Compliance Score:
Adequate
(82.7%)
Overall Rating:
Adequate

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

Compliance Testing Results

The institution scored an *adequate* 82.7 percent in this indicator. The following two tests scored in the *proficient* range:

- OIG inspectors found that all three patients sampled received the required monthly or weekly monitoring while taking TB medications (MIT 9.002).
- All 25 patients sampled received or were offered influenza vaccinations timely during the most recent influenza season (MIT 9.004).

Two tests received *adequate* scores:

- MCSP offered colorectal cancer screenings to 20 of 25 sampled patients subject to the annual screening requirement (80.0 percent). For five patients, health care staff did not offer a colorectal cancer screening within the previous 12 months and the patients did not have normal colonoscopies within the last ten years (MIT 9.005).
- Inspectors tested whether patients who suffered from chronic conditions were offered vaccinations for influenza, pneumonia, and hepatitis. At MCSP, 13 of 17 sampled patients (76.5 percent) received all recommended vaccinations at required intervals. For four patients, there was no evidence they received or refused a pneumococcal immunization within the last five years (MIT 9.008).

The following two tests revealed areas in which the institution could improve:

- OIG inspectors sampled 30 patients at MCSP to determine whether they received a tuberculosis screening within the last year. Out of the 30 patients sampled, 22 (73.3 percent) timely received their screening. For eight patients, the TB screening did not occur in the patient's birth month as required by policy (MIT 9.003).

- The OIG examined the health care records of all three patients who were on TB medications during the inspection period, and two patients received all required doses (66.7 percent). One patient did not receive or refuse his TB medication (MIT 9.001).

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10 — *QUALITY OF NURSING PERFORMANCE*

Case Review Rating:
Inadequate
Compliance Score:
Not Applicable

Overall Rating:
Inadequate

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

Case Review Results

The OIG clinicians reviewed 403 nursing encounters, of which 231 were in the outpatient setting. Most outpatient nursing encounters were for sick call requests, wound care, walk-in visits, and RN follow-up visits. In all, there were 115 deficiencies identified related to nursing care, 42 of which were significant. The quality of nursing performance at MCSP was *inadequate*.

The OIG clinicians identified several deficiency patterns that were common across various areas of nursing services. These included inadequate nursing assessments based on the patients' presenting problems, failures to implement treatment regimens as ordered, inconsistent wound care treatment, and delays in assessing patients with potentially urgent conditions.

Nursing Assessment

Nurses should sufficiently assess patients to determine which specific nursing interventions patients require. They should also determine the effectiveness of interventions by assessing patients before and after administering medications and other treatments. Nurses at MCSP often did not provide sufficient assessment. These errors occurred in cases 1, 2, 8, 16, 19, 24, 30, 36, 43, 54, 55, 64, and the following:

- In case 9, the patient had shallow, labored respirations with a slow breathing rate. The first medical responder did not assess the patient's oxygen levels and did not administer supplementary oxygen to support the patient's breathing.

- In case 17, the patient had chronic hematuria (bloody urine), a recent diagnosis of urinary tract infection, and was taking antibiotic treatment. During his wound care visit, the patient reported painful urination. The nurse instructed the patient to fill out a sick call request and did not assess the patient further.

- In case 21, the medical provider ordered daily blood pressure checks for five days. The nurses did not check the patient's blood pressure over the weekend, which caused a two-day gap in implementing the provider's orders.

Nursing Intervention

The nurses at MCSP frequently consulted with providers. However, a pattern arose in which nurses did not follow through with the provider-ordered interventions or even those that nurses could have performed independently. These problems occurred in cases 9, 16, 17, 18, 19, 24, 65, 66, and the following:

- In case 2, the patient had shortness of breath, wheezing, elevated pulse, and low peak flow readings (measurement of air flow in the lungs). The clinic nurse contacted the medical provider and received orders for a nebulizer treatment. However, the nurse did not administer the medication.

- In case 3, the clinic nurse did not call 9-1-1 immediately for the patient who walked to the clinic and reported multiple stab wounds. The nurse did not provide first medical responder nursing care or record the findings. The nurse sent the patient to the TTA via wheelchair without monitoring or accompanying the patient.

- In case 20, the medication nurse administered an extra dose of insulin without a provider's order. The nurse rechecked the patient's blood glucose two hours later and the nurse administered additional insulin, again without a provider's order.

- In case 63, the elderly patient was losing weight. The CTC nurses did not consistently follow the medical provider's orders for daily weight checks and administration of a nutrition supplement with each meal.

- In case 64, the patient had liver disease and fluid retention in his abdomen, legs, and feet. The CTC nurses did not consistently follow the provider's orders for daily weight measurements and did not apply compression stockings to his legs and feet that the podiatrist ordered to support fluid circulation.

Wound Care

Patients who needed ongoing wound care did not always receive it as ordered or at all. The following cases demonstrated deficiencies in wound care:

- In case 16, the patient had diabetes and a foot ulcer. Though a provider prescribed daily wound care, over a period of five months, nurses failed to change his wound dressing three to six times per month. The nurses also did not assess the size or describe the wound and the condition of the surrounding skin.

- In case 19, the obese patient returned to MCSP after a one-week hospital admission for pneumonia. The patient had edema in his lower extremities and developed a thigh ulcer. Over the course of one month, the nurses did not provide wound care to the high-risk patient's thigh ulcer on five different occasions.

- In case 20, the patient with stab wounds to his back was hospitalized. Hospital physicians placed a tube in his chest to drain the lung fluid and then removed the tube before his discharge. Upon the patient's return to MCSP, nurses did not provide wound care to the patient's chest wound site on five different occasions during the following month.

- In case 24, the patient underwent surgical removal of a skin cancer from his ear. MCSP nurses did not provide wound care on nine occasions in the first month and six occasions during the second month. Additionally, nurses repeatedly used cloned notes containing identical assessments and vital signs.

- In case 64, the podiatrist ordered the CTC nurses to wash the patient's foot wound and apply clean gauze daily. Instead, the CTC nurses left the patient's foot wound open to air and did not perform the wound care ordered by the podiatrist.

Nursing Communication

MCSP nurses sometimes failed to communicate pertinent patient information to providers or other nurses. This deficiency occurred in cases 9, 17, 19, 23, 24, and the following:

- In case 1, the patient returned from a cardiology appointment with recommendations for an immediate pulmonary function test. The R&R nurse did not inform the provider about the cardiologist's recommendation, and the test was delayed until the following week.

- In case 2, upon his arrival at MCSP, the patient reported a loss of appetite, weight loss, and night sweats on the tuberculosis (TB) screening form. The nurse did not refer the patient to a provider for evaluation of the TB symptoms the patient reported.

- In case 8, the nurse did not inform the provider that the patient had not picked up his 30-day supply of prednisone (steroid medication to decrease inflammation). The patient was without his daily prednisone dose for a full month. On another occasion, the patient did not

feel well and requested to see a provider. The nurse did not inform the provider about the patient's low blood pressure or recheck the blood pressure. On a third occasion, the custody officer contacted the clinic LVN and reported that the patient was "not doing well, not walking, and not eating." The LVN did not inform the TTA nurse about the ill patient who refused to go to the clinic for a nursing assessment.

- In case 21, the provider had ordered nurses to contact the provider if the patient's blood pressure rose to more than 154/96. The LVN reported the patient's blood pressure of 179/118 to the TTA nurse. The TTA nurse did not follow orders and did not contact the provider. Instead the TTA nurse directed the LVN to send the patient back to his housing unit.

- In case 64, the elderly patient had generalized weakness and unsteady gait when walking. The CTC nurse did not contact the provider regarding the patient's low blood sugars or attempt to obtain safety equipment, such as a walker and bedside commode, to decrease the patient's risk of falls and injury.

Nursing Documentation

At MCSP, the nurses used template progress notes to type or handwrite their nursing documentation. Medical records staff scanned those notes into the electronic medical record. Documentation errors occurred in cases 2, 3, 8, 16, 17, 18, 19, 20, 21, 22, 23, 24, 63, 64, and 66. These documentation deficiencies created a gap in the patients' medical records and the care provided. Several patterns of deficiencies related to the nursing documentation emerged. Some nurses re-used old and inaccurate data on an electronic note template, resulting in erroneous documentation (cloned notes). Nursing staff used typewritten cloned progress notes to document wound care assessments and interventions. Although the progress notes included encounter dates and current vital signs, numerous wound care notes had nearly identical wording from previous notes, which could have resulted in the erroneous documentation. The pattern of using cloned nursing notes at MCSP occurred in the Cycle 4 medical inspection and persisted in the Cycle 5 inspection. Cloned notes occurred in cases 17, 24, and the following:

- In case 16, the nurse repeatedly documented the incorrect location of the foot and ankle wounds as "left" instead of "right."

- In case 21, the nurse recorded inconsistent facts that were contradictory to the patient's condition, resulting in erroneous clinical findings recorded in the patient's record. The nurse mistakenly instructed the patient to apply heat and ice to his extremity injuries when he had abdominal pain. Furthermore, the nurse recorded that the patient returned to his housing unit, when in fact the nurse sent him out to the hospital.

When clinic nursing staff assessed patients before sending them to the TTA for further assessment, the clinic nurses did not document patient evaluations, interventions, and decisions for sending the patient to the TTA. This problem was widespread and occurred in virtually all applicable cases.

Nursing Sick Call

The OIG clinicians reviewed 123 sick call encounters, 43 of which resulted in face-to-face nursing assessments. Sometimes, MCSP nurses did not see patients with potentially urgent conditions the same day that the nurses reviewed the health care requests.

- In case 8, the nurse reviewed the patient's health care services request form, which described symptoms of inability to eat and abdominal pain. The nurse did not see the patient the same day to assess him for a potentially urgent condition, but instead saw him the following day.

- In case 19, the patient submitted a health care services request form for evaluation of an infected wound. The nurse never saw the patient. The nurse should have examined the wound the same day the nurse reviewed the patient's request form. Fortunately, the provider evaluated the patient the following day and ordered antibiotics and wound care.

- In case 23, the patient with Crohn's Disease (inflammatory bowel disorder) reported symptoms of explosive diarrhea and abdominal pain and claimed that he was not receiving his prescribed Remicade (Crohn's Disease medication). The nurse should have seen the patient the same day but did not. The following day, another nurse assessed the patient, referred the patient to a provider, and transferred the patient to a community hospital.

Urgent/Emergent Care

The emergency medical response services and nursing care provided in the TTA were poor due to deficient nursing performance. First medical responders often failed to provide care before the patients' arrival at the TTA. First medical responders did not assess patients adequately or provide appropriate nursing interventions to their conditions. First medical responders often failed to provide appropriate interventions at the scene of the emergency. This poor performance is further discussed in the *Emergency Services* indicator.

Care Management

CCHCS defines the care manager as a primary care RN who develops, implements, and evaluates patient care services and care plans for an assigned patient panel. The nurse care manager provides direction for the assigned patient panel and collaborates with the patient to develop and maintain the treatment plan. The nurse care manager refers to and coordinates with other services as appropriate. The nurse also reviews patient information, arranges patient care activities, provides education, and directs the members of the health care team to ensure that patients receive necessary health care services in a safe, timely, and appropriate manner. MCSP expanded the role of the clinic nurses to provide chronic care follow-up and care management responsibilities in addition to their usual episodic sick call care.

Nevertheless, during the onsite inspection the nursing staff in the clinics did not have a clear understanding of the nurse care manager functions. Nurses cited time and staffing limitations as barriers to providing care management for patients who could have benefited from nurse care management interventions. Although some nurses reported providing care management services without identifying themselves as nurse care managers, there was scant evidence of this in the cases reviewed. Only three progress notes reflected nurse care manager visits, in cases 16, 24, and 31.

Post-Hospital Returns

MCSP nurses provided poor care to patients who returned from the hospital. Medication administration problems occurred when nurses did not communicate hospital recommendations to providers or did not communicate orders to medication nurses. Nursing performance in this area is also discussed in the *Inter- and Intra-System Transfers* indicator.

Specialized Medical Housing

Nursing care in the CTC was insufficient. CTC nurses did not inform providers when there were changes in patients' conditions. Nurses did not consistently follow through with orders such as weighing patients daily, providing dressing changes, or administering nutritional supplements. These problems are also discussed in the *Specialized Medical Housing* indicator.

Offsite Specialty Services Returns

MCSP nurses often failed to order follow-up appointments for patients returning from specialty appointments. Provider follow-up appointments were often late or did not occur not at all. This problem is also discussed in the *Specialty Services* indicator.

Clinician Onsite Inspection

The OIG clinicians visited various clinic areas and interviewed nursing staff in each area. MCSP implemented the EHRS in late October 2017 and had recently undergone nursing assignment changes during early January 2018. The chief nursing executive, supervising nurse administrators, and nursing staff at MCSP were helpful during the onsite inspection visit and expressed interest in implementing quality improvement strategies.

Case Review Conclusion

Based on the OIG review, MCSP nurses performed poorly and insufficiently. This performance affected other health care indicators including *Emergency Services*, *Inter- and Intra-System Transfers*, *Specialized Medical Housing,* and *Specialty Services.* Nursing problems were widespread, consisting of poor assessment, intervention, wound care, documentation, sick call, and care management. The *Quality of Nursing Performance* at MCSP was *inadequate*.

11 — *QUALITY OF PROVIDER PERFORMANCE*

In this indicator, the OIG physicians provide a qualitative evaluation of the adequacy of provider care at the institution. The case review clinicians review the provider care regarding appropriate evaluation, diagnosis, and management plans for programs including, but not limited to, nursing sick call, chronic care programs, TTA, specialized medical housing, and specialty services. OIG physicians alone assess provider care. There is no compliance testing component associated with this quality indicator.

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

Overall Rating: *Inadequate*

Case Review Results

The OIG clinicians reviewed 223 medical provider encounters and identified 131 deficiencies related to provider performance at Mule Creek State Prison (MCSP). Of the 131 deficiencies identified, 30 were significant. MCSP provider performance was *inadequate*.

Assessment and Decision-Making

The MCSP providers consistently failed to make sound assessments and accurate diagnoses. Poor assessments and misdiagnoses occurred frequently throughout the cases reviewed. Many of the providers also made questionable medical decisions. Errors with provider assessments or decisions occurred in cases 2, 8, 9, 11, 12, 14, 17, 18, 20, 24, and 25. The following are examples of this type of deficiency:

- In case 8, the patient's anemia was progressively worsening. The provider was aware of this problem but failed to address it promptly. This same provider saw the patient in follow-up the next month and again failed to address the patient's worsening anemia. By the third month, the patient's anemia reached a critical level. The provider's failure to recognize the patient's problem not only increased the patient's risk of developing serious complications but also led to a hospitalization in which he received multiple blood transfusions. This hospitalization may have been prevented if the provider had addressed the patient's condition immediately.

- In case 17, the patient had multiple visits to the TTA for hematuria (bloody urine), but a provider never evaluated him. Instead, MCSP providers sent him back to his housing each time because this was not a new problem. In addition to the hematuria, the patient had lost a significant amount of weight. The providers failed to consider bladder cancer as a cause of the patient's symptoms. The primary provider instead improperly documented the 42-pound weight loss as "intentional." The providers' failures to appropriately address the patient's weight loss combined with their inability to assess the patient properly contributed to the delay in diagnosing the patient's bladder cancer.

- In case 20, the provider ordered an antibiotic and a chest x-ray but did not examine the patient or record a progress note. The provider had never seen this patient before and, therefore, should have examined the patient first.

- In case 25, the provider failed to address the patient's critically low blood sugar level for nearly eight days. This was a significant lapse in the patient's medical care because the low levels could have caused a seizure or loss of consciousness. At a minimum, the provider should have ordered sugar tablets for the patient to prevent his severe hypoglycemic (low blood sugar) episodes.

- Also in case 25, the provider also ordered an urgent ultrasound of the patient's thigh to evaluate for a blood clot. However, the provider failed to start the patient on a blood thinner while waiting for the ultrasound report. The patient did not receive blood thinner medication for one week, thereby increasing his risk of developing a blood clot and related complications.

Review of Records

MCSP providers often failed to sufficiently review their patients' medical records. There was an insufficient depth of review of medical records by providers in case 27, and the following:

- In case 16, the provider failed to do a thorough case review of the electronic medical record, and the provider did not realize the patient's HbA1c test (average blood sugar over three months) was significantly elevated. Due to this oversight, the provider was unaware that the patient's diabetes had progressively worsened. As a result, the provider neglected to order a follow-up HbA1c test for the following month.

- In case 18, a different provider failed to perform a thorough case review of the electronic medical record so did not realize the patient had a chronically low hemoglobin level with associated fatigue. Due to this provider oversight, the patient's anemia was not addressed for nearly three months.

- In case 19, the provider failed to perform a thorough case review and erroneously renewed the patient's blood pressure medication. Hospital doctors had stopped this medication because of the patient's abnormally low blood pressure.

- In cases 1, 8, 10, 13, 14, 18, and 25, the provider failed to thoroughly review the medical record. As a result, in each case the provider unnecessarily ordered a laboratory test that the institution had already completed.

Provider-Ordered Follow-up Intervals

While MCSP providers usually ordered appropriate follow-ups, they did not do so consistently. Inappropriate provider follow-ups occurred in cases 11, 18, and the following:

- In case 2, the patient was taking steroid medication for his asthma, which was poorly controlled. The patient needed closer monitoring, but the provider failed to order an appropriate follow-up. A provider did not see the patient again for nearly three months.

- In case 17, the provider ordered a three-month follow-up for the patient. This was not an appropriate follow-up given the patient's recurrent hematuria and significant weight loss. These were symptoms of cancer, which required immediate diagnosis and treatment.

- In case 25, the patient had severely low blood sugar and required close follow up. Instead, the provider ordered a 180-day follow-up appointment. This inappropriate follow-up interval increased the patient's risk of developing an adverse outcome such as loss of consciousness or a seizure.

Emergency Care

MCSP emergency care provider performance was extremely poor. The OIG clinicians identified a pattern whereby providers repeatedly failed to document their TTA assessments and decision-making. Potentially unstable patients never had proper TTA provider evaluations. Instead, TTA staff discharged these patients back to their regular housing, with many of them later requiring hospitalizations. In the 46 TTA encounters reviewed by the OIG, 32 errors occurred that were attributable to providers. Poor provider care in the emergency setting is further discussed in the *Emergency Services* indicator.

Chronic Care

Chronic care performance was barely sufficient; the performance worsened from Cycle 4. While many MCSP providers demonstrated satisfactory skill and knowledge in caring for patients, one provider struggled with patients who had complicated chronic medical issues.

There were no sampled patients that required HIV management or who received hepatitis C treatment during this review period.

Diabetic management was usually acceptable, though providers failed to record why they increased their patients' insulin in cases 14 and 18.

Anticoagulation management was extremely poor. By the fall of 2015, MCSP canceled its anticoagulation clinic. Instead, individual providers managed their patients who were on anticoagulation. During the Cycle 4 inspection, the OIG was concerned that MCSP providers might not sustain the quality of anticoagulation management without the involvement of a dedicated clinical pharmacist who closely monitored all patients' anticoagulation levels. In

Cycle 5, those concerns became a reality. Providers neglected several patients with low anticoagulation levels for extended periods, increasing their patients' risk of blood clots and other complications. The following cases demonstrated this poor provider care:

- In case 10, the patient had atrial fibrillation (abnormal heart rhythm), which increased his risk of stroke if his anticoagulation level was low. The provider failed to address the patient's low levels for 10 days. The following month, the patient's anticoagulation level was again low, and the provider again failed to address the problem immediately. These lapses in medical care significantly increased the patient's risk of developing a blood clot or stroke.

- In case 11, the provider failed to address the patient's low anticoagulation levels promptly. As a result, 41 days passed before the patient had another INR (anticoagulation) test. This was a significant lapse in medical care as the patient's anticoagulation levels remained low for 55 days. This lapse increased his risk for repeat clot formation.

Specialty Services

MCSP providers failed to refer patients for specialty services consistently. The *Specialty Services* indicator further addresses this.

Documentation Quality

There were numerous instances of insufficient provider documentation. Providers frequently recorded progress notes that were missing physical exams or thorough subjective narratives. Providers often failed to justify their medical decisions or failed to record anything at all. Insufficient documentation occurred in cases 8, 14, 18, 19, 20, 21, 25, 26, and 28.

As in Cycle 4, MCSP providers continued neglecting the need to record their TTA encounters. They also began the inappropriate practice of signing the TTA nurse's note instead of recording their provider note. This problem occurred in cases 1, 2, 8, 13, 16, 21, 22, 23, 26, 27, and the following:

- In case 12, the provider failed to record a TTA progress note and instead completed a brief addendum to the nurse's TTA note. The patient reported his defibrillator was "acting up last night." The provider should have recorded a thorough progress note because of the seriousness of the patient's problems and because the encounter occurred during regular work hours.

- Also in case 12, the same provider also documented a brief addendum on a sick call form five days after the nurse already completed the document. The addendum was not only illegible but also inappropriate. The provider should have documented a progress note that included a thorough eye exam to justify why the provider ordered antibiotic eye drops for this patient.

The OIG clinicians also found evidence of "cloned" progress notes, in which providers inappropriately copied outdated medical information to a current progress note. These cloned progress notes were identified in cases 1, 12, 13, 17, 20, 21, 26, and 28. The use of cloned notes was especially prevalent by one provider; most of this provider's notes were either entirely cloned or contained cloned sections. It was impossible to determine if this provider provided any care based on these cloned progress notes.

Provider Continuity

Problems with provider continuity were widespread. These problems occurred in cases 3, 9, 11, 13, 14, 16, 18, 21, 24, and 25. However, provider continuity in the CTC was adequate except in case 64 as the patient was not seen by a provider per the every 3-day policy requirement.

Clinician Onsite Inspection

The OIG clinicians observed morning huddles. The *Health Information Management* indicator further discusses the OIG's observations.

MCSP hired a new chief medical executive (CME) in May 2017. This physician had been periodically serving as acting CME before this date. During the onsite interviews, MCSP providers described the CME as supportive, fair, approachable, and willing to listen to their concerns. As in Cycle 4, the majority of MCSP providers still described the chief physician and surgeon (CP&S) as taking a hands-off approach without providing much supervision or guidance.

All provider annual performance appraisals were completed and up-to-date. The OIG clinicians attributed this change to the recent stabilization of medical leadership at MCSP when the institution hired a new CME and CEO towards the end of the case review period. During Cycle 4, MCSP providers identified one provider who was taking excessive time off. At the time, the CP&S had explained that the institution was severely short-staffed and the provider in question could retire at any time. The CP&S granted the provider liberal time off due to fear of losing the provider to retirement, thereby creating an additional provider vacancy. However, during the onsite inspection in Cycle 5, MCSP providers felt that the CP&S distributed vacation time more fairly. In addition, the new CME was aware of how much vacation time each provider was taking. While some of the providers stated that the previous provider in question was still taking more time off than the rest of the provider group, it was not as excessive as had occurred in Cycle 4.

Provider morale at MCSP had also improved. Many of the providers felt that morale "was now good" compared to during the prior OIG inspection. The providers attributed the improvement directly to the new medical leadership and to the increase in physician staffing, which decreased the burden on existing providers to care for medically complex patients. However, some of the more experienced providers expressed frustration with having to learn and adapt to the new

electronic medical record system. They described this new system as being cumbersome and "not user friendly."

Case Review Conclusion

MCSP providers demonstrated numerous problems with assessment, decision-making, documentation, review of records, and emergency services performance. During the case review period, there were multiple provider vacancies and an absence of stable medical leadership. Without stable medical leadership to guide the providers and to ensure provider accountability, patient care at MCSP was often erratic and careless. A severely understaffed institution cannot be expected to provide adequate care. Although MCSP has since hired a permanent CME and improved its provider shortage, most of this improvement occurred after the case review period. Therefore, this rating did not reflect any potential benefit resulting from MCSP's improved provider staffing or new medical leadership. Based on the issues identified during this review period, MCSP's *Quality of Provider Performance* indicator was *inadequate.*

12 — *RECEPTION CENTER ARRIVALS*

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

Overall Rating:
Not Applicable

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

MCSP does not have a reception center; therefore, this indicator does not apply.

13 — *SPECIALIZED MEDICAL HOUSING*

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

Case Review Rating:
Inadequate
Compliance Score:
Proficient
(87.5%)

Overall Rating:
Inadequate

For this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *inadequate* rating and the compliance testing resulting in a *proficient* score. The OIG's internal review process considered those factors that led to both results. The CTC nurses made too many significant errors in relation to the few CTC medical patients that MCSP cared for. These factors increased the risk of harm and resulted in the *inadequate* rating for this indicator.

Case Review Results

At the time of the OIG's inspection, MCSP had a ten-bed CTC, though it used only two of the rooms for medical care. The other eight rooms were mental health crisis beds. The OIG clinicians reviewed four CTC cases, which included 33 provider encounters and 38 nursing encounters. There were 22 deficiencies, 10 of which were significant. The OIG clinicians found significant deficiencies in all the cases reviewed. The case review rating for the indicator was *inadequate*.

Provider Performance

MCSP providers did a respectable job managing the few CTC patients at MCSP. The providers made timely and accurate assessments upon patients' admission to the CTC. Provider continuity in the CTC was adequate, except in case 64 when the provider did not see the patient every 3 days as required by CCHCS policy.

Nursing Performance

The OIG clinicians reviewed the nursing care provided to four CTC patients. CTC nurses performed well with medication administration, as there were no nursing medication administration deficiencies. However, CTC nurses had difficulty with important aspects of medical care. They did not reliably inform providers when changes occurred in patients' conditions and did not properly implement patient treatment plans.

Provider Notification

The CTC nurses did not always notify medical providers when changes occurred in the patients' condition.

- In case 64, the diabetic patient experienced low blood sugar on several occasions, but nurses did not notify the provider. The first watch nurse reported the incident to the oncoming day shift RN and requested that nurse to relay the incident to the provider. The nurse did not inform the provider.

- Additionally, in case 64, the patient had an unsteady gait and generalized weakness. Nurses did not inform the provider of the patient's condition to initiate appropriate interventions, such as ordering a bedside commode and walker.

Implementing Treatment Plans

Nurses did not consistently carry out treatment regimens such as weighing patients daily or providing wound care that the provider ordered.

- In case 63, the patient was admitted to the CTC with weight loss and was on nutrition supplements to promote weight gain. Daily weight measurements were necessary to determine the trends in weight gain or loss. During the two-month inspection review period, nurses did not weigh the patient daily or administer the nutrition dietary supplement drink with all meals as ordered.

- In case 64, the patient had cirrhosis (liver disease), edema, and ascites (fluid collection in the abdomen). Daily weight measurements were necessary to monitor the patient's fluid status and the effectiveness of treatment. The nurses did not weigh the patient numerous times. The patient also needed diabetic foot care, but nurses did not apply compression stockings or provide the daily dressing changes that the provider prescribed.

- In case 65, the nurse did not provide a timely dressing change to the patient's newly inserted peripherally inserted central catheter (PICC) intravenous line. The standard of care is to change the PICC line dressing 24 hours after insertion. Nurses did not change the dressing until four days after the PICC line was inserted. This error placed the patient at elevated risk of a serious bloodstream infection.

Clinical Onsite Inspection

During the OIG onsite inspection, the two medical CTC beds were occupied. The utilization management nurses routinely completed level-of-care reviews for appropriateness of patient assignment to the CTC. Nursing staffing levels were adequate for the two medical CTC patients. For example, on the day shift, nurse staffing included two RNs, one LVN, one licensed psychiatric

technician, and two certified nursing assistants. One medical provider had responsibility for the CTC and the TTA.

Case Review Conclusion

The *Specialized Medial Housing* indicator rating was *inadequate* due to unreliable provider notification and poor follow-through with provider-ordered treatment regimens such as weighing patients daily, obtaining vitals, performing wound care, or providing nutritional supplements. Additionally, nurses did not individualize the care plans to the patients' specific needs and did not update them every 30 days as required by CTC regulations.

Compliance Testing Results

The institution received a *proficient* compliance score of 87.5 percent in this indicator. Three tests earned scores in the *proficient* range:

- When inspectors observed the working order of call buttons in CTC patient rooms, all were working properly. In addition, according to staff members interviewed, custody officers and clinicians were able to expeditiously access patients' locked rooms when emergencies occurred (MIT 13.101).

- Providers evaluated all four sampled patients within 24 hours of admission and completed the required history and physical exam (MIT 13.002).

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

One test did indicate room for improvement:

- When the OIG tested whether providers completed their Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes at required three-day intervals, only two of the four sampled patients' notes were in compliance (50.0 percent). Two patients' provider notes were one day late (MIT 13.003).

14 — *SPECIALTY SERVICES*

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(52.1%)
Overall Rating:
Inadequate

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

Case Review Results

The OIG clinicians reviewed 240 events related to *Specialty Services*, the majority of which were specialty consultations and procedures. The OIG clinicians found 92 deficiencies in this category, 15 of which were significant. The case review rating of the *Specialty Services* indicator at MCSP was *inadequate*.

Access to Specialty Services

MCSP completed initial specialty referrals within acceptable time frames (except in cases 1, 13, 17, and 23). However, there were numerous delays in specialty follow-ups. MCSP usually failed to provide specialty follow-ups within acceptable time frames for both routine and urgent requests; this deficiency occurred in cases 1, 8, 16, 20, 21, 25, and 26. The following are just a few examples of poor specialty access:

- In case 1, the provider was concerned the patient may have had lung cancer. The provider submitted an urgent referral for a cardiothoracic surgery evaluation. However, this evaluation did not occur for two months. This was a significant delay in the setting of possible lung cancer.

- Also in case 1, the patient saw the offsite oncologist for a lung nodule. The oncologist recommended a follow-up in three to five weeks. This follow-up never occurred, which delayed the diagnosis of the patient's lung cancer and subsequent treatment.

- In case 17, the provider submitted an urgent referral for the patient to see a urologist for his hematuria (blood in the urine). This visit did not occur within the requested time interval, which delayed the diagnosis of the patient's bladder cancer.

- In case 23, the patient had been receiving intravenous medication for his inflammatory bowel disease at a previous institution. This medication was not continued after the patient arrived at MCSP, even though MCSP providers submitted multiple referrals for this offsite intravenous medication. The patient developed uncontrolled inflammatory bowel disease and required two hospitalizations. MCSP might have prevented these hospitalizations if it had scheduled the patient's medication properly.

Nursing Performance

Nurses in the R&R evaluated patients returning from specialty appointments. The OIG clinicians reviewed 56 nursing encounters for specialty services and found 14 deficiencies, 5 of which were significant. There were significant delays in specialty care due to ineffective processes for nursing staff to order timely follow-up appointments with the primary care providers and to communicate specialists' recommendations.

- In case 1, the patient returned from many specialty appointments, including urology, pulmonology, and oncology. On numerous occasions, the nurse did not order a medical follow-up appointment for the patient. The follow-up appointments with the primary care provider occurred late or not at all.

- In case 9, the nurse erroneously requested a 30-day medical provider appointment instead of the required 14-day follow-up appointment.

- In case 19, the specialty nurse did not inform the on-call provider about the cardiologist's recommendations to increase the dose of the patient's medication, order diagnostic laboratory tests, or follow up with the cardiologist. MCSP staff ignored the recommendation to increase the medication dose and did not order the cardiology follow-up appointment until one month later.

- In case 23, the patient underwent a colonoscopy, but the nurse did not arrange for a primary care provider follow-up.

Provider Performance

In Cycle 4, the OIG clinicians had observed that MCSP providers submitted appropriate referrals with the correct priority for specialty services. This practice did not continue in Cycle 5, as multiple providers often failed to submit referrals with the appropriate priority, thereby affecting patient care.

- In case 17, the patient had multiple TTA visits for recurrent hematuria. The provider should have ordered an urgent CT urogram (scan of the urinary system) based on the patient's age and significant weight loss. Due to this provider oversight, a significant delay occurred before the providers detected the patient's bladder cancer.

- Also in case 17, the same provider should have scheduled an urgent cystoscopy (camera visualization of the bladder lining) because of the patient's recurrent hematuria and significant weight loss. The provider's error resulted in a three-month delay in obtaining the patient's cystoscopy, and the error significantly delayed the diagnosis and treatment of his bladder cancer.

- In case 23, the patient was due for his intravenous medication for his inflammatory bowel disease. The provider inappropriately submitted a routine referral. The patient needed an urgent referral to receive his treatment promptly. Due to this provider's error, the patient developed uncontrolled inflammatory bowel disease and required two hospitalizations to treat his condition.

At times, providers failed to review offsite specialty reports appropriately, which directly affected patient care.

- In case 19, a provider did not appropriately review an offsite cardiology report. Several delays resulted from this provider oversight: a significant delay of one month before the provider followed the cardiologist's recommendations to increase the dose of the patient's medication; a one-month delay before the provider submitted a referral for a cardiology follow-up; and a one-month delay before the provider ordered the laboratory tests requested by the cardiologist.

- In case 24, providers did not appropriately review the telemedicine nephrologist (kidney specialist) report. As a result, the providers did not order a laboratory test and a renal biopsy for more than one month. Furthermore, the providers failed to order the medication recommended by the specialist to treat the patient's lower extremity swelling.

Health Information Management

In Cycle 4, the OIG clinicians identified problems with the processing of specialty reports. This included both delays and failures to retrieve and scan specialty reports. This was a concern for the OIG clinicians because relevant information was not available to the MCSP providers. In Cycle 5, MCSP showed significant improvement in this area. MCSP did not properly retrieve and scan specialty reports in only a few cases (22 and 27).

As in Cycle 4, MCSP continued the process of scanning specialty reports into the electronic medical record without evidence of appropriate provider review. Specialty reports that were not signed by a provider were scanned into the records in cases 1, 8, 9, 11, 12, 13, 14, 17, 18, 19, 21, 24, 25, 26, 27, and 28. MCSP staff also frequently filed specialty reports with the wrong date. This error occurred in cases 13, 21, 24, 25, and 26.

Medical records staff continued to display a pattern of erroneously scanning duplicate, non-reviewed specialty reports into the electronic medical record. These scanning errors occurred in cases 1, 8, 12, 14, 16, and 21. These errors gave the inspection team the impression

of a careless and poorly organized medical records staff who failed to filter out any duplicate copies of reports that had already been scanned. Consequently, MCSP providers may have had to spend more time searching and filtering the electronic medical record because duplicate reports would have made it more difficult to find needed medical information.

Illegible signatures or illegible dates occurred in cases 8, 13, 24, and 28. Providers did not date when they reviewed specialty reports in cases 13 and 24.

Clinician Onsite Inspection

The telemedicine clinic was clean and had sufficient space. MCSP did not provide a telemedicine nurse for the OIG clinicians to interview. The utilization management nurse primarily handled hospital reports. The offsite specialty nurse handled offsite specialty notes. During the onsite inspection, the OIG clinicians learned the specialty department hired an additional nurse in October 2017 to help the existing offsite specialty nurse. MCSP staff believed that the addition of this new offsite specialty nurse would help alleviate the workload of both scheduling offsite visits and retrieving offsite specialty reports, which was previously the responsibility of one nurse.

Case Review Conclusion

MCSP did not perform well in specialty services. Providers often submitted referrals with improper priority, which delayed patient care. MCSP also failed to establish a reliable process to forward specialty reports to providers for review. However, with the implementation of the new electronic health medical record system (EHRS), a solution may be imminent. As demonstrated in other Cycle 5 inspections, the EHRS system would allow MCSP staff to send electronic messages to alert providers to review and sign offsite specialty reports. While MCSP completed most initial specialty referrals within appropriate intervals, there were major delays in specialty follow-ups that adversely affected patient care. However, MCSP was hopeful that the addition of a second offsite specialty nurse would help resolve any future scheduling delays in specialty follow-ups. However, based on the issues that occurred during the review period, the OIG clinicians rated this indicator *inadequate*.

Compliance Testing Results

The institution received an *inadequate* compliance score of 52.1 percent in this indicator, and the following six tests demonstrated room for improvement:

- A provider reviewed specialists' reports following routine specialty service appointments timely for only one of the ten applicable patients (10.0 percent). Five patients' reports were reviewed by a provider 3 to 28 days late, and for four patients, there was no evidence that the specialty reports were reviewed by a provider at all (MIT 14.004).

- 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 MCSP, 8 of the 20 sampled transfer-in patients received their specialty services appointment within the required time frame (40.0 percent). Eight patients received their appointments between 2 and 164 days late; and for the other four patients, there was no evidence that they received their specialty service appointment at all (MIT 14.005).

- Providers timely received and reviewed the high-priority specialists' reports for only 6 of 12 applicable patients sampled at MCSP (50.0 percent). Three patients' reports were received 8 to 64 days late; two patients' reports were reviewed 7 and 16 days late; and for one patient, there was no evidence that the specialists' report was either received or reviewed timely (MIT 14.002).

- Among 20 patients sampled who had a specialty service denied by MCSP's health care management, 10 (50.0 percent) received timely notification of the denied service, including the provider meeting with the patient within 30 days to discuss alternate treatment strategies. For nine sampled patients, the denials were communicated between one and 32 days late, and there was no evidence that one patient was informed of the specialty service denial (MIT 14.007).

- The institution denied providers' specialty service requests timely for 11 of 20 patients sampled (55.0 percent). Eight of the specialty services requests were denied between one and eight days late, and one other specialty request was denied 148 days late (MIT 14.006).

- For 9 of the 15 patients sampled (60.0 percent), high-priority specialty services appointments occurred within 14 days of the provider's order. Six patients received their specialty service appointments from 4 to 13 days late (MIT 14.001).

One test earned a score in the *proficient* range:

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

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15 — *ADMINISTRATIVE OPERATIONS (SECONDARY)*

Case Review Rating:
Not Applicable
Compliance Score:
Adequate
(83.3%)

Overall Rating:
Adequate

This indicator focuses on the institution's administrative health care oversight functions. The OIG evaluates whether the institution promptly processes patient medical appeals and addresses all appealed issues. Inspectors also verify that the institution follows reporting requirements for adverse/sentinel events and patient deaths. The OIG verifies that the Emergency Medical Response Review Committee (EMRRC) performs required reviews and that staff perform required emergency response drills. Inspectors also assess whether the Quality Management Committee (QMC) meets regularly and adequately addresses program performance. For those institutions with licensed facilities, inspectors also verify that required committee meetings are held. In addition, the OIG examines whether the institution adequately manages its health care staffing resources by evaluating whether job performance reviews are completed as required; specified staff possess current, valid credentials and professional licenses or certifications; nursing staff receive new employee orientation training and annual competency testing, and clinical and custody staff have current emergency medical response certifications. The *Administrative Operations* indicator is a secondary indicator; therefore, it was not relied on for the institution's overall score.

Compliance Testing Results

The institution received an *adequate* compliance score of 83.3 percent in this indicator, with several tests earning *proficient* scores:

- MCSP promptly processed all patient medical appeals in each of the most recent 12 months (MIT 15.001).
- MCSP's QMC met monthly, evaluated program performance, and acted when management identified areas for improvement opportunities (MIT 15.003).
- The OIG inspected incident package documentation for 12 emergency medical responses reviewed by MCSP's Emergency Medical Response Review Committee (EMRRC) during the prior six-month period; all 12 sampled packages complied with policy (MIT 15.005).
- Inspectors reviewed the last 12 months of MCSP's local governing body (LGB) meeting minutes and determined that the LGB met at least quarterly and exercised responsibility for the quality management of patient health care each quarter, as documented in the meeting minutes. As a result, MCSP scored 100 percent on this test (MIT 15.006).
- Based on a sample of ten second-level medical appeals, the institution's responses addressed all the patients' appealed issues (MIT 15.102).

- Medical staff promptly submitted the initial Inmate Death Report (CDCR Form 7229A or 7229B) to CCHCS's Death Review Unit for all ten applicable deaths that occurred at MCSP in the prior 12-month period (MIT 15.103).

- The OIG's inspectors examined the nursing reviews completed by five different nursing supervisors for their subordinate nurses; in all instances, the reviews were sufficiently completed (MIT 15.104).

- All ten nurses sampled were current with their clinical competency validations (MIT 15.105).

- The OIG reviewed performance evaluation packets for MCSP's eight providers; MCSP met all performance review requirements for its providers (MIT 15.106).

- All providers at the institution were current with their professional licenses. Similarly, all nursing staff and the pharmacist in charge were current with their professional licenses and certification requirements (MIT 15.107, 15.109).

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

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

Three tests indicated areas showing room for improvement:

- The institution did not meet the emergency response drill requirements for the most recent quarter for two of its three watches, resulting in a score of 33.3 percent. More specifically, the institution's third watch drill package did not include the participation of custody, and the first watch drill package had an incomplete First Medical Responder-Data Collection Tool (CDCR form 7463) as required by CCHCS policy (MIT 15.101).

- As noted by MCSP's chief executive officer (CEO) in the pre-inspection questionnaire, the institution's QMC meetings did not discuss methodologies used to train the staff who collected Dashboard data and, therefore, MCSP received a score of zero for this test (MIT 15.004).

- One nursing staff member who was hired within the last 12 months did not receive a timely new employee orientation training, instead receiving it four weeks late. Therefore, MCSP received a score of zero for this test. (MIT 15.111).

Non-Scored Results

- The OIG gathered non-scored data regarding the completion of death review reports by CCHCS's Death Review Committee (DRC). Ten applicable deaths occurred during the OIG's review period, eight unexpected (Level 1) deaths and two expected (Level 2) deaths. The DRC is required to complete its death review summary report within 60 days from the date of death for the Level 1 deaths and within 30 days from the date of death for the Level 2 deaths; the reports should then be submitted to the institution's chief executive officer (CEO) within seven calendar days thereafter. Only one death review at MCSP, a Level 1 death review, met CCHCS's reporting guidelines. For five Level 1 deaths, the DRC completed its reports 19, 25, 34, 66, and 70 days late (79, 85, 94, 126, and 130 days after death) and submitted them to MCSP's CEO 27, 40, 71, 75, and 76 days late; and for the other two Level 1 deaths, the death reviews were neither completed nor communicated to the CEO during the inspection period. For one Level 2 death that occurred at MCSP, the DRC completed its report 22 days late (52 days after death) and submitted it to the CEO 38 days late; and for the other Level 2 death, the death review was neither completed nor communicated to the CEO during the inspection period (MIT 15.998).

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

RECOMMENDATIONS

- The CEO should rectify the EMRRC review process because the committee failed to identify problems with MCSP's emergency response as well as with the care provided by the TTA providers and nurses. The institution needs a properly functioning EMRRC to identify and correct its various lapses in emergency care.

- The CEO should develop effective methods for evaluating the quality of its providers and nurses because of the poor performance of the medical staff in our review. MCSP's development of reliable and accurate methods to assess provider and nurse performance should form the bases for subsequent quality improvement in these areas.

- The CEO should identify and correct several of its specialty services processes because of the institution's problems with providing specialty appointments for patients with urgent referrals, for newly arrived patients with pending referrals, or for patients who need specialty follow-up appointments.

- The CEO should isolate and fix those laboratory processes that resulted in the high, recurring rate of non-completion of laboratory tests we identified in this cycle.

- The CEO should analyze and adjust many of its pharmacy and nursing processes to correct the problems we found with medication administration and medication continuity.

- The CEO should create an institution-wide anticoagulation management system to help track, monitor, and intervene for patients taking anticoagulation medications because the individual providers were unable to do so independently.

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 compare the performance of health care plans accurately. 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 electronic medical records, the Master Registry (maintained by CCHCS), as well as a random sample of patient records analyzed and abstracted by trained personnel. Data obtained from the CCHCS Master Registry and Diabetic Registry was not independently validated by the OIG and is presumed to be accurate. For some measures, the OIG used the entire population rather than statistically random samples. While the OIG is not a certified HEDIS compliance auditor, the OIG uses similar methods to ensure that measures are comparable to those published by other organizations.

Comparison of Population-Based Metrics

For the Mule Creek State Prison, nine HEDIS measures were selected and are listed in the following *MCSP 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 to produce optimal results. MCSP performed well with its management of diabetes in most areas.

When compared statewide, MCSP outperformed Medi-Cal and Kaiser in four of five of the diabetic measures, with MCSP performing less well in administering diabetic eye exams, and also performed lower than Kaiser for diabetic blood pressure control.

When compared nationally, MCSP outperformed Medicaid, commercial plans, and Medicare in four of the five measures, and the institution outperformed the United States Department of Veterans Affairs (VA) in three of the four applicable measures. In comparison to all national health plans, MCSP scored lowest in diabetic eye exams.

Immunizations

Comparative data for immunizations was only fully available for the VA and partially available for Kaiser, commercial plans, Medi-Cal, Medicaid, and Medicare. With respect to administering influenza immunizations to young adults, MCSP scored higher than all other health care plans. However, for administering influenza immunizations to older adults, the institution scored lower than all applicable health care plans (Medicare and the VA). However, the 28 percent refusal rate for the older adults group negatively affected the institution's score for this measure. With regard to administering pneumococcal immunizations, MCSP scored higher than Medicare, but lower than the VA.

Cancer Screening

With respect to colorectal cancer screening, MCSP's results were mixed, with the institution scoring higher than Commercial Plans and matching Medicare, but MCSP scored lower than Kaiser and the VA. However, the 21 percent refusal rate for the cancer screening negatively affected the institutions score for this measure.

Summary

MCSP's population-based metrics performance reflected an adequate chronic care program and is comparable to other state and national health care plans the OIG reviewed. The institution may improve scores for influenza immunizations for older adults and colorectal cancer screenings through patient educations concerning the benefits of these preventive services.

MCSP Results Compared to State and National HEDIS Scores

Clinical Measures	California				National			
	MCSP Cycle 5 Results[1]	HEDIS Medi-Cal 2015[2]	HEDIS Kaiser (No. CA) 2016[3]	HEDIS Kaiser (So.CA) 2016[3]	HEDIS Medicaid 2016[4]	HEDIS Com-mercial 2016[4]	HEDIS Medicare 2016[4]	VA Average 2015[5]
Comprehensive Diabetes Care								
HbA1c Testing (Monitoring)	**100%**	86%	94%	94%	86%	90%	93%	98%
Poor HbA1c Control(>9.0%)[6, 7]	**11%**	39%	20%	23%	45%	34%	27%	19%
HbA1c Control (<8.0%)[6]	**77%**	49%	70%	63%	46%	55%	63%	-
Blood Pressure Control(<140/90)	**75%**	63%	83%	83%	59%	60%	62%	74%
Eye Exams	**52%**	53%	68%	81%	53%	54%	69%	89%
Immunizations								
Influenza Shots: Adults (18–64)	**81%**	-	56%	57%	39%	48%	-	55%
Influenza Shots: Adults (65+)	**68%**	-	-	-	-	-	72%	76%
Immunizations: Pneumococcal	**82%**	-	-	-	-	-	71%	93%
Cancer Screening								
Colorectal Cancer Screening	**67%**	-	79%	82%	-	63%	67%	82%

1. Unless otherwise stated, data was collected in July 2017 by reviewing medical records from a sample of MCSP'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 November 2016 reports for the Northern and Southern California regions.
4. National HEDIS data for Medicaid, commercial plans, and Medicare was obtained from the 2016 State of Health Care Quality Report, available on the NCQA website: www.ncqa.org. The results for commercial plans were based on data received from various health maintenance organizations.
5. The Department of Veterans Affairs (VA) data was obtained from the VA's website, www.va.gov.For the Immunizations: Pneumococcal measure only, the data was obtained from the VHA Facility Quality and Safety Report - Fiscal Year 2012 Data."
6. For this indicator, the entire applicable MCSP 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

Mule Creek State Prison Range of Summary Scores: 52.1% – 87.5%	
Indicator	**Compliance Score (Yes %)**
1–*Access to Care*	69.4%
2–*Diagnostic Services*	70.0%
3–*Emergency Services*	Not Applicable
4–*Health Information Management (Medical Records)*	68.0%
5–*Health Care Environment*	81.9%
6–*Inter- and Intra-System Transfers*	87.4%
7–*Pharmacy and Medication Management*	77.3%
8–*Prenatal and Post-Delivery Services*	Not Applicable
9–*Preventive Services*	82.7%
10–*Quality of Nursing Performance*	Not Applicable
11–*Quality of Provider Performance*	Not Applicable
12–*Reception Center Arrivals*	Not Applicable
13–*Specialized Medical Housing (OHU, CTC, SNF, Hospice)*	87.5%
14–*Specialty Services*	52.1%
15–*Administrative Operations*	83.3%

Reference Number	1–*Access to Care*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
1.001	Chronic care follow-up appointments: Was the patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter?	17	8	25	68.0%	0
1.002	For endorsed patients received from another CDCR institution: If the nurse referred the patient to a provider during the initial health screening, was the patient seen within the required time frame?	5	20	25	20.0%	0
1.003	Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received?	34	1	35	97.1%	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?	30	5	35	85.7%	0
1.005	Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter?	4	2	6	66.7%	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?	Not Applicable				
1.007	Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame?	21	4	25	84.0%	0
1.008	Specialty service follow-up appointments: Do specialty service primary care physician follow-up visits occur within required time frames?	8	8	16	50.0%	14
1.101	Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms?	5	1	6	83.3%	0
Overall percentage:					**69.4%**	

Reference Number	2–*Diagnostic Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
2.001	Radiology: Was the radiology service provided within the time frame specified in the provider's order?	10	0	10	100.0%	0
2.002	Radiology: Did the primary care provider review and initial the diagnostic report within specified time frames?	0	10	10	0.0%	0
2.003	Radiology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	10	0	10	100.0%	0
2.004	Laboratory: Was the laboratory service provided within the time frame specified in the provider's order?	9	1	10	90.0%	0
2.005	Laboratory: Did the primary care provider review and initial the diagnostic report within specified time frames?	7	3	10	70.0%	0
2.006	Laboratory: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	9	1	10	90.0%	0
2.007	Pathology: Did the institution receive the final diagnostic report within the required time frames?	7	3	10	70.0%	0
2.008	Pathology: Did the primary care provider review and initial the diagnostic report within specified time frames?	4	6	10	40.0%	0
2.009	Pathology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	7	3	10	70.0%	0
Overall percentage:					**70.0%**	

3–*Emergency Services*

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

Reference Number	4–*Health Information Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated healthcare documents (provider progress notes) scanned within 3 calendar days of the patient encounter date?	17	3	20	85.0%	0
4.002	Are dictated/transcribed documents scanned into the patient's electronic health record within five calendar days of the encounter date?	4	0	4	100.0%	21
4.003	Are High-Priority specialty notes (either a Form 7243 or other scanned consulting report) scanned within the required time frame?	13	3	16	81.3%	14
4.004	Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge?	17	3	20	85.0%	0
4.005	Are medication administration records (MARs) scanned into the patient's electronic health record within the required time frames?	13	7	20	65.0%	5
4.006	During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files?	0	24	24	0.0%	0
4.007	For patients discharged from a community hospital: Did the preliminary hospital discharge report include key elements and did a primary care provider review the report within three calendar days of discharge?	15	10	25	60.0%	0
Overall percentage:					**68.0%**	

Reference Number	5–*Health Care Environment*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
5.101	Are clinical health care areas appropriately disinfected, cleaned and sanitary?	12	2	14	85.7%	0
5.102	Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	13	1	14	92.9%	0
5.103	Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	12	2	14	85.7%	0
5.104	Does clinical health care staff adhere to universal hand hygiene precautions?	10	4	14	71.4%	0
5.105	Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	14	0	14	100.0%	0
5.106	Warehouse, Conex and other non-clinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program?	1	0	1	100.0%	0
5.107	Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	12	2	14	85.7%	0
5.108	Do clinic common areas and exam rooms have essential core medical equipment and supplies?	11	3	14	78.6%	0
5.109	Do clinic common areas have an adequate environment conducive to providing medical services?	13	1	14	92.9%	0
5.110	Do clinic exam rooms have an adequate environment conducive to providing medical services?	10	4	14	71.4%	0
5.111	Emergency response bags: Are TTA and clinic emergency medical response bags inspected daily and inventoried monthly, and do they contain essential items?	4	7	11	36.4%	3
Overall percentage:					**81.9%**	

Reference Number	6–*Inter- and Intra-System Transfers*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
6.001	For endorsed patients received from another CDCR institution or COCF: Did nursing staff complete the initial health screening and answer all screening questions on the same day the patient arrived at the institution?	18	7	25	72.0%	0
6.002	For endorsed patients received from another CDCR institution or COCF: When required, did the RN complete the assessment and disposition section of the health screening form; refer the patient to the TTA, if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening?	23	0	23	100.0%	2
6.003	For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption?	15	0	15	100.0%	10
6.004	For patients transferred out of the facility: Were scheduled specialty service appointments identified on the patient's health care transfer information form?	13	7	20	65.0%	0
6.101	For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents?	10	0	10	100.0%	0
Overall percentage:					**87.4%**	

Reference Number	*7–Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.001	Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows?	10	11	21	47.6%	4
7.002	Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames?	23	2	25	92.0%	0
7.003	Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames?	11	14	25	44.0%	0
7.004	For patients received from a county jail: Were all medications ordered by the institution's reception center provider administered, made available, or delivered to the patient within the required time frames?	Not Applicable				
7.005	Upon the patient's transfer from one housing unit to another: Were medications continued without interruption?	23	2	25	92.0%	0
7.006	For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption?	3	0	3	100.0%	3
7.101	All clinical and medication line storage areas for narcotic medications: Does the Institution employ strong medication security over narcotic medications assigned to its clinical areas?	10	1	11	90.9%	4
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?	8	5	13	61.5%	2
7.103	All clinical and medication line storage areas for non-narcotic medications: Does the institution properly store non-narcotic medications that require refrigeration in assigned clinical areas?	9	3	12	75.0%	3
7.104	Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes?	3	5	8	37.5%	7
7.105	Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients?	8	0	8	100.0%	7
7.106	Medication preparation and administration areas: Does the Institution employ appropriate administrative controls and protocols when distributing medications to patients?	1	7	8	12.5%	7

Reference Number	7–*Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.107	Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and satellite pharmacies?	2	0	2	100.0%	0
7.108	Pharmacy: Does the institution's pharmacy properly store non-refrigerated medications?	2	0	2	100.0%	0
7.109	Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications?	2	0	2	100.0%	0
7.110	Pharmacy: Does the institution's pharmacy properly account for narcotic medications?	2	0	2	100.0%	0
7.111	Does the institution follow key medication error reporting protocols?	21	4	25	84.0%	0
Overall percentage:					**77.3%**	

8–*Prenatal and Post-Delivery Services*

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

Reference Number	9–*Preventive Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
9.001	Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed?	2	1	3	66.7%	0
9.002	Patients prescribed TB medication: Did the institution monitor the patient monthly for the most recent three months he or she was on the medication?	3	0	3	100.0%	0
9.003	Annual TB Screening: Was the patient screened for TB within the last year?	22	8	30	73.3%	0
9.004	Were all patients offered an influenza vaccination for the most recent influenza season?	25	0	25	100.0%	0
9.005	All patients from the age of 50–75: Was the patient offered colorectal cancer screening?	20	5	25	80.0%	0
9.006	Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy?	Not Applicable				
9.007	Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy?	Not Applicable				
9.008	Are required immunizations being offered for chronic care patients?	13	4	17	76.5%	8
9.009	Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	Not Applicable				
Overall percentage:					**82.7%**	

10–*Quality of Nursing Performance*

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

11–*Quality of Provider Performance*

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

12–*Reception Center Arrivals*

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

Reference Number	13–*Specialized Medical Housing*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient on the day of admission, or within eight hours of admission to CMF's Hospice?	4	0	4	100.0%	0
13.002	For CTC and SNF only: Was a written history and physical examination completed within the required time frame?	4	0	4	100.0%	0
13.003	For OHU, CTC, SNF, and Hospice: Did the primary care provider complete the Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes on the patient at the minimum intervals required for the type of facility where the patient was treated?	2	2	4	50.0%	0
13.101	For OHU and CTC Only: Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter patient's cells?	1	0	1	100.0%	0
Overall percentage:					**87.5%**	

Reference Number	14–*Specialty Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	Did the patient receive the high priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service?	9	6	15	60.0%	0
14.002	Did the primary care provider review the high priority specialty service consultant report within the required time frame?	6	6	12	50.0%	3
14.003	Did the patient receive the routine specialty service within 90 calendar days of the primary care provider order or Physician Request for Service?	15	0	15	100.0%	0
14.004	Did the primary care provider review the routine specialty service consultant report within the required time frame?	1	9	10	10.0%	5
14.005	For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames?	8	12	20	40.0%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	11	9	20	55.0%	0
14.007	Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame?	10	10	20	50.0%	0
Overall percentage:					**52.1%**	

Reference Number	15–*Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.001	Did the institution promptly process inmate medical appeals during the most recent 12 months?	12	0	12	100.0%	0
15.002	Does the institution follow adverse / sentinel event reporting requirements?	Not Applicable				
15.003	Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified?	6	0	6	100.0%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	0	1	1	0.0%	0
15.005	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	12	0	12	100.0%	0
15.006	For institutions with licensed care facilities: Does the Local Governing Body (LGB), or its equivalent, meet quarterly and exercise its overall responsibilities for the quality management of patient health care?	4	0	4	100.0%	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?	1	2	3	33.3%	0
15.102	Did the institution's second level medical appeal response address all of the patient's appealed issues?	10	0	10	100.0%	0
15.103	Did the institution's medical staff review and submit the initial inmate death report to the Death Review Unit in a timely manner?	10	0	10	100.0%	0
15.104	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	5	0	5	100.0%	0
15.105	Are nursing staff who administer medications current on their clinical competency validation?	10	0	10	100.0%	0
15.106	Are structured clinical performance appraisals completed timely?	8	0	8	100.0%	0
15.107	Do all providers maintain a current medical license?	12	0	12	100.0%	0
15.108	Are staff current with required medical emergency response certifications?	3	0	3	100.0%	0

Reference Number	15–*Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.109	Are nursing staff and the Pharmacist-in-Charge current with their professional licenses and certifications, and is the pharmacy licensed as a correctional pharmacy by the California State Board of Pharmacy?	6	0	6	100.0%	1
15.110	Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	2	0	2	100.0%	0
15.111	Are nursing staff current with required new employee orientation?	0	1	1	0.0%	0
Overall percentage:					**83.3%**	

APPENDIX B — CLINICAL DATA

Table B-1: MCSP Sample Sets

Sample Set	Total
Anticoagulation	3
CTC/OHU	4
Death Review/Sentinel Events	3
Diabetes	3
Emergency Services – CPR	3
Emergency Services – Non-CPR	3
High Risk	5
Hospitalization	4
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	28
Specialty Services	4
	66

Table B-2: MCSP Chronic Care Diagnoses

Diagnosis	Total
Anemia	4
Anticoagulation	10
Arthritis/Degenerative Joint Disease	8
Asthma	14
COPD	16
Cancer	8
Cardiovascular Disease	18
Chronic Kidney Disease	7
Chronic Pain	27
Cirrhosis/End Stage Liver Disease	2
Coccidioidomycosis	3
DVT/PE	2
Deep Venous Thrombosis/Pulmonary Embolism	1
Diabetes	21
Gastroesophageal Reflux Disease	15
HIV	3

Diagnosis	Total
Hepatitis C	19
Hyperlipidemia	26
Hypertension	41
Mental Health	6
Migraine Headaches	1
Rheumatological Disease	5
Seizure Disorder	4
Sleep Apnea	7
Thyroid Disease	11
	279

Table B-3: MCSP Event – Program

Program	Total
Diagnostic Services	297
Emergency Care	109
Hospitalization	44
Intra-system Transfers-In	8
Intra-system Transfers-Out	4
Outpatient Care	608
Specialized Medical Housing	137
Specialty Services	252
	1,459

Table B-4: MCSP Review Sample Summary

	Total
MD Reviews Detailed	25
MD Reviews Focused	2
RN Reviews Detailed	16
RN Reviews Focused	40
Total Reviews	83
Total Unique Cases	66
Overlapping Reviews (MD & RN)	17

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

Mule Creek State Prison (MCSP)

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Access to Care			
MIT 1.001	Chronic Care Patients (25)	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • **Randomize**
MIT 1.002	Nursing Referrals (25)	OIG Q: 6.001	• See ***Intra-system Transfers***
MITs 1.003-006	Nursing Sick Call (5 per clinic) (35)	MedSATS	• Clinic (each clinic tested) • Appointment date (2–9 months) • **Randomize**
MIT 1.007	Returns from Community Hospital (25)	OIG Q: 4.007	• See ***Health Information Management (Medical Records)*** (returns from community hospital)
MIT 1.008	Specialty Services Follow-up (30)	OIG Q: 14.001 & 14.003	• See ***Specialty Services***
MIT 1.101	Availability of Health Care Services Request Forms (6)	OIG onsite review	• Randomly select one housing unit from each yard
Diagnostic Services			
MITs 2.001–003	Radiology (10)	Radiology Logs	• Appointment date (90 days–9 months) • **Randomize** • Abnormal
MITs 2.004–006	Laboratory (10)	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • **Randomize** • Abnormal
MITs 2.007–009	Pathology (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	(4)	OIG Q: 1.001	• Dictated documents • First 20 IPs selected
MIT 4.003	(16)	OIG Qs: 14.002 & 14.004	• Specialty documents • First 10 IPs for each question
MIT 4.004	(20)	OIG Q: 4.007	• Community hospital discharge documents • First 20 IPs selected
MIT 4.005	(20)	OIG Q: 7.001	• MARs • First 20 IPs selected
MIT 4.006	(24)	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.007	Returns From Community Hospital (25)	Inpatient claims data	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • **Randomize** (each month individually) • First 5 patients from each of the 6 months (if not 5 in a month, supplement from another, as needed)
Health Care Environment			
MIT 5.101-105 MIT 5.107–111	Clinical Areas (14)	OIG inspector onsite review	• Identify and inspect all onsite clinical areas.
Inter- and Intra-System Transfers			
MIT 6.001-003	Intra-System Transfers (25)	SOMS	• Arrival date (3–9 months) • Arrived from (another CDCR facility) • Rx count • **Randomize**
MIT 6.004	Specialty Services Send-Outs (20)	MedSATS	• Date of transfer (3–9 months) • **Randomize**
MIT 6.101	Transfers Out (10)	OIG inspector onsite review	• R&R IP transfers with medication

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Pharmacy and Medication Management			
MIT 7.001	Chronic Care Medication (25)	OIG Q: 1.001	*See* ***Access to Care*** • At least one condition per patient—any risk level • **Randomize**
MIT 7.002	New Medication Orders (25)	Master Registry	• Rx count • **Randomize** • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns from Community Hospital (25)	OIG Q: 4.007	• See ***Health Information Management (Medical Records)*** *(returns from community hospital)*
MIT 7.004	RC Arrivals – Medication Orders *(N/A at this institution)*	OIG Q: 12.001	• See ***Reception Center Arrivals***
MIT 7.005	Intra-Facility Moves (25)	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • **Randomize**
MIT 7.006	En Route (6)	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 (2)	OIG inspector onsite review	• Identify & inspect all onsite pharmacies
MIT 7.111	Medication Error Reporting (25)	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 (5)	Onsite active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in isolation units

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

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Reception Center Arrivals			
MITs 12.001–008	RC *(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 (4)	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			
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 (9)	InterQual	• Review date (3–9 months) • **Randomize**
	(11)	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • **Randomize**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Administrative Operations			
MIT 15.001	Medical Appeals (all)	Monthly medical appeals reports	• Medical appeals (12 months)
MIT 15.002	Adverse/Sentinel Events (0)	Adverse/sentinel events report	• Adverse/sentinel events (2–8 months)
MITs 15.003–004	QMC Meetings (6)	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.005	EMRRC (12)	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.006	LGB (4)	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills (3)	Onsite summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	2nd Level Medical Appeals (10)	Onsite list of appeals/closed appeals files	• Medical appeals denied (6 months)
MIT 15.103	Death Reports (10)	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.104	RN Review Evaluations (5)	Onsite supervisor periodic RN reviews	• RNs who worked in clinic or emergency setting six or more days in sampled month • **Randomize**
MIT 15.105	Nursing Staff Validations (10)	Onsite nursing education files	• On duty one or more years • Nurse administers medications • **Randomize**
MIT 15.106	Provider Annual Evaluation Packets (8)	Onsite provider evaluation files	• All required performance evaluation documents
MIT 15.107	Provider licenses (12)	Current provider listing (at start of inspection)	• Review all

Quality Indicator	Sample Category (number of samples)	Data Source	Filters

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

MIT 15.109	Nursing staff and Pharmacist in Charge Professional Licenses and Certifications (all)	Onsite tracking system, logs, or employee files	• All required licenses and certifications
MIT 15.110	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations (all)	Onsite listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 15.111	Nursing Staff New Employee Orientations (all)	Nursing staff training logs	• New employees (hired within last 12 months) •
MIT 15.998	Death Review Committee (10)	OIG summary log - deaths	• Between 35 business days & 12 months prior • CCHCS death reviews

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

July 31, 2018

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

Dear Mr. Wesley:

The Office of the Receiver has reviewed the draft report of the Office of the Inspector General (OIG) Medical Inspection Results for Mule Creek State Prison (MCSP) conducted from July 2017 to January 2018. California Correctional Health Care Services (CCHCS) acknowledges the OIG findings.

Thank you for preparing the report. Your efforts have advanced our mutual objective of ensuring transparency and accountability in CCHCS operations. If you have any questions or concerns, please contact me at (916) 691-3747.

Sincerely,

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

cc: Clark Kelso, Receiver
Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Richard Kirkland, Chief Deputy Receiver
Stephen Tseng, M.D., Chief of Medical Inspections, OIG
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