Robert A. Barton
Inspector General

Office of the Inspector General

North Kern State Prison
Medical Inspection Results
Cycle 4

October 2015

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

Office of the Inspector General
NORTH KERN STATE PRISON
Medical Inspection Results
Cycle 4

Robert A. Barton
Inspector General

Roy W. Wesley
Chief Deputy Inspector General

Shaun R. Spillane
Public Information Officer

October 2015

TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

EXECUTIVE SUMMARY

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

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

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

The OIG performed its Cycle 4 medical inspection at NKSP from April to June 2015. The inspection included in-depth reviews of 76 inmate-patient files conducted by clinicians as well as reviews of documents from 434 inmate-patient files, covering 101 objectively scored tests of compliance with policies and procedures applicable to the delivery of medical care. The OIG assessed the case review and compliance results at NKSP using 15 health care quality indicators applicable to the institution, made up of 13 primary clinical indicators and two secondary administrative indicators. Of the 13 primary indicators, eight were rated by both case review clinicians and compliance inspectors, three were rated by case review clinicians only, and two were rated by compliance inspectors only; both secondary indicators were rated by compliance inspectors only. See the *Health Care Quality Indicators* table on page ii. Based on that analysis, OIG experts made a considered and measured overall opinion that the quality of health care was ***inadequate***.

Health Care Quality Indicators

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

Overall Assessment: Inadequate

Overall Assessment Rating:

Inadequate

Based on the clinical case reviews, compliance testing, and population-based metrics, the OIG's overall assessment rating for NKSP was *inadequate*. For the 13 primary (clinical) quality indicators applicable to NKSP, the OIG found one *proficient*, seven *adequate*, and five *inadequate*. For the two secondary (administrative) quality indicators, the OIG found one *adequate* and one *inadequate*. To determine the overall assessment for NKSP, the OIG considered individual clinical ratings and individual compliance question scores within each of the indicator categories, putting emphasis on the primary indicators. Based on that analysis, OIG experts made a considered and measured overall opinion about the quality of health care observed at NKSP.

Clinical Case Review and OIG Clinician Inspection Results

The OIG's clinical case reviews of a sample of patients with high medical needs found the health care services provided at NKSP to be *inadequate*. Clinicians reviewed 1,265 patient-care events. Of the 13 primary indicators applicable to NKSP, 11 were evaluated by clinician case review; not one was *proficient*, seven were *adequate*, and four were *inadequate.* When determining the overall adequacy of care, the OIG paid particular attention to the clinical nursing and provider quality indicators. Health care staff, especially the providers, were identified as the primary weakness of the institution. Despite many adequately functioning processes for this health care system, patients did not receive the needed medical care, as provider and nursing assessments and decisions were inadequate. Improved staff performance would have changed the overall rating for NKSP to *adequate*.

<u>Program Strengths</u>

- NKSP had an efficient specialty services department. Staff assigned to specialty services were knowledgeable about their roles and responsibilities and had a tracking process to ensure specialty appointments were completed.
- Nurses in the triage and treatment area (TTA), reception center, and receiving and release (R&R) clinic performed well and provided an adequate level of care.
- *Access to Care* for patients was good, as evidenced by the *proficient* compliance score. However, while the scheduling system worked well, the nursing or provider decision-making portion of the process did not, lowering a *proficient* rating to just *adequate*.

Program Weaknesses

- Poor provider assessments and decision-making contributed to the inadequate rating in many areas. This affected not only the Quality of Provider Performance indicator for individual patient case reviews, but also the Specialized Medical Housing indicator. In addition, continuity of patient care was poor, with multiple providers rotating through the clinics, correctional treatment center (CTC), and TTA. Illegible progress notes compound the risk for poor patient care. When circumstances require providers to change assigned locations frequently, it becomes even more important that medical records are accurate and clear.

- The Quality of Nursing Performance was rated adequate, as it is primarily an evaluation of outpatient nursing performance. However, the nurses' inappropriate triage of requests for health care services showed a failure to recognize some patients' need for same-day assessments.

- NKSP medical clinics had limited space, hindering patients' auditory and visual privacy. The TTA exam room had a glass window, which compromised visual privacy.

- NKSP's Health Information Management was inadequate. Frequently, records were misfiled, missing, or unavailable when needed. Additionally, many provider progress notes were illegible and difficult to follow.

- Poor nursing performance was largely responsible for the inadequate rating of Specialized Medical Housing. Nurses in the CTC did not use the nursing process to identify individual patient needs, did not always fully implement provider orders, and demonstrated poor communication with providers and other nursing staff.

- Pharmacy and Medication Management was inadequate due to the failure to provide timely and accurate medication after hospitalizations. Nursing, pharmacy, and providers all contributed to errors in this area.

- There were five significant adverse events identified in the case reviews. Three events concerned patients with impaired blood coagulation who did not receive urgent evaluation for acute bleeding issues. Another event involved prescription of a potentially toxic dosage of seizure medication. For the fifth adverse event, a nurse failed to urgently refer a patient who had fallen twice and complained of weakness and numbness in his hand. Adverse events are further described within the Medical Inspection Results section of this report. Because of the anecdotal description of these events, the OIG cautions against drawing conclusions regarding the institution's delivery of medical care based solely on adverse events.

Compliance Testing Results

Compliance inspectors evaluated 12 of the 15 total indicators of health care applicable to NKSP. There were 101 individual compliance questions within those 12 indicators that tested NKSP's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[1] Those 101 questions are detailed in *Appendix A—Compliance Test Results*. The institution's inspection scores for the 12 applicable indicators ranged from 48.1 percent to 100 percent, with the secondary (administrative) indicator *Internal Monitoring, Quality Improvement, and Administrative Operations* receiving the lowest score, and the primary (clinical) indicator *Specialized Medical Housing* receiving the highest. For the ten primary indicators applicable to compliance testing, the OIG rated four *proficient,* three *adequate,* and three *inadequate.* For the two secondary indicators, which involve administrative health care functions, one was rated *adequate* and the other *inadequate*.

Program Strengths

As the *NKSP Executive Summary Table* on page x indicates, the institution's compliance scores were in the *proficient* range for the following four indicators: *Access to Care* (86.9 percent), *Diagnostic Services* (86.2 percent), *Pharmacy and Medication Management* (86.4 percent), and *Specialized Medical Housing* (100 percent). The following are some of NKSP's strengths based on its compliance scores for individual questions within all primary health care indicators:

- Providers conducted timely appointments with patients who suffered from chronic care illnesses, those who were seen by a provider and required a sick call follow-up, those who had specialty service appointments, and those who returned to the institution from a community hospital.
- All inmate-housing locations had Health Care Services Request forms (CDCR Form 7362) available and a standard process for submitting requests to medical staff.
- Inmate-patients timely received their radiology and laboratory diagnostic services and providers timely communicated results of the related diagnostic studies to the patients. In addition, providers reviewed radiology and pathology services test results within required periods.
- Specialty consult progress notes and community hospital discharge documents were scanned into patients' eUHRs within required periods.
- Clinicians followed universal hand hygiene precautions during patient examinations.
- Clinics demonstrated adequate bulk medical supply storage and management protocols.

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

- For inmates who transferred into NKSP from another CDCR institution, registered nurses completed an assessment and disposition of the inmate on the same day nursing staff completed the initial screening.
- For inmate-patients transferring out of NKSP, scheduled specialty appointments were identified on the patients' transfer form and required medications and related documents were included in patients' medication transfer packages.
- Nursing staff timely administered newly ordered prescriptions to inmate-patients, including reception center arrivals.
- Clinical and medication line storage areas properly stored non-narcotic medications, including those requiring refrigeration.
- Nursing staff who prepared and administered medications to patients followed proper hand hygiene contamination control protocols and proper administrative controls and protocols.
- The institution's main pharmacy followed general security, organization, and cleanliness management protocols; properly stored medications; properly stored and monitored non-narcotic medications that require refrigeration; maintained adequate controls and properly accounted for narcotic medications; and followed protocols for medication error reporting.
- The institution was prompt in offering required preventive services in the form of influenza vaccinations and colorectal cancer screenings.
- For new inmates who arrived at NKSP's reception center, nursing staff properly completed their health screening forms; providers conducted written history and physical examinations and timely reviewed and communicated the results of their intake tests.
- For patients assigned to the specialized housing CTC, nursing staff timely completed initial assessments. Providers evaluated those patients within 24 hours of admission; completed written examinations within 72 hours of admission; and timely completed progress notes at required intervals.
- The CTC had a working call button system and a procedure in place to ensure that during an emergency, medical staff could enter a patient's cell within a reasonable amount of time.
- For both high-priority and routine specialty services, NKSP provided the services within the required time frames; providers reviewed the consultants' reports timely. In addition, NKSP's denials of providers' requests for specialty services were made timely.

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

- The institution promptly processed inmate medical appeals and second-level medical appeal responses addressed all of the inmate-patients' appealed issues.
- Providers, the pharmacist-in-charge (PIC), and the pharmacy had current licenses and registrations. Nursing staff were current on required training requirements, licenses, and certifications.

Program Weaknesses

The institution received ratings in the *inadequate* range for the following primary indicators: *Health Information Management* (67.0 percent), *Health Care Environment* (57.1 percent), and *Reception Center Arrivals* (74.5 percent). The institution also received an *inadequate* rating in the secondary indicator *Internal Monitoring, Quality Improvement, and Administrative Operations* (48.1 percent). The following are some of the weaknesses identified by NKSP's compliance scores for individual questions within all primary health care indicators:

- Nursing staff did not always complete face-to-face visits with patients within one business day after a request for services was reviewed.
- Providers did not always timely communicate the results of diagnostic pathology reports to the patient.
- Health care documents were incorrectly labeled in patients' eUHRs. In addition, staff did not always timely scan non-dictated documents (initial health screening forms or health care services requests) and medication administration records into patients' eUHRs.
- Clinic common areas and exam rooms were not disinfected and cleaned as frequently as required. Some clinic restrooms did not contain operable sinks or disposable paper towels and antiseptic hand soap supplies, and some clinic exam rooms did not have sharps containers.
- Clinics and exam rooms lacked essential core medical equipment and supplies for comprehensive examinations.
- In the main medical supply storage warehouse, temperature-sensitive medical supplies were stored on the floor, which could lead to deterioration.
- Some exam rooms and clinical common areas where patient encounters were held did not provide auditory or visual privacy for the inmate-patient. Also, the space or configuration of furniture in some exam rooms was not optimal for conducting clinical exams. Outdoor waiting areas for yard pill lines did not provide overhangs or shade protection for inmate-patients during extreme or inclement weather.

- Nursing staff did not always timely administer medications to patients who suffer with chronic care illnesses. Also, nursing staff did not ensure that patients who transferred into NKSP from another institution, those temporarily housed at NKSP while en route to another institution, those who transferred from one housing unit to another, or those who returned from a community hospital received their prescribed medications without interruption.

- Nursing staff did not complete all required information on patients' annual tuberculosis (TB) screening forms. Also, nursing staff did not timely administer anti-tuberculosis medications to patients with TB or adequately monitor their treatment and condition. Further, TB skin test results were not always read by a registered nurse, public health nurse, or primary care provider.

- Inmates who arrived at NKSP's reception center did not always receive a coccidioidomycosis (valley fever) skin test screening.

- The institution did not always provide timely specialty service appointments to inmate-patients who transferred into NKSP with previously approved or scheduled specialty appointments from the sending institution. Following the denial of a specialty service, the inmate-patient was not always timely notified of the denial.

The lowest-scoring questions addressing secondary indicators resulted in identification of the following administrative deficiencies:

- Monthly meeting minutes from the Quality Management Committee (QMC) did not indicate whether the QMC used program data to evaluate and discuss each program's performance, did not identify where improvements were needed, and did not address improvement action plans. Similarly, QMC minutes did not indicate whether the institution took steps to ensure the accuracy of its Dashboard data reporting.

- NKSP either did not improve performance, did not reach its performance objective, or did not identify the status of performance objectives for most of the quality improvement initiatives identified in its 2014 Performance Improvement Work Plan.

- Required documentation was absent from both emergency medical response reviews and emergency medical response drills.

- Supervising nurses did not always conduct required reviews of nursing staff and discuss the results of those evaluations with each respective nurse. Also, supervisors had not been completing structured clinical performance appraisals for the institution's providers.

Population-Based Metrics

In general, NKSP performed well for population-based metrics. In four of the five comprehensive diabetes care measures, NKSP outperformed or closely matched other State and national organizations, including Kaiser Permanente, typically one of the highest-scoring health organizations in California. Especially notable was NKSP's low percentage of diabetics considered to be under poor control. In the fifth measure, eye exam rates in diabetic patients, NKSP outperformed Medi-Cal, Medicaid, and commercial health plans (based on data obtained from health maintenance organizations) but underperformed Kaiser, Medicare, and the U.S. Department of Veterans Affairs (VA).

With regard to the immunization measures for influenza shots, NKSP's rates were significantly lower than comparable rates reported by Kaiser Permanente, the VA, and commercial. The institution's lower performance in this area can be attributed to its high number of patient refusals. Similarly, the institution's rates were lower than other reported entities for colorectal cancer screening and the lower performance was attributed in part to its high number of patient refusals.

Overall, NKSP's performance demonstrated by the population-based metrics indicated that the chronic care program was adequately run and operating as intended.

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

NKSP Executive Summary Table

Primary Indicators (Clinical)	Case Review Rating	Compliance Score	Overall Indicator Rating
Access to Care	Adequate	86.9%	Adequate
Diagnostic Services	Adequate	86.2%	Proficient
Emergency Services	Adequate	Not Applicable	Adequate
Health Information Management (Medical Records)	Inadequate	67.0%	Inadequate
Health Care Environment	Not Applicable	57.1%	Inadequate
Inter- and Intra-System Transfers	Adequate	82.9%	Adequate
Pharmacy and Medication Management	Inadequate	86.4%	Inadequate
Preventive Services	Not Applicable	76.8%	Adequate
Quality of Nursing Performance	Adequate	Not Applicable	Adequate
Quality of Provider Performance	Inadequate	Not Applicable	Inadequate
Reception Center Arrivals	Adequate	74.5%	Adequate
Specialized Medical Housing (OHU, CTC, SNF, Hospice)	Inadequate	100%	Inadequate
Specialty Services	Adequate	83.3%	Adequate

Note: The *Prenatal and Post Delivery Services* indicator did not apply to this institution.

Secondary Indicators (Administrative)	Case Review Rating	Compliance Score	Overall Indicator Rating
Internal Monitoring, Quality Improvement, and Administrative Operations	Not Applicable	48.1%	Inadequate
Job Performance, Training, Licensing, and Certifications	Not Applicable	78.6%	Adequate

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

INTRODUCTION

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

The North Kern State Prison (NKSP) was the fifth medical inspection of Cycle 4. During the inspection process, the OIG assessed the delivery of medical care to patients using 13 primary clinical health care indicators and two secondary administrative health care indicators applicable to the institution. It is important to note that while the primary quality indicators represent the clinical care being provided by the institution at the time of the inspection, the secondary quality indicators are purely administrative and are not reflective of the actual clinical care provided.

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

ABOUT THE INSTITUTION

As a reception center, the mission of NKSP is to process and classify incoming inmates from county jails by evaluating their medical and mental health needs and determining their security level, program requirements, and appropriate institutional placement prior to their transfer. NKSP operates eight medical clinics where staff handle non-urgent requests for medical services. NKSP also treats inmate-patients who need urgent or emergent care in its triage and treatment area, and treats inmate-patients who require inpatient care in the correctional treatment center.

Based on staffing data OIG obtained from the institution in April 2015, NKSP had a vacancy rate of 13 percent for primary care providers. The institution currently has less than one nursing supervisor vacancy and 7.5 vacancies for non-supervisory nursing staff. For healthcare staff overall, NKSP has an 8 percent vacancy rate. At the time of the OIG's inspection, the chief executive officer for health care services (CEO) at NKSP was also the acting CEO at Kern Valley State Prison.

NKSP Health Care Staffing Resources—April 2015

	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff		Totals	
Description	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Authorized Positions	5	4%	11.5	9%	11.5	9%	98.5	78%	126.5	100%
Filled Positions	4	80%	10.0	87%	11.0	96%	91.0	92%	116.0	92%
Vacancies	1	20%	1.5	13%	0.5	4%	7.5	8%	10.5	8%
Recent Hires (Within 12 Months)	0	0%	6	60%	1	9%	11	12%	18	16%
Staff Utilized from Registry	0	0%	2	20%	0	0%	30	33%	32	28%
Redirected Staff (to Non-Patient Care Areas)	0	0%	0	0%	0	0%	0	0%	0	0%
Staff Under Disciplinary Review	0	0%	0	0%	0	0%	1	0%	1	1%
Staff on Long-Term Medical Leave	0	0%	0	0%	1	9%	5	5%	6	5%

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

As of September 25, 2015, California Correctional Health Care Services (CCHCS) data showed that NKSP had 4,460 inmate-patients. Within that total population, less than 1.0 percent of the inmate-patients were designated as high-risk Level I, and 2.4 percent were designated as high-risk Level II. High-risk patients are at greater risk for poor health outcomes than average patients. The chart below illustrates the inmate-patient breakdown.

NKSP Master Registry Data as of September 25, 2015

Risk Level	# of Inmate-Patients	Percentage
High I	30	0.67%
High II	108	2.42%
Medium	1,626	36.46%
Low	2,696	60.45%
Total	**4,460**	**100%**

Commonly Used Abbreviations

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

OBJECTIVES, SCOPE, AND METHODOLOGY

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

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

The OIG rates each of the quality indicators applicable to the institution under inspection based on case reviews conducted by OIG clinicians and compliance tests conducted by OIG deputy inspectors general. The ratings may be derived from the case review results alone, the compliance test results alone, or a combination of both these information sources. For example, the ratings for the primary quality indicators *Quality of Nursing Performance* and *Quality of Provider Performance* are derived entirely from the case review results, while the ratings for both of the secondary quality indicators are derived entirely from compliance test results. As another example, primary quality indicators such as *Diagnostic Services* and *Specialty Services* receive ratings derived from both sources. At NKSP, 13 of the quality indicators were applicable, consisting of 11 primary clinical indicators and two secondary administrative indicators. Of the 13 primary indicators, eight were rated by both case review clinicians and compliance inspectors, three were rated by case review clinicians only, and two were rated by compliance inspectors only; both secondary indicators were rated by compliance inspectors only.

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

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

CASE REVIEWS

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

PATIENT SELECTION FOR RETROSPECTIVE CASE REVIEWS

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

1. The goal of retrospective chart review is to evaluate all aspects of the health care system. Statewide, high-risk and high-utilization patients consume medical services at a disproportionate rate; 9 percent of the total patient population, those considered high-risk,

account for more than half of the institution's pharmaceutical, specialty, community hospital, and emergency costs.

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

Underlying the choice of high-risk patients for detailed case review are three assumptions:

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

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

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

BENEFITS AND LIMITATIONS OF TARGETED SUBPOPULATION REVIEW

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

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

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

CASE REVIEWS SAMPLED

As indicated in *Appendix B, Table B-4: NKSP Case Review Sample Summary*, OIG clinicians evaluated medical charts for 76 unique inmate-patients. Both nurses and physicians reviewed charts for 18 patients of those patients, for 94 reviews in total. Physicians performed detailed reviews of 30 charts, and nurses performed detailed reviews of 20 charts, totaling 50 detailed reviews. For detailed case reviews, physicians or nurses looked at all encounters occurring in approximately six months of medical care. Nurses also performed a limited or focused review of medical records for an additional 44 inmate-patients. These generated 1,265 clinical events for review (*Appendix B, Table B-3: NKSP Event—Program).* The reporting format provides details on whether the encounter was adequate or had significant deficiencies, and identifies deficiencies by programs and processes to help the institution focus on improvement areas.

While the sample method specifically pulled only seven chronic care patient records, i.e., four diabetes patients and three anticoagulation patients (*Appendix B, Table B-1: NKSP Sample Sets*), the 76 unique inmate-patients sampled included patients with 163 chronic care diagnoses, including ten additional patients with diabetes (for a total of 14) and two additional anticoagulation patients (for a total of five) (*Appendix B, Table B-2: NKSP Chronic Care Diagnoses*). Many chronic care programs were evaluated with the OIG's sample selection tool because the complex and high-risk patients selected from the different categories often had multiple medical problems. While not every chronic disease or health care staff member was evaluated, the overall operation of the institution's system and staff were assessed for adequacy. The OIG's case review methodology and sample size matched other qualitative research. The empirical findings, supported by expert statistical consultants, showed adequate conclusions after 10 to 15 charts had undergone full clinician review. In qualitative statistics, this phenomenon is known as "saturation." The OIG asserts that the sample size of over 30 detailed reviews certainly far exceeds the saturation point necessary for an adequate qualitative review. With regard to reviewing charts from different providers, the case review is not intended to be a focused search for poorly performing providers; rather, it is focused on how the system cares for those patients who need the most care. Nonetheless, while not sampling cases by each provider at the institution, the OIG's pilot inspections adequately reviewed most providers. Providers would only escape OIG case review if institutional management successfully mitigated patient risk by having the more poorly performing PCPs care for the less complicated, low-utilizing,

and lower-risk patients. The OIG's clinicians concluded the sample size was adequate to assess the quality of services provided.

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

COMPLIANCE TESTING

SAMPLING METHODS FOR CONDUCTING COMPLIANCE TESTING

From April to June 2015, deputy inspectors general attained answers to 101 objective medical inspection test (MIT) questions designed to assess the institution's compliance with critical policies and procedures applicable to the delivery of medical care. To conduct most tests, inspectors randomly selected samples of inmate-patients for whom the testing objectives were applicable and reviewed their electronic unit health records. In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed health records for 434 individual inmate-patients and analyzed specific transactions within their records for evidence that critical events occurred. Inspectors also reviewed management reports and meeting minutes to assess certain administrative operations. In addition, during the week of April 20, 2015, field inspectors conducted a detailed onsite inspection of NKSP's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,443 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 NKSP's plant infrastructure, protocols for tracking medical appeals and local operating procedures, and staffing resources.

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

SCORING OF COMPLIANCE TESTING RESULTS

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

- Primary indicators: *Access to Care*, *Diagnostic Services*, *Health Information Management (Medical Records)*, *Health Care Environment*, *Inter- and Intra-System Transfers*, *Pharmacy*

and Medication Management, Preventive Services, Reception Center Arrivals, Specialized Medical Housing, and *Specialty Services*.

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

After compiling the answers to all 101 applicable questions, the OIG derived a score for each primary and secondary quality indicator identified above by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Based on those results, the OIG assigned a rating to each quality indicator of *proficient, adequate,* or *inadequate*.

DASHBOARD COMPARISONS

For some of the individual compliance questions, the OIG identified where similar metrics were available within the CCHCS Dashboard. There is not complete parity between the metrics due to time frames when data was collected. As a result, there is some difference between the OIG's findings and the Dashboard metrics. The OIG compared its compliance test results with the institution's Dashboard results and reported on that comparative data under various applicable quality indicators within the *Medical Inspection Results* section of this report.

OVERALL QUALITY INDICATOR RATING FOR CASE REVIEWS AND COMPLIANCE TESTING

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

To derive an overall assessment rating for 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 for the primary quality indicators, which directly relate to the health care provided to inmate-patients. Based on that analysis, OIG experts made a considered and measured overall opinion about the quality of health care observed.

POPULATION-BASED METRICS

The OIG identified a subset of HEDIS measures applicable to the CDCR inmate-patient population. To identify outcomes for NKSP, the OIG reviewed some of the compliance testing results, randomly sampled additional inmate-patients' records, and obtained NKSP data from the CCHCS Master Registry. The OIG compared those results to metrics reported by other State and federal agencies.

MEDICAL INSPECTION RESULTS

PRIMARY (CLINICAL) QUALITY INDICATORS OF HEALTH CARE

The primary quality indicators address the clinical aspects of health care. As shown on the *Health Care Quality Indicators* table on page ii of this report, 13 of the OIG's primary indicators were applicable to NKSP. Of those 13 indicators, eight were rated by both the case review and compliance components of the inspection, three were rated by the case review component alone, and two were rated by the compliance component alone.

Summary of Case Review Results: The clinical case review component assessed 11 of the 13 primary (clinical) indicators applicable to NKSP. For these 11 indicators, OIG clinicians rated seven *adequate* and four *inadequate*.

Clinicians reviewed 30 cases, rating the adequacy of care for each case. Of these 30 cases, 5 were *proficient*, 16 were *adequate,* and 9 were *inadequate*. For 1,265 events reviewed, there were 374 deficiencies, of which 53 were of such magnitude that they would likely contribute to patient harm if left unaddressed.

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

There were five significant adverse events identified in the case reviews. These events were illustrative of the types of problems identified at NKSP.

- In case 1, an RN received and reviewed a sick call request on February 8, 2015. The patient stated he was bleeding from his nose and mouth and that he was on a blood thinner. He had spoken with a nurse, who told him to fill out a medical form. The RN assessed the patient the next business day. An immediate encounter was necessary.

- In case 13, despite a pharmacist questioning a potentially toxic phenytoin (seizure medication) dose of 800 mg daily, the provider confirmed the incorrect dosage.

- In case 26, a nurse failed to urgently see a patient with end-stage liver disease, low blood platelets, and the complaint "I feel like throwing up blood."

- Also in case 26, a provider evaluated the patient after violent head trauma. With a low blood platelet count, this patient was at risk for serious bleeding of the brain. The provider failed to monitor the patient for bleeding or check for this type of injury with either an MRI or a CT scan of the head.

- In case 27, the nurse failed to urgently refer a patient with arm weakness, unsteady gait, and falls to a provider.

Compliance Results: The compliance component assessed 10 of the 13 primary (clinical) indicators applicable to NKSP. For these ten indicators, OIG inspectors rated four *proficient*, three *adequate*, and three *inadequate*. The results of those assessments are summarized within this section of the report. The test questions used to assess compliance for each indicator are detailed in *Appendix A*.

ACCESS TO CARE

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

Case Review Rating:
Adequate
Compliance Score:
86.9%

Overall Rating:
Adequate

Case Review Results

The OIG clinicians reviewed 245 provider and 436 outpatient nursing encounters and found 43 deficiencies related to primary care provider (PCP) and nursing *Access to Care*. Most deficiencies were minor in nature. Appointments were not timely in some cases reviewed, including RN sick call appointments, nurse-to-provider sick call referrals, triage and treatment area (TTA) and hospital follow-ups, intra-system transfers, specialty appointments, and outpatient provider follow-ups. Overall, NKSP's performance was *adequate* with regard to *Access to Care*.

Four significant deficiencies were identified:

- In case 1, the patient's sick call request for knee pain was scheduled for an RN assessment 17 days after it was received and reviewed. While assessment is required for all patients with symptoms within one day, this complex patient on blood thinning medication, warfarin, with multiple conditions such as congestive heart failure, had a higher risk of serious causes for his pain.

- Also in case 1, there was a seven-day delay in access to care for anal irritation and a wound on the patient's foot.

- In case 19, the patient completed a request on August 11, 2014, with multiple symptoms, including shortness of breath due to asthma. The Form 7362 lacked documentation as to when this request was received and reviewed by the nurse. The face-to-face visit with the patient happened three days after the patient completed the 7362 form.

- In case 10, the patient refused an appointment for the administrative segregation unit PCP to follow up after hospitalization for care of multiple stab wounds to his arm and back. The PCP rescheduled the patient for a four-day follow-up, but the appointment did not occur.

Minor deficiencies were identified in the following areas:

Sick Call Requests

Delays of 3 to 17 days occurred in some sick call requests. Delays occurred in either reviewing sick call requests on the day received or in scheduling RN assessments for patients for sick call requests. These deficiencies occurred in cases 7, 13, 31, 32, 37, 39, 48, 50, 64, 65, 67, 69, 75, and 76. Examples were:

- In case 50, the patient's sick call request for a rash on his legs was reviewed on a Friday, but the RN assessment did not occur until the following Tuesday.
- In case 69, the patient's sick call request for a rash, unresponsive to medication, was scheduled for an RN assessment four business days after review.

RN-to-Provider Referrals

Nurses performing a sick call assessment were required to refer the patient to a provider when situations arose that required a higher level of evaluation. Delays occurred for several of these PCP referrals.

- In case 49, a PCP follow-up did not occur to assess a patient with elbow pain and swelling.
- In case 51, a PCP follow-up for a patient with an earache did not occur, even after a second RN sick call request 15 days after the initial request.
- In case 66, a PCP referral for a patient with a urinary complaint occurred nine days beyond the time frame requested.
- In case 75, the PCP requested a follow-up visit in four to seven days for an infected finger; the visit occurred six days beyond the time frame requested.

Provider-to-RN Referrals

Providers often make referrals to the clinic nurse to follow up with patients for a variety of reasons. Untimely completions of nursing follow-up visits occurred in two cases: case 2 (swollen hand), and case 7 (ear flushing and blood pressure checks).

Provider Follow-up Visits, Intra-System Transfers, Hospitalizations, and TTA Visits

A provider usually saw patients new to the institution, patients with visits to the triage and treatment area, and patients returning from hospitalization or follow-up visits in a timely manner.

Clinician Onsite Inspection

During the OIG clinician onsite visit, the OIG nurse manually reviewed sick call requests scheduled for that day. Two of the requests were ten days old—one request was for a change of medication, and the other was a complaint about an earache. These patients had transferred from Facility D to Facility C. The OIG also noted a two- to three-day backlog of RN assessments in Facility D.

Clinician Summary

Delays in scheduling provider visits, provider visits that were never scheduled, and backlogs of RN assessments were problematic. NKSP provided an RN seven days a week on second and third watch who was available to review sick call requests and perform RN assessments, yet there continued to be a backlog. One concern was that nurses may have been responding to the backlog by not addressing all of each patient's complaints, or by processing some requests as only medication refills when an RN assessment was actually indicated. It was also possible that some complaints were resolved by the time of the morning huddle. However, if this was the case, there was no documentation to reflect the patient's complaints had been resolved.

Compliance Testing Results

The institution received an overall score of 86.9 percent in the *Access to Care* indicator, scoring *proficient* in five of the nine areas tested, as described below:

- The OIG inspectors found that inmates had access to Health Care Services Request forms (CDCR Form 7362) at all six housing units inspected, receiving a score of 100 percent for this test (MIT 1.101).

- All ten inmate-patients sampled (100 percent) who were referred to and seen by a PCP, and for whom the PCP ordered a sick call follow-up appointment, received a timely appointment (MIT 1.006).

- Of the 30 inmate-patients the OIG sampled who had been discharged from a community hospital, 29 patients (97 percent) received a proper follow-up appointment within the required time frame of five days after discharge. The remaining one patient did receive a timely follow-up appointment, but the details of the provider visit were illegible and the inspectors could not ascertain the purpose or details of the appointment (MIT 1.007).

- Of the 30 sampled inmate-patients with chronic care conditions, 27 of the patients (90 percent) received timely appointments. For one patient, the appointment occurred three weeks late; for two other patients, the appointment occurred four weeks late (MIT 1.001).

- Inspectors sampled 27 inmate-patients who had received a specialty service and found that 24 of them (89 percent) received a timely follow-up appointment with a PCP. For two

patients who received high-priority specialty services, their follow-up visits were one and eight days late. For one patient who received a routine specialty service, the follow-up visit was one day late (MIT 1.008).

The institution scored within the *adequate* range for the following three tests:

- Inspectors sampled 30 Health Care Services Request forms submitted by inmate-patients across all facility clinics. In 25 instances (83 percent), the nursing staff reviewed the request form on the same day it was received, as documented on the service request (CDCR Form 7362). Of the five deficiencies, three request forms were reviewed one or two days late while two additional forms did not contain clear and determinable information to identify the review date (MIT 1.003).

- For 13 health care service requests sampled where the nursing staff referred the inmate-patient for a primary care provider (PCP) appointment, 10 of the inmate-patients (77 percent) received a timely appointment. The follow-up appointment occurred 16 days late for one patient and did not occur at all for two other patients (MIT 1.005).

- Inspectors sampled 30 inmate-patients who had been transferred into NKSP from another institution and referred to a PCP for a routine appointment based on nursing staff's initial health screening. Only 23 patients (77 percent) were seen timely. For the seven inmate-patients who were not seen timely, six patients were seen within one and six days late while the seventh patient was seen 17 days late (MIT 1.002).

The institution has room for improvement in the following area:

- For the 30 service request forms (CDCR Form 7362) sampled, nursing staff completed face-to-face encounters with 21 of the inmate-patients within one business day of reviewing the request (70 percent). Eight face-to-face encounters were conducted between one and 21 days late. For the ninth patient, nursing staff did not document their evaluation of his service request because the patient already had a scheduled provider appointment the following day (MIT 1.004).

CCHCS Dashboard Comparative Data

The Dashboard uses the average of nine medical access performance measures to calculate the score for access to medical services. The OIG compared applicable NKSP compliance scores with that Dashboard average.

As noted in the table below, the OIG testing results were based on a review of current documents as well as documents dating up to nine months back; NKSP's April Dashboard data reflected only the institution's March 2015 results. Regardless of the disparity in the sampling review periods, both the Dashboard's and the OIG's scores were in the *proficient* range overall.

Access to Care—CCHCS Dashboard and OIG Compliance Results

CCHCS Dashboard Results	OIG Compliance Results
Scheduling & Access to Care: Medical Services April 2015	*Access to Care* (1.001, 1.004, 1.005, 1.007) *Diagnostic Services* (2.001, 2.004) *Specialty Services* (14.001, 14.003) July 2014–April 2015
90%	**88%**

Note: The CCHCS Dashboard data includes access to care for inmate-patients returning from CDCR inpatient housing units and emergency departments. The OIG does not specifically test follow-up appointments for these patients.

Recommendations

The institution received an overall rating of *adequate* for this indicator and can easily address areas needing improvement by adhering to established policy and procedure and implementing the following specific recommendation:

- To reduce the backlog of RN and provider visits, the OIG recommends assigning the supervision of office technicians (OTs) responsible for scheduling to the clinic's supervising registered nurse (SRNII). Currently the OTs are supervised by the health records department. In addition, in order to reduce the backlog, the OTs should monitor inmates who transfer in or out of the yard, and new referrals to the PCPs. SRNIIs should evaluate the duties of the RNs on third watch, weekends, and holidays to improve efficiency of the sick call process.

DIAGNOSTIC SERVICES

Case Review Rating:
Adequate
Compliance Score:
86.2%

Overall Rating:
Proficient

This indicator addresses several types of diagnostic services. Specifically, it addresses whether radiology and laboratory services are timely provided to inmate-patients, whether the primary care provider (PCP) timely reviews the results, and whether the results are communicated to the inmate-patient within the required time frames. In addition, for pathology services, the OIG determines whether the institution receives a final pathology report and whether the PCP timely reviews and communicates 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 292 diagnostic events and found 18 deficiencies. All the other reviewed tests were performed as ordered, reviewed timely by providers, and relayed quickly to patients.

For critical lab values or x-ray findings, there should be documentation of verbal communication of the abnormalities by the nursing staff and providers. In a significant deficiency, a critical x-ray finding was not communicated to the provider in a timely manner.

- In case 15, while the patient resided in the correctional treatment center, a chest x-ray done on March 6, 2015, showed right upper lobe and right lower lobe infiltrates suggestive of pneumonia. The provider was not alerted to the x-ray finding until March 10, 2015.

Staff performed most laboratory, x-ray, and EKGs timely; however, there was a delay in the following cases:

- In case 1, a provider ordered a blood coagulation test (INR) to be drawn on November 10, 2014, but it was not performed until November 12, 2014.
- In case 5, an INR ordered for December 4, 2014, was not performed until December 8, 2014.
- In case 35, a baseline EKG ordered on December 23, 2014, was done 40 days later.

Health information management also contributed to diagnostic services deficiencies. Some diagnostic reports were not routed to the providers for review or scanned into the eUHR.

- In cases 5, 18, and 21, diagnostic reports were not retrieved or scanned into the eUHR.

- In case 20, the laboratory effective communication screening form was misfiled.
- In cases 10, 17, 19, 24, 26, 27, and 28, diagnostic reports were not appropriately signed or dated by a provider before scanning.
- In cases 15 and 30, there were six-day delays in the provider review of diagnostic reports.

The OIG rated *Diagnostic Services* at NKSP as *adequate* since the low number of improperly processed laboratory orders and failures to retrieve diagnostic reports did not significantly affect patient care.

Compliance Testing Results

The institution received an overall score of 86.2 percent in the *Diagnostic Services* indicator, which encompasses radiology, laboratory, and pathology services. For clarity, each type of diagnostic service is discussed separately below:

Radiology Services

- Inspectors found that for all ten radiology services sampled (100 percent), the service was performed timely (MIT 2.001). Also, for nine of those ten services (90 percent), the diagnostic report results were timely reviewed by the ordering provider and timely communicated to the inmate-patient. The one exception was a radiology result that was reviewed by the provider and communicated to the patient five days late (MIT 2.002, 2.003).

Laboratory Services

- Nine of ten laboratory services ordered (90 percent) were performed timely; one order was performed four days late. Providers timely communicated lab results to nine of the ten inmate-patients sampled; one patient received his results one day late (MIT 2.004, 2.006). Also, eight of the ten laboratory diagnostic reports (80 percent) included evidence that the provider had timely reviewed and initialed the diagnostic test results. The two exceptions included a provider who reviewed a report one day late and another report that lacked clear evidence of a provider review (MIT 2.005).

Pathology Services

- Final pathology reports were received and documented timely in the eUHR for eight of ten patients sampled (80 percent). For one patient, a provider's progress note indicated the final pathology report was still outstanding; inspectors found no eUHR evidence that the institution ever attempted to obtain the outstanding pathology report. In the second case, a final report was received three days late (MIT 2.007). The provider timely reviewed the pathology results for all nine patients (100 percent) (MIT 2.008).

- With regard to providers' communication of pathology results, the institution has room for improvement. Inspectors found that final pathology results were timely communicated to only five of the nine inmate-patients sampled (56 percent). For four patients, the provider did not discuss the final pathology results with the patient within two business days of receipt of the final diagnostic test results. Providers communicated the results between one and four days late (MIT 2.009).

Recommendations

The institution received an overall rating of *adequate* for this indicator; staff can easily address areas needing improvement by adhering to established policy and procedure and implementing the following specific recommendations:

- The OIG recommends that NKSP identify and correct the shortcomings that led to the provider's delayed receipt of the abnormal x-ray report in case 15.
- The OIG recommends that NKSP implement an effective tracking system for diagnostic orders to ensure that all diagnostic orders are followed in the time frame requested.

EMERGENCY SERVICES

Case Review Rating:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

An emergency medical response system is essential to providing effective and timely emergency medical response, assessment, treatment, and transportation 24 hours per day. Provision of urgent/emergent care is based on a patient's emergency situation, clinical condition, and need for a higher level of care. The OIG reviews emergency response services including first aid, basic life support (BLS), and advanced cardiac life support (ACLS) consistent with the American Heart Association guidelines for cardiopulmonary resuscitation (CPR) and emergency cardiovascular care, and the provision of services by knowledgeable staff appropriate to each individual's training, certification, and authorized scope of practice. The OIG evaluates this quality indicator entirely through clinicians' reviews of case files and conducts no separate compliance testing element.

Case Review Results

The OIG clinicians reviewed 79 urgent/emergent events and found 26 deficiencies in a variety of areas. Most deficiencies were minor and not considered likely to affect patient care. In general, NKSP performed well with emergency response times, BLS care, and 9-1-1 call activation times. Overall, the case reviews found that patients requiring urgent or emergent services received timely and adequate care in the majority of cases reviewed. The quality of provider emergency care was barely adequate, and would have been scored higher if not for the five cases described below. These cases are also described in the inspection report indicator *Quality of Provider Performance,* which had an overall rating of *inadequate.*

Provider Performance

The TTA providers usually evaluated the patients timely and made adequate assessments. Triage decisions were sound, and patients were sent to the appropriate levels of care. However, all five serious deficiencies identified in this indicator related to the quality of provider care in emergency services.

- In case 7, the on-call PCP failed to carefully assess a patient with new onset of chest pain during a TTA telephone call. While the PCP only managed the patient by telephone, the management still required a carefully patient assessment, including a cardiac risk stratification and review of a markedly abnormal EKG. The patient returned to his prison housing, where he had a myocardial infarction with cardiac arrest two days later. Fortunately, the provision of advanced cardiac life support (ACLS) successfully restored heart function, allowing the patient to be transferred to the community hospital. The patient underwent successful cardiac stent placement and returned three days later to the prison.

- In case 19, the PCP felt the patient's chest pain suggested myocardial ischemia, but failed to prescribe nitroglycerin to treat this condition.

- In case 26, the patient had an altercation and sustained multiple facial injuries. His chronically low platelet count (31,000) placed him at risk for serious brain hemorrhage. A CT scan of the head or admission of the patient to the correctional treatment center (CTC) for observation was necessary but not ordered.

- For another TTA encounter in case 26, the on-call PCP failed to assess appropriately a complaint of coughing up blood. The patient's platelet count had dropped as low as 11,000 since the above-described event, further increasing the risk of severe blood loss. The patient had end-stage liver disease and esophageal varices, which further increased bleeding risk.

- In case 27, the patient had signs and symptoms of acute neurological deficits. In addition, the patient had a recent cervical spine x-ray that showed severe collapse of a cervical vertebrae. The provider failed to evaluate the patient for spinal cord compression with an urgent MRI scan or transfer to a higher level of care.

Nursing Performance

Emergency nursing care was adequate. There were 39 nursing care events with 15 minor deficiencies. The following case examples are given for improvement purposes and all relate to incomplete or inaccurate documentation:

- The RN did not monitor vital signs or pain levels with sufficient frequency in cases 9, 12, 13, 14, and 18.

- In case 12, the patient was transported to the TTA for chest pain. The TTA RN did not evaluate if the nitroglycerin relieved the pain.

- In case 14, the TTA RN did not perform a complete subjective assessment of the patient's severe abdominal pain. The RN called emergency medical services an hour after the provider ordered Code 2 ambulance transport to the local emergency room. During this time, the patient continued to complain of severe abdominal pain. The RN failed to check vital signs with sufficient frequency while awaiting transport.

- In case 18, the patient called in an emergency at 5:39 p.m. for swollen arms, stomach pain, back pain, and inability to sleep. During the one-hour delay in transporting the patient to the TTA, a nurse did not remain with the patient to monitor his condition. The patient arrived in the TTA at 6:52 p.m. The provider on call gave a telephone order for intravenous fluids and pain medication as needed. The RN failed to administer the medication, despite the patient continuing to complain of severe pain. The RN did not check vital signs with sufficient frequency while awaiting transport to a community hospital.

- Clinicians found in cases 2 and 8 numerous time discrepancies in the documentation of different medical staff members and within the documentation by an individual staff member.

Patient Care Environment

- In case 1, handcuffs prevented nursing assessment of the patient's ability to move his swollen elbow.

Onsite Clinician Inspection/Patient Care Environment

During the onsite visit, the OIG clinicians found that the TTA had ample space for patient evaluation and working areas for both nurses and providers. The TTA had adequate lighting, medication stock, and medical equipment, such as an automated external defibrillator (AED) and an emergency crash cart. However, the TTA exam room with a glass window lacked visual privacy.

Conclusion

North Kern State Prison staff provided adequate emergency services to their patients. However, the PCPs need improvement in their assessment and care of the more complex medical patients. The layout of the TTA was adequate for required services to the inmate population, except for the lack of visual privacy.

Recommendations

The emergency services provided at NKSP were appropriate and adequately documented. The OIG recommends that custody, medical, and nursing administrators work collaboratively to implement the necessary changes within the TTA room to ensure that health care staff can provide privacy for patients without compromising the safety and security of staff and inmates within the vicinity.

The OIG recommends that supervisors review the poor provider performance in the cases above and implement strategies to help the providers improve their assessment and documentation skills. Training is advised for management of cardiac, hematologic, and neurological emergencies.

HEALTH INFORMATION MANAGEMENT (MEDICAL RECORDS)

Case Review Rating:
Inadequate
Compliance Score:
67.0%

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 Unit Health Record (eUHR); whether the various medical records (internal and external, e.g., hospital and specialty reports and progress notes) are obtained and scanned timely into the inmate-patient's eUHR; whether records routed to clinicians include legible signatures or stamps; and whether hospital discharge reports include key elements and are timely reviewed by providers.

Case Review Results

The OIG clinicians identified a number of deficiencies related to health information management. Of 381 deficiencies at NKSP, the OIG clinicians identified 57 related to *Health Information Management* processes. These processes are subcategorized as follows:

Hospital Records

- The most severe deficiencies occurred when hospital records (especially discharge summaries) were not retrieved or scanned into the eUHR. These types of records contain the most vital information for the continuity of care between the inpatient and outpatient settings. In cases 1, 3, and 9, hospital discharge summaries were not retrieved or found in the eUHR.
- Providers failed to initial many hospital records to indicate they were appropriately reviewed. This deficiency occurred in cases 1, 2, 7, 12, 17, 18, 26, 27, and 43.

Missing Encounters

- Most nursing and provider progress notes were scanned into the eUHR; however, progress notes were missing in cases 2, 4, 7, 60, and 73.

Specialty Services

- Health information management staff processed most specialty reports without any significant problems. However, deficiencies occurred for specialty consult reports. These findings are discussed in detail in the *Specialty Services* section.

Scanning Performance

- While the scanning times for all documents were adequate overall, numerous deficiencies related to scanning performance were found. The majority of these deficiencies were associated with the mislabeling or misfiling of documents, which hinders the medical staff's ability to find relevant clinical information. There were also a few instances of pages missing from a report and documents being filed in the wrong patient's chart. Cases 6, 20, 22, 51, and 71 had mislabeled or misfiled documents.

Legibility

- Throughout the period of review, both NKSP nurses and providers had illegible progress notes, signatures, or initials. Illegible progress notes posed a significant medical risk to patients, especially for medical care reviewed by other staff or for transfer of care to another team.

Miscellaneous

- Health care staff members at NKSP, especially providers, have to contend with misfiled documents in the eUHR and illegible provider progress notes and orders. Combined with underlying human lapses and errors, these issues have the potential to increase medical risk. The mitigation of these additional deficiencies is dependent on each employee's computer expertise, personal efficiency, attention to detail, and ability to decipher illegible handwriting. These abilities vary among staff members.

Compliance Testing Results

The institution received an overall score of 67.0 percent in the *Health Information Management (Medical Records)* indicator and has room for improvement in the following areas:

- The institution scored zero in its labeling and filing of documents that were scanned into the inmate-patients' eUHR. The most common error involved medication administration records (MARs) that were mislabeled (incorrect date). One patient's health screening form (CDCR Form 7277) was incorrectly scanned into another patient's eUHR file and another patient's health screening form was not located in the patient's eUHR (MIT 4.006).

- Miscellaneous non-dictated documents, including providers' progress notes, inmate-patients' initial health screening forms, and requests for health care services were not timely scanned. Only 11 of the 20 documents sampled (55 percent) were appropriately scanned into the patient's eUHR within three calendar days of the patient's encounter. The nine documents scanned late included five Health Care Services Requests (CDCR Form 7362) and four Initial Health Screenings (CDCR Form 7277) (MIT 4.001). Similarly,

MARs were not always timely scanned. Only 12 of the 20 sampled documents (60 percent) were scanned within three calendar days. The untimely documents were scanned from one to six days late (MIT 4.005).

The institution scored in the *adequate* range for the following two areas:

- The OIG reviewed eUHR files for 30 sampled inmate-patients who were sent or admitted to the hospital to determine if a NKSP provider reviewed the patients' community hospital discharge reports or treatment records within three calendar days of the patients' discharge. Inspectors found that providers timely reviewed the records for only 23 of the patients (77 percent). For one patient, the discharge summary lacked evidence that the NKSP provider had reviewed the report at all; for six other patients, the provider reviewed the records one or two days late (MIT 4.008).

- When the OIG reviewed various medical documents such as hospital discharge reports, initial health screening forms, certain medication records, and specialty service reports to ensure that clinical staff legibly documented their names on the forms, inspectors found that 33 of 40 samples (83 percent) showed compliance (MIT 4.007).

The institution performed well in its scanning of community hospital discharge summary reports and specialty service consultant reports:

- Community hospital discharge summary reports were timely scanned into the inmate-patient's eUHR within three calendar days of the hospital discharge for all 20 reports sampled (100 percent) (MIT 4.004). Specialty service consultant reports were also timely scanned, with 19 of the 20 sampled documents (95 percent) scanned within five calendar days. One report was scanned two days late (MIT 4.003).

CCHCS Dashboard Comparative Data

As indicated on the following page, for two of three applicable comparative measures, the OIG's compliance results for NKSP's availability of health information were consistent with the April 2015 NKSP Dashboard results. As noted in the following table, the OIG testing results were based on a review of current documents as well as documents up to nine months old; NKSP's April Dashboard data reflected only the institution's March 2015 results. Given these disparate time frames, the OIG's compliance scores were lower than the Dashboard results for miscellaneous non-dictated medical documents. However, both the Dashboard's and the OIG's results indicate that the institution needs to improve in its scanning of non-dictated medical documents. For specialty documents and community hospital records, the Dashboard's and the OIG's results were in the *proficient* range. For dictated documents, the OIG did not identify any comparable documents during the sample test period from which to make a comparison to the Dashboard results.

Health Information Management—
NKSP Dashboard and OIG Compliance Results

NKSP Dashboard Results	OIG Compliance Results
Availability of Health Information: Non-Dictated Medical Documents April 2015	*Health Information Management* (4.001) Non-Dictated Medical Documents July 2014–April 2015
67%	**55%**

Note: The Dashboard results were obtained from the Non-Dictated Documents Drilldown data for "Medical Documents 3 Days."

NKSP Dashboard Results	OIG Compliance Results
Availability of Health Information: Dictated Documents April 2015	*Health Information Management* (4.002) Dictated Documents April 2015 (No dictated documents)
74%	**N/A for NKSP**

Note: The Dashboard results were obtained from the Dictated Documents Drilldown data for "Medical Dictated Documents 5 Days."

NKSP Dashboard Results	OIG Compliance Results
Availability of Health Information: Specialty Notes April 2015	*Health Information Management* (4.003) Specialty Documents August 2014–February 2015
92%	**95%**

Note: The Dashboard measure includes specialty notes from dental, optometry, and physical therapy appointments, which the OIG omits from its sample.

NKSP Dashboard Results	OIG Compliance Results
Availability of Health Information: Community Hospital Records April 2015	*Health Information Management* (4.004) Community Hospital Discharge Documents October 2014–April 2015
100%	**100%**

Recommendations

Both the case review and compliance testing assessed this indicator at the *inadequate* level. However, the institution can address most areas needing improvement by adhering to established policy and procedure.

In addition, the OIG recommends NKSP implement processes that ensure the following:

- Timely retrieval, review, signing, time-stamping, scanning, and filing of documents, such as hospital and specialty reports, dictated or transcribed providers' progress notes, and medication administration records.
- Legibility of clinicians' signatures. Consider requiring dictation of all provider encounters.

HEALTH CARE ENVIRONMENT

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

Case Review Rating:
Not Applicable
Compliance Score:
57.1%

Overall Rating:
Inadequate

Compliance Testing Results

The institution received an overall score of 57.1 percent in the *Health Care Environment* indicator. There are opportunities for improvement in the following six areas:

- Inspectors found that the non-clinic medical storage area located in NKSP's main medical storage warehouse generally met the supply management process and support needs of the medical health care program. However, inspectors deemed the actual warehouse storage practices inadequate. Specifically, bulk medical supplies such as disposable gloves were stored directly on the ground subject to excessive heat or moisture, which could lead to premature deterioration (see Figure 1). As a result, the institution scored 0 percent for this test (MIT 5.106).

Figure 1: Medical supplies stored directly on the ground

- The OIG inspected exam rooms within the 11 clinics to determine if appropriate space, configuration, supplies, and equipment allowed clinicians to perform a proper clinical exam. Only 2 of the 11 clinics (18 percent) complied with this test; one or more exam rooms in the remaining 9 clinics had deficiencies. Inspectors found exam rooms in two clinics that measured only 60 square feet and 66 square feet, and another clinic with an exam room only 5'4"

Figure 2: Exam room used for wheelchair storage

wide. Also, five clinics had exam rooms with excessive, large, or poorly placed furniture leaving little remaining useable space. In the correctional treatment center (CTC), inspectors found an exam room used to store multiple wheel chairs and other excess equipment (see Figure 2). In addition, clinicians used exam tables as desks or countertops in two exam rooms (see Figure 3). As a result of these cramped conditions, in some exam rooms patients could not lie on exam tables in a fully extended supine position and clinicians did not have unimpeded access to patients being examined.

Figure 3: Exam table used as desk

Inspectors also had concerns with inmate-patient privacy. In four clinics, adequate window or door privacy curtains were not readily available. In the receiving and release (R&R) clinic, the triage floor plan allowed two inmates in close proximity to be medically screened at the same time, negating reasonable assurance of patients' auditory privacy (see Figure 4). Also, the R&R clinic's confidential medical records designated for shredding were visible and easily accessible to inmates. Finally, NKSP's On-Site Specialty clinic had an optometry chair with a worn vinyl spot that could not be adequately disinfected, and the administrative segregation unit clinic had a disorganized and unlabeled medical cabinet that could prevent a newly assigned clinician from readily determining its contents (MIT 5.110).

Figure 4: Triage area where patients sit back-to-back

- Inspectors found that only 3 of 11 clinics (27 percent) were appropriately disinfected, cleaned, and sanitary. More specifically, in five different clinics inspectors observed areas that were visibly dusty, dirty, or not sufficiently clean for a clinical setting. In addition, inspectors also found that five of the clinics were not cleaned daily because the clinic was too busy or because cleaning crews were either not let out to perform the cleaning or did not have access to exam rooms (MIT 5.101).

- Clinic common areas and exam rooms were sometimes missing essential core medical equipment or supplies. As a result, only 4 of the 11 clinics (36 percent) received a passing score for this test. Two clinics were missing nebulization units; six clinics had equipment that showed no evidence of current calibration; and five clinics did not have an established

distance marker for the Snellen vision chart. Also, exam rooms in two clinics were missing bio-hazard waste receptacles and hemoccult cards, and the R&R clinic did not have an exam table in the immediate area (MIT 5.108).

- When inspecting for proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste, the OIG found that only 6 of the 11 clinics (55 percent) were compliant. Exam rooms in five clinics did not have a sharps container. One of those clinics also did not have personal protective equipment kits; replacement kits had been ordered but had not yet been received (MIT 5.105).

- Inspectors found that only 8 of NKSP's 11 clinics (73 percent) had operable sinks with sufficient hygiene supplies. In two clinics, the inmate-patient restroom lacked disposable towels or antiseptic hand soap. In the diagnostics clinic, blood-draw station staff did not have reasonable access to a working sink or disposable paper towels (MIT 5.103).

The institution performed at an *adequate* level in the following three areas:

- The OIG examined emergency response bags to determine if they were inspected daily and inventoried monthly and whether they contained all essential items. NKSP's emergency response bags were compliant in only six of the eight applicable clinics inspected (75 percent). In two clinics, the staff had not completed the April 2015 monthly inventories of the response bag contents. The inventories are due every 30 days and should have been conducted at the beginning of April, which was two weeks prior to the OIG's onsite inspection (MIT 5. 111).

- Health care staff in only eight of ten applicable clinics (80 percent) ensured that reusable invasive and non-invasive medical equipment was properly sterilized or disinfected. In two clinics, inspectors observed that a provider did not change the exam table paper after a patient encounter (MIT 5.102).

- The institution's clinic common area environments were mostly adequate for providing medical services, but improvement is still needed. While 9 of 11 clinics received passing scores (82 percent), two lacked adequate auditory privacy for inmate-patients seen in the clinic common areas during initial triage and vital sign encounters (MIT 5.109).

The institution performed at a *proficient* level in the following two areas:

- OIG inspectors observed clinicians' encounters with patients in 11 clinics and found that clinicians followed good hand hygiene practices in 10 of the clinics, scoring 91 percent for this test. The one notable area for improvement related to hand sanitation practices used by a wound care nurse in one facility. The nurse did not have immediate access to a sink, disposable towels, and antiseptic soap. As a result, the nurse only used hand sanitizer prior

to putting on protective gloves after caring for a patient's wound. Because wound care is an invasive procedure, a higher level of hand cleansing was warranted (MIT 5.104).

- Ten of the eleven clinics inspected followed adequate medical supply storage and management protocols in their clinical areas, scoring 91 percent for this test. In the administrative segregation unit clinic, staff did not maintain a core inventory of regularly used medical supplies. Instead, nurses brought in supplies they expected to use each day. An inventory of core medical supplies allows new or unfamiliar nurses to more efficiently perform their job duties with fewer interruptions (MIT 5.107).

Other Information Obtained from Non-Scored Results

The OIG gathered information to determine if the institution's physical infrastructure is maintained in a manner that supports health care management's ability to provide timely or adequate health care. The information was based on interviews with NKSP's health care management. When asked if all clinical areas have physical plant infrastructures sufficient to provide adequate health care services, management stated that the current health care environment hinders, but does not prevent, the institution from delivering adequate health care to patients. The institution does have a $37.6 million health care improvement program that was scheduled to begin 18-months of construction between July and September 2015. Improvements include reception center health care processing renovations and a correctional care management building (MIT 5.999).

Recommendations

The institution performed in the *inadequate* range in many areas and could easily improve its overall score by adhering to recognized health care guidelines and implementing the following specific recommendations:

- The OIG recommends that NKSP work with the PIA to develop a system that ensures clinics are cleaned each day the clinics are operational. The cleaning process must ensure that all floor and countertop surfaces are regularly cleaned, including floor corners and other hard-to-reach locations. When cleaning clinics, the PIA must ensure that all clinic restrooms are stocked with disposable paper towels and antiseptic soap.

- The OIG recommends that all clinics have a full complement of core items that includes a nebulization unit and Snellen chart (with an established line marker), that clinic exam rooms have a sharps container and biohazard waste receptacle (or leak-proof bag), and that provider exam rooms have hemoccult cards and a developer. Also, the receiving and release clinic should have an exam table in the immediate area.

- Clinical staff must ensure that clinic common areas and exam areas maintain auditory and visual privacy for patients being examined or triaged in those areas, and shred or secure

patients' confidential medical records so they are inaccessible to other inmates and non-health-care staff.

- NKSP management must ensure that exam rooms have sufficient space to conduct patient examinations. For example, exam rooms should have minimal clutter, adequate floor space to allow for a standing exam, and exam tables positioned such that patients can lie fully extended on the table and clinicians have unhindered access to the patient.
- The institution's warehouse staff must ensure that warehoused medical supplies are not stored directly on the ground.

INTER- AND INTRA-SYSTEM TRANSFERS

Case Review Rating:
Adequate
Compliance Score:
82.9%

Overall Rating:
Adequate

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

Case Review Results

Forty-three encounters were reviewed relating to *Inter- and Intra-System Transfers*, including information from both the sending and receiving institutions. Sixty hospitalization events were reviewed, a majority of which resulted in a transfer back to the institution. The inter- and intra-system transfer processes at NKSP were adequate, with the majority of transferring inmates receiving timely continuity of health care services.[2] However, there were a few important deficiencies. Case 6 had a serious lapse in receipt of medications after discharge from a mental health crisis bed to the enhanced outpatient program (EOP) yard, discussed below. There were three other serious deficiencies related to health information management's failure to obtain or scan hospital discharge summaries. This is also mentioned in *Health Information Management* (cases 1, 3, and 9). Other minor deficiencies related to a delay in appointment scheduling for specialty services, missed medication doses, and incomplete nursing documentation. Specific examples of case review findings are listed below.

[2] The OIG case review rating is applicable only to NKSP's existing, nursing-only inter- and intra-system transfer processes. The rating is not applicable to the CCHCS systemwide transfer process, which the OIG has significant concerns with and which is discussed within this section.

Transfers In

The following nursing deficiency should be reviewed for quality improvement:

- In case 6, the patient missed many medical and mental health medications. This EOP patient, with an educational level less than the 4th-grade equivalent, may have required additional help to learn the new routine upon transferring to the new yard. However, nursing staff failed to contact him the day after transfer when he did not report to the medication line. This case is also discussed in *Pharmacy and Medication Management.*

Examples of other minor deficiencies were:

- In case 39, the patient did not receive his morning or noon medications after transfer from the CTC to his assigned housing unit.

- In case 44, the patient arrived at NKSP from another facility on August 7, 2014. The RN made a PCP referral within 14 days, but the visit did not occur.

Transfers Out

Deficiencies found with inmates transferring out of NKSP were largely due to incomplete nursing documentation of significant medical information on the Health Care Transfer Information form (CDCR Form 7371). The following deficiencies were found:

- In case 7, the RN's information on the transfer out form was inaccurate and incomplete but did not result in a delay of care.

- In case 12, the RN did not document a cardiology visit due in three months on the transfer out form.

- In case 51, the nurse failed to document the pending provider follow-up visit due in seven to ten days as a referral from an RN visit.

Hospitalizations

Patients returning from hospitalizations are some of the highest risk encounters due to two factors. First, these patients are generally hospitalized for a severe illness or injury. Second, they are subject to potential lapses in care that can occur during any transfer. At NKSP, hospital return patients were processed by a TTA RN, who usually appropriately reviewed the discharge medications and plan of care and obtained provider orders to implement them. However, the OIG found multiple medication deficiencies, including medications not administered on the first day of return. In several cases, nurses administered the first doses on time from an Omnicell (automated medication dispensing cabinet), but there was a lapse for the next one or two days until printed medication administration records were received.

Most hospital discharge summaries were timely received, reviewed by a provider, and timely scanned into the eUHR, as discussed in the *Health Information Management* indicator section of this report. Primary care providers followed up with patients in a timely manner. This process worked well for the majority of hospitalization events reviewed. The following are examples of the deficiencies found:

- Hospital discharge summaries were not properly signed by the provider in cases 1, 2, 7, 12, 17, 18, 26, 27, and 43.
- Medication lapses occurred after return from hospitalization in cases 1, 2, 7, 9, 12, 39, and 43. Cases 1 and 2 involved multiple hospitalizations, each with deficiencies.
- In case 1, the patient did not receive Coumadin on the day of his return. Two medications (clindamycin and pantoprazole) were not ordered as recommended in the hospital discharge summary.
- In case 9, in addition to delayed medications, the RN obtained an incorrect telephone order for seizure medication, probably due to misreading the recommended dose from the hospital. The provider corrected the error the next day.
- NKSP utilizes a pre-printed progress note form for the RN to document the patient evaluation upon return from outside medical appointments and hospitalizations. The OIG clinicians found that documentation on these forms was often minimal. Inaccurate or incomplete nursing documentation was found in cases 1, 2 (twice), 7, 15, and 17 (twice).

Onsite Visit

During the onsite visit, the clinicians observed that the receiving and release (R&R) clinic did not provide auditory privacy for patients during initial screening.

Compliance Testing Results

North Kern State Prison obtained an *adequate* score of 82.9 percent in the *Inter- and Intra-System Transfers* indicator and scored in the *proficient* and *adequate* ranges in four of the five tests, as described below:

- For all 29 of the patients sampled (100 percent), inspectors found that NKSP's registered nurses completed the assessment and disposition sections of the Initial Health Screening form (CDCR Form 7277) on the same day staff completed an initial screening of the patient (MIT 6.002).

- Inspectors found that the transfer packages for all eight inmate-patients tested who transferred out of the institution during the onsite inspection included required medications and related documentation (MIT 6.101).

- The institution scored 95 percent when the OIG tested 20 inmate-patients who transferred out of NKSP to another CDCR institution to determine whether their scheduled specialty service appointments were listed on the Health Care Transfer Information form (CDCR Form 7371). The inspectors only identified one specialty service appointment that was not identified on a patient's transfer form (MIT 6.004).

- The institution received a score of 83 percent when the OIG tested 29 patients who transferred into NKSP from another CDCR institution to determine whether they received a complete initial health screening assessment from nursing staff on their day of arrival. Nursing staff timely completed the Initial Health Screening (CDCR Form 7277) assessment for 24 of the patients sampled but neglected to answer all screening questions for five others (MIT 6.001).

There is room for improvement in the area described below:

- Nineteen of the sampled inmate-patients who transferred into NKSP had an existing medication order upon arrival. Inspectors tested those patients' records to determine if they received their medications without interruption and found that only 7 of the 19 patients (37 percent) received their medications timely. Of the 12 exceptions found, 7 patients did not receive their next scheduled nurse-administered medications without interruption. The medication was administered at the subsequent dosing interval on the next day. For five other patients who did not arrive at NKSP with their KOP medication, nursing staff failed to reissue the medication to the patient upon arrival. In one instance, a patient did not receive his KOP medications (asthma inhalers) for one week after arrival (MIT 6.003).

Recommendations

Although both the case review and compliance testing assessed this indicator at the *adequate* level, the institution could easily improve its overall rating by adhering to established policy and procedure and implementing the following specific recommendations regarding medication continuity for patients returning from hospitalization:

- Create a special hospital return medication order that discontinues all prior outpatient medications and specifies the medication, dose, route, frequency, duration, and start time for each new prescription. When given verbally, nurses can be expected to verify each prescription in detail with read-back with the ordering physician.

- Audit the orders to ensure completeness by both physicians and nurses.

- Remove pre-hospitalization medication administration records from the medication binder, or clearly mark pre-hospital medications as discontinued. Initiate a quality improvement activity to resolve the delays and lapses in medication continuity after hospitalization.

PHARMACY AND MEDICATION MANAGEMENT

***Case Review Rating**:*
Inadequate
***Compliance Score**:*
86.4%

Overall Rating:
Inadequate

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

Based on results from pilot inspections, the OIG has found that the most accurate evaluation of this indicator is derived largely from a detailed analysis of the OIG compliance scores in addition to the clinical case reviews. The case reviews often add specific examples of the findings revealed by the compliance scores and identify problems in other processes that may not be evident when viewed solely from a compliance standpoint.

Case Review Results

The OIG clinicians evaluate *Pharmacy and Medication Management* as secondary processes as they relate to the quality of clinical care provided. Compliance testing is a more targeted approach and factors heavily into the overall rating for this indicator.

Case review found that out of 21 reviewed events, 33 deficiencies were found. The deficiencies' frequency, severity, and pattern led to the overall rating of *inadequate*. This was in contrast to the compliance rating, which took a more targeted approach looking at administrative issues. Compliance scores were high for elements like medication storage areas, security controls for narcotics, and medication preparation areas. However, compliance scores were lower for most indicators that directly affected patient care, such as chronic care medication administration and continuity of medications after transfer and during layovers. Chronic care medication administration scored 51.7 percent. Compliance sample sizes for *Pharmacy and Medication Management* ranged from 2 to 30 patients and were much lower than the number of medication events reviewed in case reviews. Due to serious deficiencies found in case reviews and low compliance scores for patient-related indicators, the case review and overall rating was *inadequate*.

New Prescriptions

Case review found that in the majority of cases, patients received their new medications timely and as prescribed. However, there were rare cases where prescriptions were not processed correctly:

- In case 19, the patient arrived at NKSP on August 8, 2014, from a county jail. Medications ordered at 11:45 a.m. were filled by the pharmacy at 8:08 p.m. Therefore, the patient did not receive warfarin (blood thinner) and the levalbuterol (asthma medication) inhaler until the following day.

- In case 38, the patient arrived at NKSP from a county jail on October 27, 2014, receiving most medications the following morning. Furosemide (diuretic) was not given until October 29, 2014.

Chronic Care Medication Continuity

- Case reviews revealed that the majority of patients received their chronic care medications without interruption. However, a small number of cases suggested possible problems with chronic care medication continuity. In case 8, the patient did not receive his asthma inhaler until he submitted a second sick call request.

Intra-System Transfers-in, Intra-Facility Transfers, and Reception Center Arrivals—Medication Continuity

North Kern State Prison maintained medication continuity in the majority of transfer and reception cases reviewed. However, deficiencies were found in the following cases:

- In case 6, the patient was not given three medications on the evening after transfer to the enhanced outpatient program (EOP) housing unit from a mental health crisis bed (MHCB): simvastatin (for cholesterol), atenolol (for blood pressure), and hydroxyzine (for mental health). Hydroxyzine was re-ordered at the time of transfer but was not given for 13 days. The patient did not report to the medication line the morning after transfer, and the nurses did not attempt to locate him. The nurses continued to document that the patient either refused or "no-showed" for his medications but did not notify the provider. This patient missed medications for both medical and mental health conditions after transfer. The patient was designated as EOP and had an educational level less than 4th grade. Accordingly, he may have required additional help upon arriving at his new housing location to understand how to continue receiving his medications. In addition, the nurses failed to notify the provider when the patient continued to not report to the medication line. In addition, the nurses did not meet with the patient to discuss his reason for not reporting to the medication line. The patient died of coronary artery disease 17 days after transfer to the EOP yard.

- In case 39, after transfer from the CTC to a yard, the patient did not receive his morning or noon medications.

- Medication delays occurred for cases 19, 34, and 38 in the Reception Center.

Post-Hospitalization Medication Continuity

Medication continuity for patients returning from a hospitalization revealed multiple deficiencies, some of which were serious, illustrating the OIG's concerns regarding this process.

- In case 1, when the patient returned from the hospital, all medications were reordered on January 13, 2015, at 3:40 p.m. However, the carvedilol medication (for heart and blood pressure) was not given to the patient until January 15, 2015.

- In case 1, the patient returned on February 11, 2015, with medications to be started the following morning. However, the morning medications were not started until February 13, 2015.

- In case 1, on March 8, 2015, the patient was discharged from a community hospital with a diagnosis of acute blood loss likely secondary to duodenal ulcer, requiring four units of blood transfusion. The patient did not receive the hospitalist-recommended omeprazole (ulcer medication).

- In case 2, the patient returned on February 11, 2015, at 3:48 p.m., and was not given his glipizide, hydrochlorothiazide, labetalol, metformin, simvastatin, and terazosin medications (for blood pressure, diabetes, and high cholesterol) until the next morning.

- In case 2, the patient returning on March 2, 2015, did not receive his pantoprazole, allopurinol, aspirin, clopidogrel, docusate, and hydrochlorothiazide medications (for ulcer, gout, blood clots, constipation, and high blood pressure) until March 4, 2015.

- In case 7, the patient returned on September 20, 2014, at 8:41 p.m., but did not receive any medications that were due on that evening.

- In case 9, the patient returned on January 3, 2015, with a list of prescribed medications. The RN incorrectly identified the dose of the seizure medication, levetiracetam, as 500 mg twice a day and administered it to the patient that evening. The next morning, the provider corrected the order to 750 mg twice a day. In addition, on January 5, 2015, morning and noon doses were not given. Aspirin was ordered on January 3, 2015, but not given until January 6, 2015.

- In case 12, the patient returned on October 1, 2014, at 3:26 p.m., but did not receive atorvastatin ordered at bedtime that night, as ordered.

- In case 13, the patient, who was being treated for seizures, returned from a hospitalization on June 19, 2014, with orders for 300 mg of phenytoin daily. The nurse obtained a telephone order from the provider, administered the phenytoin that evening, and documented the encounter on a handwritten medication administration record (MAR). The handwritten dose was illegible and appeared to read either 300 or 800. On June 20, 2014, the printed MAR from the pharmacy listed the medication dose as 800 mg. The pharmacist questioned the provider about the high dose, and the provider confirmed the dosage of 800 mg daily without checking the hospital discharge records. A dosage this high, should have alerted the provider that an error had occurred.

- In case 39, the patient returned from a community hospital on October 3, 2014. The following day, the morning dose of rifaximin (for liver disease) was not given to the patient. Three days later, the morning dose of spironolactone (diuretic) was not given. On both occasions, the medication administration record was blank without reasons why the medications were not given.

- In case 43, the patient was admitted to the CTC after abdominal surgery. The RN who performed the admission assessment observed a clonidine patch (for high blood pressure) on the patient's chest. The RN documented removing the patch because the patient had other blood pressure medications. The RN did not obtain an order to discontinue the patch. The next day the provider noted the patch had been stopped and ordered clonidine by mouth three times daily to prevent possible seriously high blood pressure from the medication withdrawal.

Medication Administration

Case review found the following deficiencies in medication administration. This topic is also addressed in the indicator *Quality of Nursing Performance*.

- In case 6, nurses did not complete refusal forms or notify the provider when the patient refused or did not come to the medication line on multiple occasions in December 2014 (also discussed above on page 37).

- In case 12, nurses left multiple spaces blank for simvastatin on the medication administration record from November 18, 2014, to December 3, 2014.

- In case 13, the patient refused to report to the medication line for phenytoin (for seizures) during most of the month of July 2014. Nurses did not notify the provider nor document educating the patient about the medication's importance.

Medication Follow-up

Case review found that medication line nurses sometimes did not perform timely notification when patients missed medications (cases 6 and 13, above).

Onsite Clinician Inspection

During the onsite visit, OIG clinicians met with medical, nursing, and pharmacy representatives regarding case review findings. NKSP administrators were aware of these specific cases and had conducted interdisciplinary internal discussions and root cause analysis exercises regarding some of the issues. The pharmacy demonstrated logging procedures and ensured that medications were well stocked in the TTA Omnicell. Nursing had implemented various training interventions and monitoring strategies with TTA nursing staff to improve the continuity of care for patients returning after being discharged from the hospital.

Conclusion

The OIG rated overall *Pharmacy and Medication Management* as *inadequate*; specific concerns are noted above.

Compliance Testing Results

The institution received a *proficient* score of 86.4 percent overall for the *Pharmacy and Medication Management* indicator. For discussion purposes below, this indicator is divided into three sub-indicators: Medication Administration, Observed Medication Practices and Storage Controls, and Pharmacy Protocols.

Medication Administration

For this sub-indicator, the institution scored an average of 75 percent. There is room for improvement in the following areas:

- NKSP timely dispensed chronic care medications to only 15 of the 29 inmate-patients sampled, scoring 52 percent for this test. Inspectors identified one or more exceptions in fourteen patients' medication records for a three-month test period. These exceptions included late renewals of existing medication orders; late delivery or non-delivery of new medication orders; missed dosages, incorrect dosages, or double dosages of medications; and patient counseling (for missed dosages) received late or not received at all (MIT 7.001).
- The institution timely provided hospital discharge medications to only 20 of 30 patients sampled who had returned from a community hospital (67 percent). Eight patients received their medications one or two days late, one patient received his medication 27 days late, and

inspectors found no evidence that another patient received his new medication order at all (MIT 7.003).

- Of the 30 patients sampled who transferred from one housing unit to another, only 21 (70 percent) continued to receive their medications without interruption. Three patients' records showed no evidence that medications were received for periods of seven and eight days at a time; for six other patients, nurses either failed to document why medications were not received or documented that the patient was a "no-show" but did not document that any follow-up effort was made to bring the patient to the medication line location or to deliver the medication to the patient (MIT 7.005).

- When the OIG sampled ten inmate-patients who were en route to another institution and temporarily laid over at NKSP for one night, inspectors found that only seven of the patients (70 percent) received their nurse-administered and KOP medications without interruption (MIT 7.006).

The institution scored well in the following medication administration areas:

- Inspectors reviewed files of 20 sampled inmate-patients who recently arrived at NKSP from a county jail to identify those patients for whom a NKSP provider had ordered medications upon their arrival. Inspectors found only two applicable patients and both patients received their mediations timely. As a result, the institution received a score of 100 percent for this test (MIT 7.004).

- The OIG found that NKSP's compliance with the administration of new medication orders was high, scoring 93 percent. Twenty-eight of the 30 patients sampled received their medications timely. One patient's medication was not administered at all. For another patient, the nurse documented that the patient was a "no show," but did not document that any follow-up effort was made to call the patient's housing unit or to bring the patient to the pill-line (MIT 7.002).

Observed Medication Practices and Storage Controls

For this sub-indicator, the institution scored an average of 87 percent. NKSP scored within the *proficient* range in five of the six tests, as described below:

- At each of the seven medication preparation and medication administration locations inspectors observed, nursing staff followed proper hand hygiene contamination control protocols (100 percent), and practiced appropriate administrative controls and protocols during medication preparation (100 percent) (MIT 7.104, 7.105).

- North Kern State Prison scored 100 percent by properly storing non-narcotic medications that did not require refrigeration at all of its 13 applicable clinics and medication line storage locations (MIT 7.102).

- The institution properly stored non-narcotic medications that require refrigeration at nine out of ten storage locations (90 percent). Inspectors found one clinic location where the door was unlocked to the refrigeration unit that stored non-narcotic medications and medical staff stored personal drinking water with the refrigerated medications (MIT 7.103).

- The institution employed strong medication security control over narcotic medications in seven of its eight applicable pill line locations that stored narcotics (88 percent). For one pill line location, inspectors found that all three nurses working on the same shift had keys to the narcotics locker, creating a lack of separation of duties and a lapse in accountability (MIT 7.101).

While NKSP performed at the proficient level in other test areas, the following area presents opportunity for improvement:

- When observing the medication distribution process at seven applicable pill line locations, inspectors found that only three of the seven (43 percent) were compliant with appropriate administrative controls and protocols. At three pill lines, inmate-patients waiting outside to receive their medications did not have an overhang or shade protection available during extreme or inclement weather. Also, during the inspectors' observation of a cell-front distribution pill line, the nurse pulled the wrong patient's pill envelope and gave the patient the wrong medication. The patient alerted the nurse and handed it back. The nurse then alerted a supervisor and asked for a medication error report (MIT 7.106).

Pharmacy Protocols

For this sub-indicator, the institution scored an average of 99 percent, scoring 100 percent in four tests and 96 percent in the remaining test, as indicated below.

- In its main pharmacy, the institution follows general security, organization, and cleanliness management protocols; properly stores both non-refrigerated and refrigerated medications; and maintains adequate controls and properly accounts for narcotic medications. As a result, NKSP received a score of 100 percent in each of these areas (MIT 7.107, 7.108, 7.109, 7.110).

- The institution's pharmacist-in-charge (PIC) properly processed 24 of the 25 (96 percent) medication error reports tested. For one medication error report, the PIC did not complete the follow-up review within five business days; the review was conducted eight days late (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 found during the case reviews or compliance testing to determine whether the errors were properly identified and reported. None of the five significant medication errors identified by OIG clinicians and inspectors during their case reviews and compliance testing were reported to the institution's PIC by healthcare staff (MIT 7.998).

The OIG also tested inmate-patients in isolation units to determine if they had immediate access to their prescribed KOP rescue inhalers and nitroglycerin medications. Ten of 11 applicable patients interviewed had access to their asthmatic inhaler or nitroglycerin medications. The OIG reported to NKSP medical staff that one patient did not have his inhaler; the patient received a new inhaler that same day (MIT 7.999).

CCHCS Dashboard Comparative Data

Medication Administration: The CCHCS Dashboard uses performance measures from the Medication Administration Process Improvement Program (MAPIP) audit tool to calculate the average score for medication administration. The OIG compared similar NKSP compliance scores with applicable April 2015 Dashboard measures. As noted in the following table, the OIG test results were based on a review of current documents as well as documents dating up to eight months back; NKSP's April Dashboard data reflected only the institution's March 2015 results. Given these variable time frames, the OIG's compliance score was 31 percentage points lower than the Dashboard's score.

Pharmacy and Medication Management—
NKSP Dashboard and OIG Compliance Results

NKSP DASHBOARD RESULTS	OIG COMPLIANCE RESULTS
Medication Management: Medication Administration April 2015	Medication Administration (7.001, 7.002) (Chronic Care & New Meds) *Preventive Services* (9.001) (Administering INH Medication) September 2014–May 2015
99%	**68%**

Note: The Dashboard results were obtained from the Medication Administration Drilldown data for Chronic Care Meds—Medical; New Outpatient Orders—Medical; New Outpatient Orders—Psychiatric; and Administration—TB Medications. Variances may exist because CCHCS includes medication administration of KOP medications only for the first two drilldown measures, while the OIG tests KOP, DOT, and nurse-administered (NA) medication administration.

Recommendations

No specific recommendations. Although the institution received an overall rating of *inadequate* for this indicator, staff can address areas needing improvement by adhering to established policy and procedure.

PREVENTIVE SERVICES

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

Case Review Rating:
Not Applicable
Compliance Score:
76.8%

Overall Rating:
Adequate

Compliance Testing Results

The institution performed in the *adequate* range in the *Preventive Services* indicator, with an overall score of 76.8 percent. The institution scored at the *adequate* to *proficient* level in four of the seven tests. The stronger areas are described below:

- The institution was 100 percent compliant in offering 30 sampled inmate-patients their annual influenza vaccinations (MIT 9.004).
- The institution offered colorectal cancer screenings to 29 of 30 sampled inmate-patients subject to the annual screening requirement (97 percent). One patient's records contained no evidence in the eUHR that he was offered a fecal occult blood test within the previous 12 months, after receiving an abnormal colonoscopy result in August 2013 (MIT 9.005).
- The OIG sampled 17 inmate-patients at high risk for contracting the coccidioidomycosis (valley fever) infection who were medically restricted and ineligible to reside at NKSP to determine if the patients were transferred out of the institution within 60 days from the time they were determined ineligible. Inspectors found that NKSP was compliant for 15 of the 17 inmate-patients sampled, scoring 88 percent. One inmate-patient was transferred out of NKSP 19 days late (79 days after being deemed ineligible); another, 113 days late (173 days after the ineligibility determination) (MIT 9.009).
- The OIG tested whether inmate-patients who suffered from a chronic care condition were offered vaccinations for influenza, pneumonia, and hepatitis. At NKSP, 14 of 17 chronic care patients sampled (82 percent) received all recommended vaccinations at the required interval for their chronic care conditions. Three patients had no evidence of a pneumonia immunization (MIT 9.008).

The OIG identified the following opportunities for improvement:

- When the OIG reviewed the eUHR for 30 patients who received anti-tuberculosis medications (INH), inspectors found the institution did not always adequately monitor their

condition and treatment. Of the 30 patients sampled, only 11 (37 percent) received their required monthly monitoring during a three-month review period. Nursing staff did not include the inmate-patients' weight change data on the monitoring form (CDCR Form 7406, Tuberculosis (TB) Monthly Monitoring for Drug Toxicity) for 16 patients whose weight had fluctuated during the review period. For one of those patients and three additional patients, inspectors did not find monitoring forms in the patients' eUHR for one or more months of the three-month review period (MIT 9.002).

- The institution did not score well in administering INH to inmate-patients with tuberculosis. Only 18 of the 30 patients sampled (60 percent) received their INH medication at the ordered dosing intervals. Ten patients did not receive all required doses for one or more weeks during a three-month test period. One patient missed six doses of his medication because the PCP did not timely renew the patient's medication order. For another patient, inspectors could not find any evidence in the eUHR that the patient either received or refused his INH medication for one of the three months tested (MIT 9.001).

- The institution scored 74 percent for conducting annual tuberculosis screenings. For 5 of 19 patients sampled, nursing staff did not complete the "history" section of the annual TB screening form (MIT 9.003).

CCHCS Dashboard Comparative Data

As indicated below, the OIG's *proficient* compliance results for colon cancer screening were consistent with the data reported within the CCHCS Dashboard for NKSP.

Preventive Services—NKSP Dashboard and OIG Compliance Results

NKSP DASHBOARD RESULTS	OIG COMPLIANCE RESULTS
Colon Cancer Screening April 2015	Colon Cancer Screening (9.005) April 2015
94%	**97%**

Recommendations

No specific recommendations. The institution scored within the *adequate* range for this indicator and can easily improve its overall rating by adhering to established policy and procedure.

QUALITY OF NURSING PERFORMANCE

Case Review Rating:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

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

Case Review Results

Nursing Sick Call

A total of 234 outpatient nursing encounters were evaluated for NKSP case reviews, with 77 identified deficiencies. Six of the case reviews had deficiencies of a serious nature, as shown below (cases 1, 7, 16, 26, 27, and 67). Areas of deficiencies identified generally fell into the four broad categories of documentation, nursing triage, nursing assessment, and medication administration. Because the majority of the deficiencies were minor, OIG nursing clinicians rated the overall *Quality of Nursing Performance* at NKSP *adequate*.

Nursing Documentation Deficiencies

Eleven minor nursing documentation deficiencies were noted. However, the following findings demonstrate deficiencies in the documentation requirements clearly established by CCHCS nursing policy and protocols, and are part of the institutional nursing education and training orientation.

- Examples of incomplete documentation include the lack of a nursing diagnosis (cases 49 and 76), failure to complete a refusal form (case 10), not documenting how a sick call request was addressed (case 13), failure to document patient education specifically regarding medication noncompliance (case 61), and inadequate description of a wound (case 65).

- In case 16, the nurses did not complete section 2 of the TB Monthly Monitoring for Drug Toxicity form for three months.

Nursing Sick Call Triage Deficiencies

CCHCS policy requires an RN to review every sick call request on the day it is received. The purpose of this review is to identify symptoms that may result in harm to the patient if not addressed on a same-day, urgent/emergent basis, and to schedule all other patients for RN assessments on the next business day. Serious deficiencies occurred for nurses reviewing sick call requests, who failed to recognize the need for same-day RN assessments or provider evaluations. Nursing sick call triage was inadequate. The following examples were found:

- In case 1, the patient reported bleeding from his nose and mouth, and was on a blood thinner. The sick call request was received and reviewed at 7:00 a.m., but the patient was scheduled for a routine RN assessment on the next business day.

- In case 7, the nurse assessed the patient for a complaint of chest pain. The nurse inappropriately released the patient to return to housing before discussing an EKG with an abnormal computer interpretation with the on-call provider.

- In case 26, the patient complained that he felt like throwing up blood. The patient had severe thrombocytopenia (low blood platelet count) and esophageal varices (enlarged fragile blood vessels). This unsafe condition called for an urgent transfer to an emergency department. However, the RN scheduled the patient for a follow-up assessment in two days.

- In case 48, the patient complained of pain in his leg and stated the leg may be infected again. The patient had a history of deep vein thrombosis (blood clots). The sick call request was received and reviewed at 9:50 p.m. on December 30, 2014, but the RN assessment was not scheduled until January 6, 2015. The reviewing RN should have scheduled the patient for an RN assessment the next morning.

- In case 65, the patient submitted a sick call request stating the dressing on a leg abscess was saturated and causing discomfort. He asked to have the dressing changed. The patient had a long history of a non-healing wound, and was monitored by the wound clinic. The RN received the call and reviewed the request on one day, then scheduled the RN assessment for two days later. The RN should have evaluated the patient on the same day.

- In case 67, the patient reported that the right side of his body was going numb and that he could not breathe nor control the right side of his body. The RN did not assess the patient that day. Also, the RN's signature was illegible.

- In case 75, the patient complained of a bite on his hand that was infected and swollen, had drainage, and was very painful. The RN reviewed the request eight hours after it was made and scheduled a next-day appointment, when it should have been reviewed immediately and assessed the same day due to the severity of the complaint.

Nursing Assessment Deficiencies

The majority of nursing encounters demonstrated adequate subjective and objective assessment of medical complaints and appropriate referral to a provider when a higher level of evaluation was needed. Among the deficiencies for inadequate or incomplete assessments, most were determined not likely to have caused harm. In many of these cases, the nurse used an encounter form but left areas on the form blank. The OIG clinicians could not determine if the RN asked important questions, performed necessary measurements, or examined pertinent areas of the body. Nurses also failed to document the presence or absence of common accompanying signs and symptoms. Although nursing assessments were mostly rated as adequate, the following cases demonstrate areas for nursing assessment improvement:

Inadequate or Incomplete Assessments

- In case 11, the patient complained of vomiting, abdominal pain, and jaundice. The RN's objective assessment did not describe the type of bowel sounds, the color of his skin, urine, and sclera (eyes) to determine jaundice, or signs of dehydration.

- Case 31 involved a patient with HIV and end-stage liver disease who submitted a sick call request stating his vision was deteriorating and that it was hard to do anything. The RN noted that he had a pending optometry referral but did not assess the patient's vision to ensure he could safely attend to his daily activities or to ensure he did not have a sudden loss or decrease of visual acuity.

- In case 32, the patient complained of skin irritation on his hands and feet. The RN did not examine the patient's feet to verify whether the skin appeared the same as on his hands and that it was not a different problem requiring different treatment.

- In case 50, the patient reported a leg rash. The RN did not include the date of onset nor pertinent accompanying symptoms (such as itching, fever, fatigue, or chills) to help determine the appropriate intervention.

- In case 52, the patient complained of a rash on his head. The RN did not obtain an adequate history of the problem nor describe the rash's distribution or pattern, skin thickening, or pigmentation changes.

- In case 53, the patient had lower back pain and a sore throat. The RN failed to examine his eyes and ears and failed to assess the back pain.

- In case 54, the patient submitted two sick call requests for knee pain and constipation. The pain assessment lacked documentation of quality of pain, prior history, and range of motion. The RN did not document symptoms related to constipation such as nausea, vomiting, or cramping.

- In case 62, the patient submitted a sick call request stating he was having complications from an upper endoscopic procedure he had two months prior. Although the RN noted the type of procedure, the nurse did not obtain an adequate subjective assessment of throat pain.

- In case 63, the patient reported having "pink eye." The RN did not test visual acuity or examine the eye for any foreign body, redness, swelling, or discharge.

Failure to Address All of the Patient's Concerns or Requests

Another problem identified was the failure of the nurses to address all of a patient's complaints or to document the reason whenever a complaint was not addressed. The following individual cases exemplify these patterns and should be reviewed for quality improvement.

- In case 7, the RN did not address the patient's request for nasal spray.

- In case 9, the patient submitted a sick call request for arthritis pain he had been experiencing in his right leg for the past year. A nurse interpreted this as a medication refill request and noted on the form that a medication renewal request was submitted. The RN did not meet with the patient to ensure he had no complaints. A month later the patient submitted another sick call request asking for medication for headaches and arthritis in his legs. Nurses did not obtain a new order for his ibuprofen nor perform a nursing assessment.

- In case 19, a 63-year-old inmate-patient had multiple chronic medical conditions, including asthma, cardiac disease, and diabetes. The patient submitted two sick call requests received and reviewed by an RN on the same date. The RN signed the bottom of the forms three business days later. The RN did not assess the patient's complaint of hair loss to ensure there was no infection of his scalp, nor did the RN address his complaints of nasal drip and cough. The nurse noted on the form that the patient agreed to wait until a scheduled provider visit in 18 days.

- In case 36, the patient complained of seasonal allergy symptoms. The RN examined the patient but was unable to see the left eardrum due to wax. The RN did not remove the earwax as permitted by the nursing protocol.

- In case 47, the patient complained of headaches, sore eyes, shoulder pain, and stomach issues. The RN did not assess the patient's complaint of headaches.

- In case 53, the RN did not perform an assessment of the patient's second complaint of back pain on the sick call form.

- In case 67, the patient requested a refill of ibuprofen. He complained of swelling in his legs and back. The medication was refilled, but there was no assessment of the swelling.

- In case 71, the patient reported extreme hip pain and requested a refill of his pain medication. The refill order was obtained, but the patient was not scheduled for an RN assessment. The OIG clinicians determined the RN should have assessed this extreme hip pain to ensure there was no acute issue and that the patient could walk safely.

- In case 74, the RN did not assess the patient's second complaint, which was pain and swelling in his legs due to old gunshot wounds.

Medication Management and Administration

Outpatient medication administration was usually timely and reliable. During the onsite inspection visit, the OIG noted that the medication line LVNs participated in morning huddles. Nursing medication administration was rated as adequate. See the *Pharmacy and Medication Management* section for additional findings. The following examples should be reviewed for quality improvement:

- In case 8, the patient submitted a sick call request for a refill of his asthma inhaler. The RN obtained a new order from the provider, but the patient did not receive the inhaler until he submitted a second request 12 days later.

- In case 11, the nurse did not document the date on the keep-on-person medication administration record.

- Case 13 involved a patient with an order for phenytoin (for seizures) each day. The patient refused the medication on 23 days in July 2014 with nurses failing to notify the provider.

- In case 50, the patient reported a leg rash. The RN assessed the patient and gave him triamcinolone cream. This medication was not included in the nursing protocol "Inflammatory Skin Conditions—Rash," and required a provider order. An order was written five business days later.

- In case 75, the patient was seen on a Friday by a provider for an ear infection. It was the patient's third provider visit in three days for this problem. The provider ordered a keep-on-person antibiotic. The RN did not arrange for the patient to receive a supply of the medication that same day to take over the weekend. However, the antibiotic was dispensed by the pharmacy to the patient on Saturday.

Reception Centers, Inter- and Intra-System Transfers, and Hospitalizations

Deficiencies were found related to missed medication doses for patients transferring into NKSP, after return from hospitalization, and after transferring from the CTC to a housing unit. The OIG also found incomplete nursing documentation on transfer forms for patients transferring out of NKSP. The problems identified appear to be mostly system issues that need to be addressed by NKSP executive staff. Transfers were found to be adequate. See the *Inter- and Intra-System Transfers* and *Pharmacy and Medication Management* sections for specific findings.

Emergency Care

Nurses working in the TTA and as emergency responders at NKSP were found to be knowledgeable and skillful in providing emergency nursing care. Documentation demonstrated evidence of adequate nursing decision-making and good performance during some challenging cases. A few deficiencies were found, such as insufficient monitoring of vital signs and inadequate assessments, but none was likely to contribute to patient harm. Nursing emergency care was adequate, with the deficiencies in this area are described in the *Emergency Services* section.

Specialized Medical Housing

At the time of the OIG inspection, NKSP had six medical beds in the CTC. Nursing services in the CTC were found to be inadequate due to nursing practice issues primarily related to a failure to follow provider orders, failure to communicate timely with providers on urgent cases, and incomplete nursing care plans. Examples of deficiencies are found in the *Specialized Medical Housing* section.

Onsite Clinician Inspection

During the onsite visit by the OIG clinicians, the nurses in C yard were active participants in morning huddles, coordinating and communicating care management needs of patients. For example, the clinic RN effectively facilitated the morning huddle by efficiently covering such topics as patients with TTA visits, transfers out and in, patients who were noncompliant with medications, patients who returned from outside hospitals, significant labs or diagnostic reports, PCP and RN line backlogs, add-ons, and referrals from the previous day. The morning huddle started with good attendance, including the provider, sick call RNs, clinic LVNs, the SRN II, custody, medication LVNs, and office technicians. The primary care team did not use a huddle script, but the RN

appeared knowledgeable about the topics to be covered. The SRN II reported that all clinics manage their huddles in a similar manner.

The OIG clinicians visited various clinical areas and freely spoke with nursing staff during walking rounds, including specialty services, preventive services, reception center, CTC, TTA, Facility C, and Facility D. Supervising nurses, RNs, and LVNs were knowledgeable about their duties and responsibilities, the patient populations within their assigned clinical areas, specific communication channels for making requests and reporting issues, and the nursing performance and improvement monitoring strategies currently underway at NKSP. Nursing staff at all levels verbalized having no major barriers with initiating communication with PCPs, nursing supervisors, and custody staff in meeting patient care needs and providing nursing care. The OIG RN reviewed ten supervisory files for nurses assigned to yard clinics, receiving and release, and public health, as well as one supervisory file for the nurse instructor. Two of the 11 files did not have a current annual performance evaluation.

Recommendations

The case review process revealed that although the quality of nursing for outpatient care at NKSP was rated *adequate*, it still needs improvement. Strategies for quality improvement are indicated for ongoing nursing education and monitoring of nurses' performance.

- The chief nurse executive and supervising registered nurses should review and discuss the current process for evaluating an RN's competency to ensure it is an accurate measure of a nurse's knowledge and skill.
- Nurses must prioritize sick call requests appropriately, recognizing cases requiring same-day assessment. SRNs should perform routine audits to evaluate the RNs' dispositions.
- Nurses who triage sick call requests should review the eUHR for the patient's medical history.
- RNs should not leave elements on CCHCS nursing protocol encounter forms blank, and they must document the presence or absence of usual accompanying symptoms of the patient's condition.
- Nurses should develop and document nursing diagnoses and conclusions in accordance with NANDA[3] taxonomy.
- Handwriting and signatures should be legible. All nurses should use a signature stamp.

[3] Previously North American Nursing Diagnosis Association, now officially NANDA International, Inc.

- When a sick call request is reviewed late in the evening on the third watch and requires same-day RN assessment, the patient should be sent to the TTA.
- The chief nurse executive should determine the reasons the SRN IIs are not identifying the failure of nurses to follow CCHCS policy for medication refusals and "no-shows."

QUALITY OF PROVIDER PERFORMANCE

In this indicator, the OIG physicians provide a qualitative evaluation of the adequacy of provider care at the institution. Appropriate evaluation, diagnosis, and management plans are reviewed for programs including, but not limited to, nursing sick call, chronic care programs, TTA, CTC, and specialty services. The assessment of provider care is performed entirely by OIG physicians. Therefore, 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 245 NKSP medical provider encounters and identified 91 deficiencies related to provider performance. Of those 91 deficiencies, 23 were of such magnitude that, if left unaddressed, they would likely contribute to patient harm. The OIG rated NKSP provider performance *inadequate* overall.

Assessment and Decision-Making

The following deficiencies in provider encounters reviewed demonstrated inadequate assessment and unsound medical decision-making:

- In case 1 (also discussed in *Pharmacy and Medication Management*), on March 8, 2015, the patient was discharged from the community hospital with a diagnosis of acute blood loss, likely secondary to duodenal ulcer, requiring four units of transfused blood. The patient did not receive the hospital's recommended ulcer medication, omeprazole.

- In case 7 (also discussed in *Emergency Services*), the on-call PCP failed to carefully assess a patient with a new onset of chest pain during a TTA telephone call. The assessment lacked cardiac risk stratification and review of a markedly abnormal EKG. The patient returned to his assigned housing unit, where he suffered a myocardial infarction with cardiac arrest two days later. Fortunately, the provision of advanced cardiovascular life support (ACLS) successfully restored the patient's heart function, allowing the patient to be transferred to the community hospital. The patient underwent successful cardiac stent placement and returned to NKSP three days later.

- In case 9, the provider did not prescribe a seizure medication as recommended in the hospital discharge instructions.

- In case 13, an x-ray of the right shoulder showed a possible impaction fracture, but the provider did not address this on the patient's subsequent visits.

- Again in case 13 (also discussed in *Pharmacy and Medication Management)*, the patient, with treatment for seizures, returned from a hospitalization on June 19, 2014, with orders for 300 mg of phenytoin daily. The nurse obtained a telephone order from the provider, administered the phenytoin that evening, and documented the encounter on a handwritten medication administration record (MAR). The handwritten dose was illegible and appeared to read either 300 or 800. On June 20, 2014, the printed MAR from the pharmacy listed the medication dose as 800 mg. The pharmacist questioned the provider about the high dose, and the provider confirmed the dosage of 800 mg daily. The provider failed to check the hospital discharge instructions for this unusually high dose of phenytoin, and failed to document why he ordered a dose different than the hospital instructions.

- Case 15 (also discussed in *Specialized Medical Housing*) involved a hypotensive patient with a systolic blood pressure of 70. Despite the low blood pressure, the provider failed to stop some of the multiple blood pressure medications—metoprolol, furosemide, and spironolactone. Furthermore, the patient, who was recently hospitalized for hyponatremia (low salt level in blood) for which he was receiving salt tablets, had an inappropriate order for a low sodium diet.

- In case 16 (also discussed in *Specialized Medical Housing*), the provider failed to obtain baseline visual acuity and color testing when starting the patient on ethambutol (medication for tuberculosis). It is recommended that patients receiving ethambutol as part of combination therapy receive visual testing to monitor for side effects, most notably optic neuritis.

- In case 17, the patient had severe neutropenia (low white blood cell count). The provider failed to monitor vital signs for any suggestion of infection and obtain a complete blood count with differential to assess the absolute neutrophils count.

- In case 26, the patient had severe thrombocytopenia (low blood platelet count) and esophageal varices (enlarged fragile blood vessels); the platelet count at which a patient bled previously can be a good predictor of future bleeding. This patient had a prior gastrointestinal bleed with a platelet count of 14,000. When the patient's platelet count dropped to 11,000, the provider failed to transfuse platelets or provide romiplostim (a medication to stimulate platelet production). Also, the provider failed to advise the patient to alert medical staff with any signs of bleeding, not just "profuse bleeding," and to avoid contact sports or fighting.

Anticoagulation Management

NKSP providers had difficulty managing anticoagulation due to incorrect warfarin adjustments according to the patient's INRs (blood coagulation levels). Furthermore, CCHCS's anticoagulation care guide was not followed.

- In case 1, for a patient with an INR of 2.1 (therapeutic target range of 2.5 to 3.5), the provider increased warfarin from 5 mg to 6 mg daily. This was a 20 percent increase, instead of the recommended 10 percent increase. This placed the patient at risk of over-anticoagulation and bleeding.

- In case 22, for a therapeutic INR at 2.2, the provider inappropriately decreased the warfarin doses by 16 percent.

Enoxaparin, a low molecular weight heparin (a blood thinner) was used extensively at NKSP. Improper prescribing of enoxaparin was identified. This placed patients at risk for thromboembolism, bleeding, or possible serious adverse effect of heparin-induced thrombocytopenia.

- In case 1, the patient had mechanical mitral valve (artificial heart valve). The INR was subtherapeutic at 1.5 (acceptable range 2.5 to 3.5). The provider should have extended the enoxaparin until the INR was at a therapeutic level.

- In case 19, the enoxaparin was not indicated as an anticoagulation treatment for atrial fibrillation.

- In case 21, the prescribed enoxaparin did not have a progress note documenting the reason for enoxaparin.

Emergency Care

The TTA providers usually evaluated patients timely and made adequate assessments. Triage decisions were sound, and patients were sent to the appropriate levels of care. However, there were five serious deficiencies identified related to the quality of provider care in emergency services. The cases below are also discussed in the *Emergency Services* indicator.

- In case 7, the on-call PCP failed to carefully assess a patient with a new onset of chest pain during a TTA telephone call. The assessment lacked cardiac risk stratification and review of a markedly abnormal EKG. The patient returned to his assigned housing unit, where he suffered a myocardial infarction with cardiac arrest two days later. Fortunately, the provision of ACLS successfully restored heart function, allowing the patient to be transferred to the community hospital. The patient underwent successful cardiac stent placement and returned to NKSP three days later.

- In case 19, the PCP felt the patient's chest pain suggested myocardial ischemia, but the PCP failed to prescribe nitroglycerin.

- In case 26, the patient was involved in a physical altercation and sustained multiple facial injuries. His chronically low platelet count (31,000) placed him at risk for serious brain hemorrhage. A CT scan of the head or admission of the patient to the correctional treatment center (CTC) for observation was necessary.

- For another TTA encounter in case 26, the on-call PCP failed to appropriately assess the patient's complaint of coughing up blood. The platelet count had dropped as low as 11,000 since the above-described event, further increasing this patient's risk for severe blood loss. The patient had end-stage liver disease and esophageal varices, which further increased bleeding risk.

- In case 27, the patient had signs and symptoms of acute neurological deficits. In addition, the patient had a recent cervical spine x-ray that showed severe collapse of a cervical vertebrae. The provider failed to evaluate the patient for spinal cord compression with an urgent MRI scan or transfer to a higher level of care.

Chronic Care

Chronic care performance was mostly adequate, as most providers demonstrated good care with regard to hypertension, asthma, hepatitis C, and cardiovascular disease. However, as the following examples demonstrate, there were deficiencies in this area:

- In case 5, the patient with cardiomyopathy and asthma did not receive a pneumococcal vaccine.

- In case 11, the provider failed to discuss hepatitis C treatment with the patient. Also, the provider should have addressed the lab test which was unclear as to whether the patient had immunity to hepatitis B. The provider should have repeated the hepatitis B surface antibody titer (antibody level) or offered hepatitis B vaccine.

- In case 19, the provider failed to provide an inhaled corticosteroid for a poorly controlled asthma patient (asthma control score of 16).

- In case 24, the provider stated that the patient's hypertension was "at goal" for a patient with blood pressure of 147/83.

The management of diabetes was occasionally inadequate.

- In case 4, the patient had poorly controlled diabetes with a hemoglobin A1c (HbA1c) of 10.1 and elevated pre-meal blood glucose levels. The prescribed increase in the insulin glargine dose was insufficient, as was the follow-up interval to ensure proper management of the fasting glucose.

- In case 24, the patient had poorly controlled diabetes with an HbA1c of 9.9. This required monitoring blood glucose levels and medication changes with provider follow-up sooner than one to two months.

- In case 24, the provider did not ask the patient with an HbA1c of 13.0 for symptoms of severe hyperglycemia like polydipsia and polyuria (increased drinking and increased urination). The provider failed to document any signs of dehydration, which might have required intervention.

- In case 25, the provider's assessment was "diabetes not at goal" but the provider inappropriately decreased the metformin doses (diabetes medication). The patient was also not offered a pneumococcal vaccine.

- In case 77, the provider failed to adequately adjust the patient's basal insulin for optimal fasting glucose levels and failed to arrange a follow-up visit to assess the medication adjustment.

Specialty Services

Institution providers generally referred patients appropriately and reviewed specialty reports timely; however, not all the reports were properly signed by the providers. Specialty care performed well except in two cases:

- In case 26, the patient, with severe thrombocytopenia, was recommended romiplostim (medication to stimulate platelet production) by a hematology consultant on December 22, 2014, but it was never provided to the patient.

- In case 27, the patient with plasmacytoma (cancer) and with extensive lytic lesions of the spine, pelvis, and rib cage, did not receive oncology-recommended bisphosphonates.

Pain Management

NKSP providers appropriately managed acute pain, chronic arthritic pain, neuropathic pain, and cancer pain. However, there was one deficiency:

- In case 27, above, for the patient with plasmacytoma, a provider noted a normal physical exam, which did not reflect the patient's neck pain. There was no documentation of a pain-management plan to address the patient's neck pain.

Health Information Management

Providers generally documented outpatient and TTA encounters on the same day, but illegibility was found in cases 1, 4, 10, 11, 15, 16, 17, 19, 26, 27, 28, 29, and 30. Illegible progress notes pose a

significant medical risk to patients, especially when other staff must review previous medical care or when a patient is transferred to a different care team.

Onsite Inspection

The NKSP providers were rotating through all the clinics, the TTA, and the CTC every six months. This impaired continuity of patient care. The providers worked ten hours per day, four days per week, and saw approximately 20 patients per day. Many providers felt overworked, especially with a 1.5 physician vacancy and one provider out on long-term sick leave. The OIG found most of the providers were supportive of the CME. All providers attended the daily meeting as they discussed significant medical care issues that occurred on the previous day. Morning huddles led by the providers and attended by nurses and office technicians were productive. Most providers expressed general job satisfaction with their positions and overall morale was good.

Conclusion

The volume and severity of the deficiencies in provider performance led to an *inadequate* rating in *Quality of Provider Performance*. Provider deficiencies led to inadequate ratings in 10 of 30 physician-reviewed cases.

Recommendations

The OIG recommends provider continuing medical education for the management of diabetes, thrombocytopenia, neutropenia, and anticoagulation. NKSP should commit itself to a primary care home model, with each patient assigned to a primary provider to ensure continuity of care. All physician vacancies should be filled as quickly as feasible to ensure the providers are not overworked.

The OIG recommends NKSP improve anticoagulant therapy (warfarin and enoxaparin), and have a process in place to reduce the risk of anticoagulant-associated patient harm. Patients receiving anticoagulants should receive individualized care through a defined process, such as a Coumadin clinic, that includes standardized ordering, dispensing, administration, monitoring, and education.

NKSP should have an effective medication reconciliation process. The providers should compare the discharge medications from hospital discharge summaries with the facility's current medications to complete accurate medication reconciliation. This is necessary to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions. It should be done at every transition of care.

RECEPTION CENTER ARRIVALS

Case Review Rating:
Adequate
Compliance Score:
74.5%

Overall Rating:
Adequate

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 (including tuberculin-screening tests), initial health assessments, continuity of medications, and completion of required screening tests; address and provide significant accommodations for disabilities and health care appliance needs; and identify health care conditions needing treatment and monitoring. The patients reviewed for reception center cases are those received from non-CDCR facilities, such as county jails.

Case Review Results

Clinicians reviewed 51 reception center patient encounters, including information from sending county jails. The reception center process at NKSP was rated *adequate*, with the majority of arriving inmates receiving timely initial assessments and determination of health care needs. All nine deficiencies found were minor. Nurses performed initial health screenings well and completed timely assessments identifying patients with ongoing medical needs.

The reception center portion of care for case 15 was managed well. The patient, with end-stage liver disease in poor control, arrived through the triage and treatment area, was sent to the reception center for initial screening, and was then transferred appropriately to the correctional treatment center for further care.

Examples of minor deficiencies are listed below.

- In cases 19, 34, and 38, deficiencies were found related to delayed medications. This issue is addressed in the *Pharmacy and Medication Management* section.
- In cases 9 and 26, deficiencies were found with provider performance.
- In case 35, a baseline EKG was completed 40 days after it was ordered.
- In case 23, nurses did not follow the provider order to check blood pressures for seven days.

Onsite Clinician Inspection

The onsite visit noted no auditory privacy for the interviewed patients during initial screening in the receiving and release (R&R) clinic. This issue is discussed in *Health Care Environment*.

Compliance Testing Results

The institution received a marginally *inadequate* score of 74.5 percent for the *Reception Center Arrivals* indicator. Although NKSP scored well in five of the seven tests conducted, improvement is needed in two areas that dropped the overall score significantly.

As indicated below, NKSP scored within the *proficient* level in four areas:

- When the OIG tested 20 inmate-patients who arrived at the NKSP reception center to determine whether nursing staff conducted an initial health screening of the patients on their day of arrival, the institution received a score of 90 percent. Nursing staff timely completed the screening for 18 of the patients; for the two other patients, nursing staff failed to answer all questions on the Initial Health Screening form (CDCR Form 7277). For example, staff did not answer questions about whether the patient had diabetes, whether medications arrived with the patient, and whether the patient was scheduled to be seen by a specialist or provider (MIT 12.001). For 19 of those 20 patients (95 percent), registered nurses (RN) completed the assessment and disposition sections of the screening form on the same day staff conducted the initial screening of the patient. In one instance, the RN failed to sign the CDCR Form 7277 (MIT 12.002).

- The OIG found that providers evaluated 18 of the 20 inmate-patients (90 percent) and timely completed a written history and physical examination within seven calendar days of arrival. For two patients, the history and physical examination was completed one and three weeks late, respectively (MIT 12.004).

- For intake tests ordered for reception center arrivals, the provider timely reviewed and communicated the test results for 18 of the 20 inmate-patients sampled (90 percent). For one patient, the provider reviewed and communicated the test results one day late. For another patient, the provider failed to document the date on which the test results were communicated on the Notification of Diagnostic Test Results form (CDCR Form 7393) (MIT 12.006).

The institution scored adequately in the following test:

- For intake tests completed for reception center arrivals, the provider timely ordered the required tests for 17 of the 20 sampled inmate-patients (85 percent). For the other three patients, the provider did not order gonorrhea and chlamydia lab tests; these tests are required for patients younger than 36 years. In addition, for one of the three patients who received incomplete tests, the tests were ordered three weeks late (MIT 12.005).

The institution has opportunities for improvement in the following two areas:

- When OIG tested the inmate-patients who arrived at NKSP's reception center after January 15, 2015, to determine whether the patients were offered or administered the coccidioidomycosis (valley fever) test, inspectors found that only four of the six applicable patients (67 percent) were timely offered the test and had their test results read. Inspectors did not find evidence that two patients were administered or offered the valley fever skin test after their arrival on January 16, 2015, and February 6, 2015, respectively (MIT 12.008).
- Although the OIG found that all of the 20 sampled patients received a timely TB test upon arrival at NKSP's reception center, only one patient's TB skin test result (5 percent) was read by an RN, PHN, or PCP. For the other 19 patients, their TB test results were read by an LVN (MIT 12.007).

Recommendations

No specific recommendations. The institution received an overall rating of *adequate* for this indicator and can easily address areas needing improvement by adhering to established policy and procedure.

SPECIALIZED MEDICAL HOUSING

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

***Case Review Rating**:*
Inadequate
***Compliance Score**:*
100%

Overall Rating:
Inadequate

Case Review Results

North Kern State Prison had 16 CTC beds on site with 10 beds designated for mental health and 6 beds for medical. During the OIG clinicians' visit, five medical beds were occupied. The OIG clinicians reviewed 43 provider and 90 nursing encounters. Provider performance was inadequate for this indicator. Nursing services were inadequate due to a failure to follow provider orders, inadequate care coordination with other clinical staff, and lack of timely communication with providers on urgent cases.

Provider Performance

Multiple PCPs provided care in the CTC. The providers generally performed admission exams and follow-up care timely. They dictated discharge summaries for all CTC patients transferring to the general population. The 43 CTC provider encounters reviewed identified 6 important deficiencies, which contributed to the *inadequate* rating.

- In case 1, the patient was discharged from a community hospital after treatment for acute blood loss requiring blood transfusion. The blood loss was likely secondary to a duodenal ulcer. After his return to NKSP and placement in the CTC, the patient did not receive the hospital-recommended omeprazole (a proton pump inhibitor to reduce stomach acid, and allow ulcers to heal).

- Also in case 1, the provider wrote in the progress note to continue the pantoprazole (medication similar to omeprazole), but failed to write the order.

- In case 15, for a hypotensive patient with a systolic blood pressure of 70, the provider failed to reduce some of the blood pressure medications—metoprolol, furosemide, and spironolactone. Furthermore, the patient, who was recently hospitalized for hyponatremia (low salt level in blood) for which he was receiving salt tablets, had an inappropriate order for a low sodium diet.

- For another case 15 encounter, the progress note was illegible. Furthermore, the PCP failed again to change blood pressure medications for this hypotensive patient with a systolic blood pressure of 86.

- Also in case 15, the PCP failed to administer naloxone (antidote for morphine) to a patient with altered mental status who was recently started on morphine sulfate.

- In case 16, the provider failed to obtain baseline visual acuity and color testing when starting the patient on ethambutol. It is recommended that patients receiving ethambutol as part of combination therapy receive visual testing to monitor for the medication's side effects, most notably optic neuritis.

Nursing Performance

Three important individual deficiencies and a pattern of less concerning deficiencies led to the inadequate rating for nursing performance. Deficiencies included failure to initiate adequate nursing care plans, failure to follow or implement providers' orders, failure to communicate abnormal findings to the provider, inadequate nursing assessments, and incomplete documentation. Of the 90 nursing encounters reviewed, there were 31 deficiencies. Three deficiencies had the potential to contribute to patient harm:

- In case 15, the patient was admitted from a local hospital as a reception center patient. The nursing care provided to the patient was inadequate. The patient had ascites (abnormal accumulation of fluid in the abdomen), and the provider orders included daily weight checks and measuring of his fluid intake and urine output. The nurses neither consistently measured the urine output nor advised the patient to use a hand-held urinal each time he voided. On March 9, 2015, the patient had no urine output during the morning and afternoon shifts. The patient's weight and abdominal girth increased, yet the RNs did not recognize the problem until the following afternoon. On March 10, 2015, the CTC RN did not adequately monitor the patient's low blood pressure while waiting for emergency medical services personnel to arrive, and failed to assess the patient's mental status. At 2:10 p.m., the nurse failed to recheck a low blood pressure (82/59) until 6:26 p.m., at which time it was 87/56. On April 4, 2015, the nurse failed to timely notify the provider of the patient's deteriorating condition. The RN noted at 6:30 a.m. that the patient's lungs sounded moist, his abdomen was distended and firm, and his legs were severely swollen. The patient had decreased urine output and periods of confusion. The RN did not notify the provider until 4:42 p.m.

- In case 18, the patient was admitted after a hospitalization. The RN failed to initiate the care plan of measuring intake and output of all fluids while the patient received intravenous fluids. The admitting RN also failed to notify or make a referral to mental health when the patient reported severe depression. The patient was not seen by a mental health clinician for over a month.

- In case 43, the patient was admitted to the CTC after a hospitalization. The RN noted a blood pressure clonidine patch on the patient's chest. The RN documented removing the patch because the patient was on other blood pressure medications. The RN did not contact the provider for an order to discontinue the clonidine. The next day, the provider examined the patient and noted the clonidine patch had been "just stopped" and ordered oral clonidine for three days to prevent the adverse reaction of event rebound hypertension, an excessive elevation in blood pressure from rapid withdrawal of this medication. This deficiency was also reported under *Pharmacy and Medication Management*.

Examples of minor deficiencies were:

- Nursing care plans did not always address all of the patient's important issues (cases 3, 15, 39, 40, 41, and 43). Several of these cases are described below.
- In case 3, there was a failure to weigh the patient as ordered by the provider.
- In case 14, a dose of an essential medication was not given and the nurse failed to document the reason.
- In case 39, the admitting nurse documented the patient's stated weight rather than his actual weight, which was important for his medical condition. The nursing care plan was inadequate. It did not address the actual or potential issues including weight monitoring, poor appetite, recent history of altered mental status, intake and output measurement, or physical therapy.
- In case 41, the nursing care plan was inadequate. The RN failed to identify mobility impairment as the patient used crutches to walk, had the potential for infection due to open wounds, displayed activity intolerance due to pain, and exhibited potential constipation with the use of pain medication.
- In case 43, the RN did not initiate a care plan for post-operative nutritional status and a liquid diet. The admitting RN took over three hours to call the provider for a pain medication order. On June 20, 2014, the patient weighed 145 pounds. If this weight and the admission weight were correct, the patient had lost 15 pounds in four days. The RN did not communicate this information to the provider or the dietician. On July 13, 2014, the RN did not adequately assess the patient after vomiting, did not listen for bowel sounds, and did not palpate his abdomen to check for tenderness and distention.

Health Information Management

The health information management services were adequate. The provider and most nursing progress notes were legible and timely scanned into the eUHR, although nurses' signatures were sometimes illegible. Consultation reports were generally available for the providers to review and

were timely scanned into the eUHR. The CTC discharge summaries were timely completed and scanned into the eUHR.

Onsite Visit

CTC staff reported that they maintained weekly huddles to review all cases and daily huddles for significant patient-specific cases. During the OIG onsite visit, the CTC unit and its equipment were clean.

Conclusion

OIG found the specialized medical housing care to be inadequate. The compliance score was *proficient*; however, compliance only reviewed a small sample of encounters and addressed only administrative issues, such as timely nursing visits and frequency of provider visits and provider progress notes. Case reviews, in contrast, focused on the quality of care, concluding that patients did not receive appropriate care.

Compliance Testing Results

The institution received a *proficient* score of 100 percent for the *Specialized Medical Housing* indicator, which focused on the institution's correctional treatment center (CTC). The following comprised the five test results for this indicator:

- For all ten inmate-patients sampled, nursing staff timely completed an initial assessment on the day the patient was admitted to the CTC (MIT 13.001).
- The OIG found that providers evaluated all ten inmate-patients within 24 hours of admission and completed a written history and physical examination within 72 hours of admission (MIT 13.002, 13.003). Providers also completed their subjective, objective, assessment, plan, and education (SOAPE) notes at required 14-day intervals for all ten patients (MIT 13.004).
- When the OIG observed the working order of a sample of call buttons in the CTC patient rooms, inspectors found that the call buttons were in good working condition. Inspectors also found the call button test log up to date and complete. Lastly, according to knowledgeable staff working in the CTC, custody officers and clinicians respond and access inmate-patients' rooms in less than one minute when an emergent event occurs (MIT 13.101).

Recommendations

There is room for improvement for patient care within the CTC. NKSP must ensure there is a process to perform continuous quality monitoring and provide nurses with training on the above issues. Even though the number of CTC patients is small, CTC nurses could benefit from their own nursing staff meetings and quality improvement team. The improvement team could identify indicators pertinent to the CTC, perform audits, collect data, analyze findings, develop and implement improvement strategies, and monitor change. One example for improvement is for nursing care plans. NKSP nursing staff meeting minutes show that care plan training was provided to nurses working in all clinical areas last summer (2014). However, the OIG clinicians found care plans were still a problem. Medication management could also be improved. Medication administration was challenging in the CTC due to the frequent changes in orders received on all shifts and the complexity of treatment regimens.

The SRN II should provide closer clinical supervision with more time spent on the unit mentoring the nurses. The SRN II should observe the nurses, review charts, and visit the patients. This may offset deficiencies like failure to measure urine output and failure to obtain actual weights. The SRN II should also help identify medication errors such as discontinuing the clonidine patch without an order. The error had not been identified prior to the OIG inspection.

The Quality Management Committee should incorporate review and improvement plans for medication errors. Providers would benefit from continuing medical education for the management of patients with multiple complex medical conditions. Providers should thoroughly review and address all hospital discharge summaries and instructions.

SPECIALTY SERVICES

Case Review Rating:
Adequate
Compliance Score:
83.3%

Overall Rating:
Adequate

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

Case Review Results

The OIG clinicians reviewed 92 events related to *Specialty Services*, the majority of which were specialty consultations and procedures. Seventeen deficiencies were found in this category.

Provider Performance

NKSP providers appropriately referred patients to specialist providers when needed. Occasionally, providers failed to process specialist recommendations. These episodes are discussed further in the indicator *Quality of Provider Performance*.

Specialty Access

Case review found that specialty services were provided within excellent time frames for both routine and urgent services, and recommendations were generally addressed timely. However, delays in care occurred in cases 14, 26, and 29.

- In case 14, an abdominal ultrasound was not performed as requested.
- In case 26, oncology recommended the patient receive romiplostim (a platelet-stimulating factor) on December 22, 2014; however, the patient did not receive the medication until more than one week later.
- In case 29, a hematologist requested an ultrasound of the patient's abdomen to be performed prior to the patient's follow-up appointment in three to four weeks, but the ultrasound was not performed until nine weeks later.

Health Information Management

Case review found that specialty reports were generally retrieved, sent to providers for their review, and scanned into the eUHR in a timely manner. However, a few exceptions are identified below.

- In cases 2, 19, 27, and 29, some specialty reports were neither retrieved from nor found in the eUHR. In case 19, cardiology evaluated the patient, but the consultation report was not available for the provider to review.

- Specialty reports were sometimes not signed off by a provider. This deficiency was found in cases 1, 17, and 19. Most cases showed that providers were aware of the specialty reports and their recommendations at follow-up visits.

Compliance Testing Results

The institution received an *adequate* overall score of 83.3 percent in the *Specialty Services* access indicator. As indicated below, NKSP scored in the *proficient* range for five out of seven tests:

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

- For 14 of 15 inmate-patients sampled (93 percent), routine specialty service appointments (or services) occurred within 90 calendar days of the provider's order. For one patient, the routine appointment was provided nine days late (MIT 14.003). In addition, providers reviewed 14 of the 15 related specialists' reports (93 percent) within three business days after the service was provided. Inspectors did not find evidence that the provider had reviewed a consultant's report for one patient (MIT 14.004).

- For 13 of 15 inmate-patients sampled (87 percent), high-priority specialty service appointments (or services) occurred within 14 calendar days of the provider's order. For two patients, the high-priority appointments were provided 3 and 12 days late, respectively (MIT 14.001). The OIG also found that providers timely reviewed the specialists' reports within three business days for 14 of the 15 sampled patients (93 percent). The provider reviewed one patient's report two days late (MIT 14.002).

The OIG identified the following opportunities for improvement at NKSP:

- For 19 patients sampled who were denied a specialty service, inspectors found that 12 (63 percent) received timely notification of the denied service. California Correctional Health Care Services policy requires that when a specialty service is deferred or denied, the provider will communicate the decision to the patient and provide the patient with alternate treatment strategies during a follow-up visit within 30 days. For six patients, this requirement was not met at all; one other patient was offered a follow-up visit 11 days late and refused it (MIT 14.007).

- When inmate-patients are approved or scheduled for specialty services appointments at one institution and then transfer to another institution, policy requires that the receiving

institution ensure that the patient's appointment is timely rescheduled or scheduled, and held. For 8 of the 15 patients sampled (53 percent), the patient received the specialty service appointment within the required action date. However, three patients did not receive their specialty service appointment at all, and four patients received their appointment from one to 145 days late (MIT 14.005).

Recommendations

Although both the case review and compliance assessed this indicator at the *adequate* level, the institution could easily improve its overall rating by adhering to established policy and procedure and implementing the following specific recommendation:

- The OIG recommends NKSP review the deficiencies in this indicator and utilize the quality improvement process, with the goals of improving the retrieval of specialty reports in a timely fashion, having them reviewed and signed off on by a provider, and ensuring they are available to the provider at the time of the provider follow-up appointment.

SECONDARY (ADMINISTRATIVE) QUALITY INDICATORS OF HEALTH CARE

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

To test both the scored and non-scored areas within these two secondary quality indicators, OIG inspectors interviewed key institutional employees and reviewed documents during their onsite visit to NKSP in April 2015. They also reviewed documents obtained from the institution and from CCHCS prior to the start of the inspection.

INTERNAL MONITORING, QUALITY IMPROVEMENT, AND ADMINISTRATIVE OPERATIONS

Case Review Rating:
Not Applicable
Compliance Score:
48.1%

Overall Rating:
Inadequate

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

Compliance Testing Results

The institution scored poorly in the *Internal Monitoring, Quality Improvement, and Administrative Operations* indicator, receiving an overall score of 48.1 percent. Although NKSP received a score of 100 percent in three of the nine test areas applicable to the institution, improvement could be easily achieved in several areas.

The low-scoring areas are described below:

- The OIG reviewed the institution's Quality Management Committee (QMC) meeting minutes for a recent six-month period to determine if the QMC met monthly, evaluated program performance, and took action when improvement opportunities were identified. Inspectors found that meeting minutes for five of the six months did not address whether the QMC used Scorecard data to evaluate and discuss each program's performance, identify where improvements were needed, and identify improvement action plans. Also, no QMC meeting was held during the month of November 2014. Consequently, the institution received a score of 0 percent for this test (MIT 15.003).

- The OIG inspectors also determined that NKSP did not take adequate steps to ensure the accuracy of its Dashboard data reporting, scoring 0 percent for this test. According to the institution's CEO, Dashboard data has been discussed at QMC meetings and Medical Program Sub-Committee meetings in the past, but those discussions were not formally documented (MIT 15.004).

- When the OIG inspected documentation for 12 emergency medical response incidents reviewed by the Emergency Medical Response Review Committee (EMRRC) during the prior six-month period, inspectors found that the current Emergency Medical Response

Event Checklist (revised June 2011) was not included for any of the incidents reviewed. Therefore, NKSP scored 0 percent for this test (MIT 15.007).

- When the OIG reviewed NKSP's 2014 Performance Improvement Work Plan, inspectors found that the institution improved or reached the targeted performance objectives for only two of its eight quality improvement initiatives (25 percent). For the six remaining initiatives, the institution did not improve performance or reach its performance objective, or did not identify the status of its performance objective (MIT 15.005).

- When the OIG reviewed the summary reports and related documentation for three medical emergency response drills conducted in the prior quarter, inspectors found that one of the three drills did not include a completed Medical Report of Injury or Unusual Occurrence (CDCR Form 7219), and another drill did not include a completed Crime/Incident Report (CDCR Form 837-C) to document an emergent medical response incident. As a result, the institution received a score of 33 percent for this test (MIT 15.101).

The institution scored within the adequate range for the following test:

- Medical staff sent the Initial Inmate Death Report (CDCR Form 7229A) to CCHCS's Death Review Unit timely for three of four deaths that occurred at NKSP in the prior 12-month period, resulting in a score of 75 percent. In the untimely case, the death was reported more than one hour late, but had occurred at an outside hospital, which can cause delays in reporting time frames (MIT 15.103).

The institution scored 100 percent in the following test areas:

- Inspectors reviewed the institution's medical appeal data and found that NKSP promptly processed inmate medical appeals for all 12 of the most recent months. Based on NKSP's reported data, only 2 of 1,326 medical appeals were categorized as overdue during the 12 months tested (MIT 15.001). Also, for ten sampled second-level medical appeals, the institution's response addressed all of the patients' appealed issues (MIT 15.102).

- Reviewing local governing body meeting minutes for the four-quarter period of 2014, the OIG found that meetings were held quarterly and required topics were discussed (MIT 15.006).

Other Information Obtained From Non-Scored Areas

- The OIG gathered non-scored data regarding the completion of death review reports and found that CCHCS's Death Review Committee did not timely complete its death review summary for any of the four deaths that occurred at NKSP during the testing period. The CCHCS Death Review Committee is required to complete a death review summary within 30 business days of the death and submit it to the institution's CEO. The committee

completed the four death review summaries from 9 to 53 days late (55 to 96 days after the death). Consequently, the committee did not submit any of the summaries to NKSP timely (MIT 15.996).

- Inspectors met with the institution's chief executive officer (CEO) to inquire about NKSP's protocols for tracking appeals. The CEO indicated that the health care appeals coordinator provides management a daily outstanding appeals report and weekly and monthly meetings are scheduled to discuss overdue appeals, when applicable. The reports break down the number of appeals submitted, number of appeals closed, and number of appeals overdue, with each appeal's category or subject area. According to the CEO, all staff complaints are subject to a higher level of scrutiny or inquiry. The CEO responds to all staff complaints and looks for patterns in complaints to identify problem areas. If the problem area involves staff, the CEO and management will initiate the progressive discipline process, usually beginning with on-the-job training. In the previous six months, there was only one problem area that related to a staff complaint involving an RN making an insensitive remark to an inmate. On-the-job training was subsequently provided to the RN (MIT 15.997).

- Data gathered regarding the institution's practices for implementing local operating procedures (LOPs) indicated that NKSP has an effective process in place for developing LOPs. The institution's chief support executive (CSE) indicated that two health program specialist I's (HPS-1s) are responsible for monitoring existing LOPs to ensure they are current and determine whether they need to be revised. A collaborative team composed of a local subject-matter expert and an HPS-1 determines whether a statewide policy and procedure (P&P) requires a new LOP. The team evaluates the P&P to determine whether the statewide policy needs additional clarification to fit the attributes of the institution's mission. The health care executive team then meets to discuss the LOP and make modifications, if needed. Once approved, the LOP is sent via email to all health care supervisors. The institution has implemented 45 of 49 applicable stakeholder-recommended LOPs (92 percent) (MIT 15.998).

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

CCHCS Dashboard Comparative Data

Both the Dashboard and OIG testing results show that NKSP demonstrates a high level of compliance for timely processing its medical appeals.

Internal Monitoring, Quality Improvement, and Administrative Operations— CCHCS Dashboard and OIG Compliance Results

CCHCS DASHBOARD RESULTS	OIG COMPLIANCE RESULTS
Timely Appeals February 2015	Medical Appeals—Timely Processing (15.001) 12 months Ending February 2015
100%	**100%**

Note: The CCHCS Dashboard data includes appeal data for: American Disability Act (ADA), mental health, dental, and staff complaint areas, whereas the OIG excluded these appeal areas.

Recommendations

No specific recommendations. Although the institution scored within the *inadequate* range for this indicator, staff can easily address areas needing improvement by adhering to established policy and procedure.

JOB PERFORMANCE, TRAINING, LICENSING, AND CERTIFICATIONS

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

Case Review Rating:
Not Applicable
Compliance Score:
78.6%

Overall Rating:
Adequate

Compliance Testing Results

The institution received an *adequate* overall score of 78.6 percent in the *Job Performance, Training, Licensing, and Certifications* indicator. For six of the indicator's eight tests, the institution scored 100 percent. Those tests included the following:

- The OIG found that all nursing staff and the PIC are current with their professional licenses and certification requirements. All providers are also current with their professional licenses (MIT 16.105, 16.001).
- The institution's pharmacy and providers who prescribe controlled substances are current with their Drug Enforcement Agency registrations (MIT 16.106).
- When the OIG reviewed training records for ten nursing staff members who administer medications, inspectors found that all ten had current clinical competency validations (MIT 16.102). Inspectors also confirmed that all nursing staff hired within the prior year timely received new employee orientation training (MIT 16.107).
- The OIG found that all provider, nursing, and custody staff have current emergency response certifications (MIT 16.104).

While NKSP scored well in the areas above, the institution has room for improvement in the following two areas:

- The institution does not perform complete structured clinical performance appraisals for its providers. Inspectors reviewed performance evaluation packets for the institution's 11 providers and found that NKSP completed the required 360-Degree Evaluation for only one of the institution's eight physician and surgeons (P&S), all of whom are subject to the requirement. Also, an annual performance review was not timely conducted for six of them. In addition, one nurse practitioner had not received an annual performance evaluation in several years. Further, the chief physician and surgeon received neither a PCP review nor an

annual performance review in the prior year. As a result, the institution received a score of 9 percent for this test (MIT 16.103).

- The OIG found that supervising registered nurses (SRNs) are not conducting required periodic reviews of nursing staff. Inspectors reviewed files for five nurses and found that during the sampled month, the SRN had completed the required nursing reviews for only one nurse (20 percent). For the remaining four nurses, there was no evidence that the SRN discussed the results of the review with the nurse; for one of those four nurses, the supervisor did not conduct a sufficient number of reviews during the month (MIT 16.101).

Recommendations

No specific recommendations. The institution scored within the *adequate* level for this indicator and can easily address areas needing improvement by adhering to established policy and procedure.

POPULATION-BASED METRICS

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

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

Methodology

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

Comparison of Population-Based Metrics

For NKSP, seven HEDIS measures were selected and are listed in *Table 1—NKSP Results Compared to State and National HEDIS Scores* on page 84. 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. In addition, the OIG selected California's Medi-Cal Managed Care Program as the population most similar to that of the

CDCR inmate population. As indicated in *Table 2—NKSP Results Compared to Medi-Cal Minimum and Maximum Performance* on page 85, the California Department of Health Care Services annually establishes a minimum performance level (MPL) and a high performance level (HPL) for each of its required performance measures. Where applicable, the OIG compared NKSP's results to the Medi-Cal MPL and HPL results.

Results of Population-Based Metric Comparison

Comprehensive Diabetes Care

For chronic care management, the OIG chose measures related to the management of diabetes. Diabetes is the most complex common chronic disease requiring a high level of intervention on the part of the health care system in order to produce optimal results. NKSP performed very well with its management of diabetes.

When compared statewide, NKSP significantly outperformed the Medi-Cal average scores (*Table 1*) for all five diabetic measures tested, and exceeded the Medi-Cal HPL scores (*Table 2*) for four of the five measures—eyes exams being the exception. In fact, for diabetic patients whose diabetes was considered to be under poor control and patients whose diabetes was considered to be under good control, NKSP's scores outperformed Medi-Cal's average scores by 33 and 19 percentage points, respectively. North Kern State Prison also outperformed or closely matched Kaiser Permanente (*Table 1*) in most of the diabetic measures. Again, the institution scored lower in diabetic patient eye exams.

When compared nationally (*Table 1*), NKSP outperformed averages for Medicaid and commercial health plans (based on data obtained from health maintenance organizations) in all five diabetic measures listed and outperformed Medicare in four of the five measures. For diabetic eye exams, NKSP scored 4 percentage points lower than Medicare. When compared to the U.S. Department of Veterans Affairs (VA), NKSP scored slightly higher than the VA in its diabetic monitoring and outperformed the VA with respect to diabetics considered to be under poor control and to blood pressure control for diabetic patients. The institution scored significantly lower (25 percentage points) than the VA in diabetic patient eye exams.

Although NKSP scored low when measuring the number of diabetic patients who actually received eye exams, inspectors noted that an additional 19 percent of the patients tested were offered the eye exam but refused it.

Immunizations

Comparative data for immunizations (*Table 1*) was only fully available nationally for the VA and partially available for Kaiser Permanente (statewide) and commercial (national). With respect to administering influenza shots to adults up to age 64, NKSP performed significantly lower than all three organizations that reported data. The OIG inspectors found that only 11 of NKSP's 39 patients

sampled (28 percent) actually received the influenza shot. However, the institution offered the shot to all of the remaining 28 patients (72 percent), but the patients refused it.

As a reception center with a high turnover rate, NKSP only had four patients over the age of 65. Therefore, no comparative data was presented for adults aged 65 and older for influenza and pneumococcal vaccinations.

Cancer Screening

With respect to colorectal cancer screening (*Table 1*), NKSP's score of 59 percent was significantly lower than all other entities that reported data for this measure. However, an additional 36 percent of NKSP's sampled patients who did not receive colorectal cancer screenings were offered the screening but refused it.

Summary

North Kern State Prison's population-based performance exceeded or closely matched State and national level results for four of the seven comparative measures. NKSP scored lower than other comparative entities in the measures for diabetic patient eye exams, influenza immunizations, and colorectal cancer screenings. However, NKSP's scores were negatively impacted by patients who were offered eye exams, immunizations, and cancer screenings but refused them.

Overall, NKSP's performance reflects an adequately performing chronic care program, further corroborated by the institution's *adequate* rating in the *Access to Care* and *Preventive Services* indicators. With regard to the institution's low scores for diabetic patient eye exams, influenza immunizations, and colorectal cancer screenings, the institution should take steps to lower the rate of patient refusals.

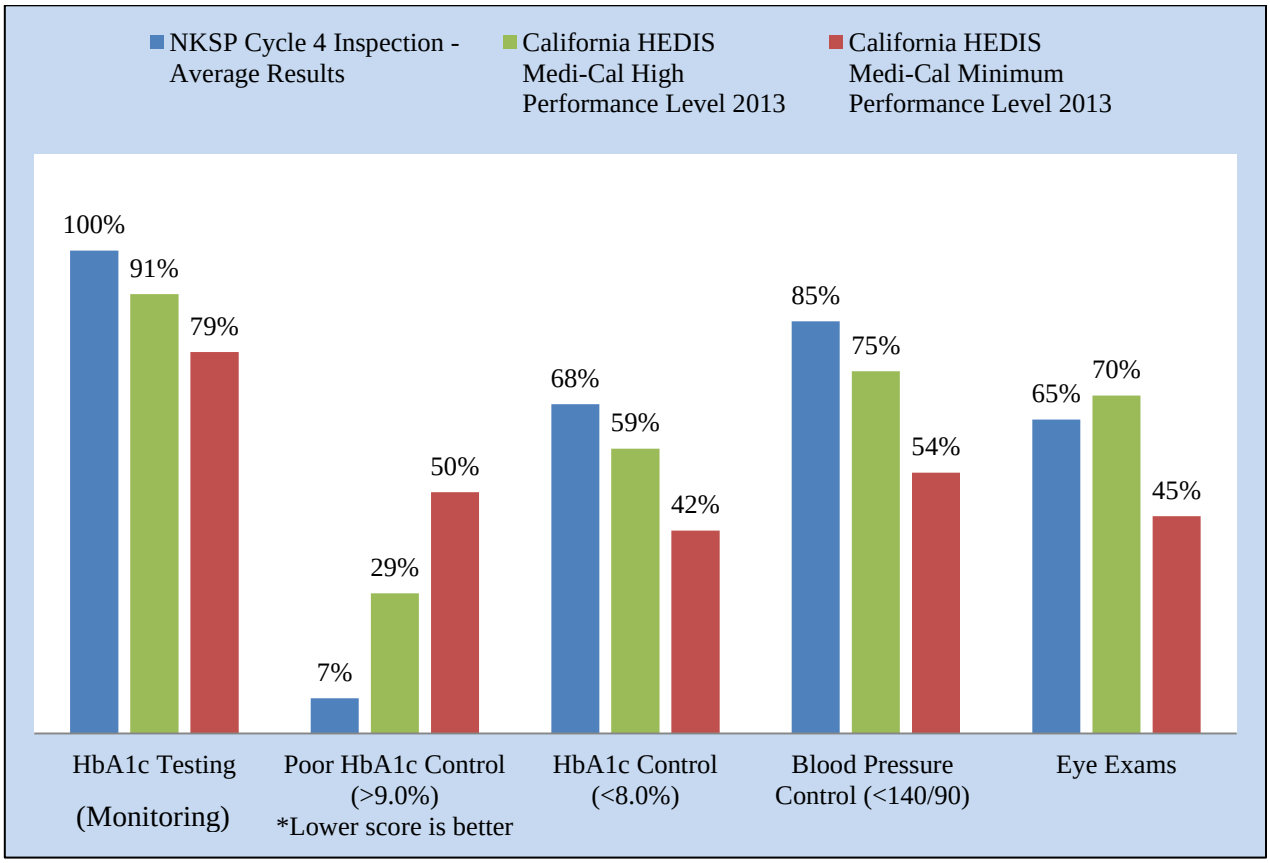
Table 1—NKSP Results Compared to State and National HEDIS Scores

Clinical Measures	California				National			
	NKSP Cycle 4 Results [1]	HEDIS Medi-Cal 2013 [2]	Kaiser (No.CA) HEDIS Scores 2014 [3]	Kaiser (So.CA) HEDIS Scores 2014 [3]	HEDIS Medicaid 2013 [4]	HEDIS Com-mercial 2013 [4]	HEDIS Medicare 2013 [4]	VA Average 2012 [5]
Comprehensive Diabetes Care								
HbA1c Testing (Monitoring)	**100%**	83%	95%	94%	84%	90%	92%	99%
Poor HbA1c Control (>9.0%) [6,7]	**7%**	40%	18%	21%	46%	31%	25%	19%
HbA1c Control (<8.0%) [6]	**68%**	49%	70%	67%	46%	59%	66%	-
Blood Pressure Control (<140/90) [6]	**85%**	63%	82%	85%	60%	65%	66%	80%
Eye Exams	**65%**	51%	69%	82%	54%	56%	69%	90%
Immunizations								
Influenza Shots - Adults (18–64) [8]	**28%**	-	59%	55%	-	50%	-	65%
Influenza Shots - Adults (65+) [9]	**-**	-	-	-	-	-	-	76%
Immunizations: Pneumococcal [9]	**-**	-	-	-	-	-	-	93%
Cancer Screening								
Colorectal Cancer Screening	**59%**	-	78%	80%	-	63%	64%	82%

1. Unless otherwise stated, data was collected in March 2015 by reviewing medical records from a sample of NKSP'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 2013 *HEDIS Aggregate Report for the Medi-Cal Managed Care Program*.
3. Data was obtained from Kaiser Permanente November 2014 reports for the Northern and Southern California regions.
4. National HEDIS data for Medicaid, commercial, and Medicare was obtained from the 2014 *State of Health Care Quality Report*, available on the NCQA website: www.ncqa.org. The results for commercial were based on data received from various health maintenance organizations.
5. The Department of Veterans Affairs (VA) data was obtained from the *VHA Facility Quality and Safety Report - Fiscal Year 2012 Data*.
6. For this indicator, the entire applicable NKSP population was tested.
7. For this measure only, a lower score is better. For Kaiser, the OIG derived the Poor HbA1c Control indicator using the reported data for the <9.0% HbA1c control indicator.
8. The VA data is for the age range 50–64.
9. Sample limited to only four participants over the age of 65; therefore, sample omitted from the comparative analysis.

Table 2—NKSP Results Compared to Medi-Cal Minimum and Maximum Performance

Clinical Measures	**NKSP** Cycle 4 Inspection Results	California HEDIS Medi-Cal High Performance Level 2013	California HEDIS Medi-Cal Minimum Performance Level 2013
Comprehensive Diabetes Care			
HbA1c Testing (Monitoring)	**100%**	91%	79%
Poor HbA1c Control (>9.0%) **Lower score is better*	**7%**	29%	50%
HbA1c Control (<8.0%)	**68%**	59%	42%
Blood Pressure Control (<140/90)	**85%**	75%	54%
Eye Exams	**65%**	70%	45%



APPENDIX A—COMPLIANCE TEST RESULTS

North Kern State Prison Range of Summary Scores: 48.15%–100%	
Indicator	**Overall Score (Yes %)**
Access to Care	86.9%
Diagnostic Services	86.2%
Emergency Services	Not Applicable
Health Information Management (Medical Records)	67.0%
Health Care Environment	57.1%
Inter- and Intra-System Transfers	82.9%
Pharmacy and Medication Management	86.4%
Prenatal and Post-Delivery Services	Not Applicable
Preventive Services	76.8%
Quality of Nursing Performance	Not Applicable
Quality of Provider Performance	Not Applicable
Reception Center Arrivals	74.5%
Specialized Medical Housing (OHU, CTC, SNF, Hospice)	100%
Specialty Services	83.3%
Internal Monitoring, Quality Improvement, and Administrative Operations	48.1%
Job Performance, Training, Licensing, and Certifications	78.6%

Reference Number	*Access to Care*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
1.001	**Chronic care follow-up appointments:** Was the inmate-patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter?	27	3	30	90.0%	0
1.002	**For endorsed inmate-patients received from another CDCR institution:** If the nurse referred the inmate-patient to a provider during the initial health screening, was the inmate-patient seen within the required time frame?	23	7	30	76.67%	0
1.003	**Clinical appointments:** Did a registered nurse review the inmate-patient's request for service the same day it was received?	25	5	30	83.33%	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?	21	9	30	70.00%	0
1.005	**Clinical appointments:** If the registered nurse determined a referral to a primary care provider was necessary, was the inmate-patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter?	10	3	13	76.92%	17
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?	10	0	10	100%	20
1.007	**Upon the inmate-patient's discharge from the community hospital:** Did the inmate-patient receive a follow-up appointment with a primary care provider within the required time frame?	29	1	30	96.67%	0
1.008	**Specialty service follow-up appointments:** Do specialty service primary care physician follow-up visits occur within required time frames?	24	3	27	88.89%	3
1.101	**Clinical appointments:** Do inmate-patients have a standardized process to obtain and submit Health Care Services Request forms?	6	0	6	100%	0
	Overall percentage:				**86.94%**	

Reference Number	*Diagnostic Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
2.001	**Radiology orders:** Was the radiology service provided within the time frame specified in the provider's order?	10	0	10	100%	0
2.002	**Radiology orders:** Did the primary care provider review and initial the diagnostic report within specified time frames?	9	1	10	90.00%	0
2.003	**Radiology orders:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	9	1	10	90.00%	0
2.004	**Laboratory orders:** Was the laboratory service provided within the time frame specified in the provider's order?	9	1	10	90.00%	0
2.005	**Laboratory orders**: Did the primary care provider review and initial the diagnostic report within specified time frames?	8	2	10	80.00%	0
2.006	**Laboratory orders:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	9	1	10	90.00%	0
2.007	**Pathology:** Did the institution receive the final diagnostic report within the required time frame?	8	2	10	80.00%	0
2.008	**Pathology:** Did the primary care provider review and initial the diagnostic report within specified time frames?	9	0	9	100%	1
2.009	**Pathology:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	5	4	9	55.56%	1
	Overall percentage:				**86.17%**	

Reference Number	*Emergency Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
3	Assesses reaction times and responses to emergency situations. The OIG RN clinicians will use detailed information obtained from the institution's incident packages to perform focused case reviews.	**Not Applicable**				

Reference Number	*Health Information Management (Medical Records)*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated progress notes, initial health screening forms, and health care service request forms scanned into the eUHR within three calendar days of the inmate-patient encounter date?	11	9	20	55.00%	0
4.002	Are dictated/transcribed documents scanned into the eUHR within five calendar days of the inmate-patient encounter date?	Not Applicable				20
4.003	Are specialty documents scanned into the eUHR within five calendar days of the inmate-patient encounter date?	19	1	20	95.00%	0
4.004	Are community hospital discharge documents scanned into the eUHR within three calendar days of the inmate-patient date of hospital discharge?	20	0	20	100%	0
4.005	Are medication administration records (MARs) scanned into the eUHR within the required time frames?	12	8	20	60.00%	0
4.006	During the eUHR review, did the OIG find that documents were correctly labeled and included in the correct inmate-patient's file?	0	12	12	0.00%	0
4.007	Did clinical staff legibly sign health care records, when required?	33	7	40	82.50%	0
4.008	**For inmate-patients discharged from a community hospital:** Did the preliminary hospital discharge report include key elements, and did a provider review the report within three calendar days of discharge?	23	7	30	76.67%	0
	Overall percentage:				**67.02%**	

Reference Number	*Health Care Environment*	Scored Answers Yes	No	Yes + No	Yes %	N/A
5.101	**Infection control:** Are clinical health care areas appropriately disinfected, clean, and sanitary?	3	8	11	27.27%	0
5.102	**Infection control:** Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	8	2	10	80.00%	1
5.103	**Infection control:** Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	8	3	11	72.73%	0
5.104	**Infection control:** Do clinical health care staff adhere to universal hand hygiene precautions?	10	1	11	90.91%	0
5.105	**Infection contro**l: Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	6	5	11	54.55%	0
5.106	**Warehouse, Conex, and other non-clinic storage areas:** Does the medical supply management process adequately support the needs of the medical health care program?	0	1	1	0.00%	0
5.107	**Clinical areas:** Does each clinic follow adequate medical supply storage and management protocols?	10	1	11	90.91%	0
5.108	**Clinical areas:** Do clinic common areas and exam rooms have essential core medical equipment and supplies?	4	7	11	36.36%	0
5.109	**Clinical areas:** Do clinic common areas have an adequate environment conducive to providing medical services?	9	2	11	81.82%	0
5.110	**Clinical areas:** Do clinic exam rooms have an adequate environment conducive to providing medical services?	2	9	11	18.18%	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?	6	2	8	75.00%	3
5.999	**For Informational Purposes Only:** Does the institution's health care management believe that all clinical areas have physical plant infrastructures sufficient to provide adequate health care services?	Information Only				
	Overall percentage:				**57.07%**	

Reference Number	*Inter- and Intra-System Transfers*	Scored Answers: Yes	No	Yes + No	Yes %	N/A
6.001	**For endorsed inmate-patients received from another CDCR institution:** Did nursing staff complete the initial health screening and answer all screening questions on the same day the inmate-patient arrived at the institution?	24	5	29	82.76%	1
6.002	**For endorsed inmate-patients received from another CDCR institution:** When required, did the RN complete the assessment and disposition section of the health screening form; refer the inmate-patient to the TTA, if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening?	29	0	29	100%	1
6.003	**For endorsed inmate-patients received from another CDCR institution:** If the inmate-patient had an existing medication order upon arrival, were medications administered or delivered without interruption?	7	12	19	36.84%	11
6.004	**For inmate-patients transferred out of the facility:** Were scheduled specialty service appointments identified on the Health Care Transfer Information Form 7371?	19	1	20	95.00%	0
6.101	**For inmate-patients transferred out of the facility:** Do medication transfer packages include required medications along with the corresponding Medical Administration Record and Medication Reconciliation?	8	0	8	100%	2
	Overall percentage:				**82.92%**	

Reference Number	*Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.001	Did the inmate-patient receive all chronic care medications within the required time frames, or did the institution follow departmental policy for refusals or no-shows?	15	14	29	51.72%	1
7.002	Did health care staff administer or deliver new order prescription medications to the inmate-patient within the required time frames?	28	2	30	93.33%	0
7.003	**Upon the inmate-patient's discharge from a community hospital:** Were all medications ordered by the institution's primary care provider administered or delivered to the inmate-patient within one calendar day of return?	20	10	30	66.70%	0
7.004	**For inmate-patients received from a county jail or COCF:** Were all medications ordered by the institution's reception center provider administered or delivered to the inmate-patient within the required time frames?	2	0	2	100%	18
7.005	**Upon the inmate-patient's transfer from one housing unit to another:** Were medications continued without interruption?	21	9	30	70.00%	0
7.006	**For inmate-patients en route who lay over at the institution:** If the temporarily housed inmate-patient had an existing medication order, were medications administered or delivered without interruption?	7	3	10	70.00%	0
7.101	**All clinical and medication line storage areas for narcotic medications:** Does the institution employ strong medication security controls over narcotic medications assigned to its clinical areas?	7	1	8	87.50%	10
7.102	**All clinical and medication line storage areas for non-narcotic medications:** Does the institution properly store non-narcotic medications that do not require refrigeration in assigned clinical areas?	13	0	13	100%	5
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	1	10	90.00%	8
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?	7	0	7	100%	11
7.105	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when preparing medications for inmate-patients?	7	0	7	100%	11

Reference Number	*Pharmacy and Medication Management*	Scored Answers Yes	No	Yes + No	Yes %	N/A
7.106	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when administering medications to inmate-patients?	3	4	7	42.86%	11
7.107	**Pharmacy:** Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and satellite pharmacies?	1	0	1	100%	0
7.108	**Pharmacy:** Does the institution's pharmacy properly store non-refrigerated medications?	1	0	1	100%	0
7.109	**Pharmacy:** Does the institution's pharmacy properly store refrigerated or frozen medications?	1	0	1	100%	0
7.110	**Pharmacy:** Does the institution's pharmacy properly account for narcotic medications?	1	0	1	100%	0
7.111	**Pharmacy:** Does the institution follow key medication error reporting protocols?	24	1	25	96.00%	0
7.998	**For Information Purposes Only—Medication Errors:** During eUHR compliance testing and case reviews, did the OIG find that medication errors were properly identified and reported by the institution?	Information Only				
7.999	**For Information Purposes Only—Pharmacy:** Do inmate-patients in isolation housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications?	Information Only				
	Overall percentage:				**86.36%**	

Reference Number	*Prenatal and Post-Delivery Services*	Scored Answers Yes	No	Yes + No	Yes %	N/A
8	This indicator is not applicable to this institution.	**Not Applicable**				

Reference Number	*Preventive Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
9.001	**Inmate-patients prescribed INH:** Did the institution administer the medication to the inmate-patient as prescribed?	18	12	30	60.00%	0
9.002	**Inmate-patients prescribed INH:** Did the institution monitor the inmate-patient monthly for the most recent three months he or she was on the medication?	11	19	30	36.67%	0
9.003	**Annual TB screening:** Was the inmate-patient screened for TB within the last year?	14	5	19	73.68%	0
9.004	Were all inmate-patients offered an influenza vaccination for the most recent influenza season?	30	0	30	100%	0
9.005	**All inmate-patients from the age of 50 through the age of 75:** Was the inmate-patient offered colorectal cancer screening?	29	1	30	96.67%	0
9.006	**Female inmate-patients from the age of 50 through the age of 74:** Was the inmate-patient offered a mammogram in compliance with policy?	Not Applicable				
9.007	**Female inmate-patients from the age of 21 through the age of 65:** Was the inmate-patient offered a pap smear in compliance with policy?	Not Applicable				
9.008	Are required immunizations being offered for chronic care inmate-patients?	14	3	17	82.35%	13
9.009	Are inmate-patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	15	2	17	88.24%	3
	Overall percentage:				**76.80%**	

Reference Number	*Quality of Nursing Performance*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
10	The quality of nursing performance will be assessed during case reviews, conducted by OIG clinicians, and is not applicable for the compliance portion of the medical inspection. The methodologies OIG clinicians use to evaluate the quality of nursing performance are presented in a separate inspection document entitled *OIG MIU Retrospective Case Review Methodology*.	**Not Applicable**				

Reference Number	*Quality of Provider Performance*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
11	The quality of provider performance will be assessed during case reviews, conducted by OIG clinicians, and is not applicable for the compliance portion of the medical inspection. The methodologies OIG clinicians use to evaluate the quality of provider performance are presented in a separate inspection document entitled *OIG MIU Retrospective Case Review Methodology*.	**Not Applicable**				

Reference Number	*Reception Center Arrivals*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
12.001	**For inmate-patients received from a county jail:** Did nursing staff complete the initial health screening and answer all screening questions on the same day the inmate-patient arrived at the institution?	18	2	20	90.00%	0
12.002	**For inmate-patients received from a county jail:** When required, did the RN complete the assessment and disposition section of the health screening form, and sign and date the form on the same day staff completed the health screening?	19	1	20	95.00%	0
12.003	**For inmate-patients received from a county jail:** If, during the assessment, the nurse referred the inmate-patient to a provider, was the inmate-patient seen within the required time frame?	Not Applicable				20
12.004	**For inmate-patients received from a county jail:** Did the inmate-patient receive a history and physical by a primary care provider within seven calendar days?	18	2	20	90.00%	0
12.005	**For inmate-patients received from a county jail:** Were all required intake tests completed within specified timelines?	17	3	20	85.00%	0
12.006	**For inmate-patients received from a county jail:** Did the primary care provider review and communicate the intake test results to the inmate-patient within specified timelines?	18	2	20	90.00%	0
12.007	**For inmate-patients received from a county jail:** Was a tuberculin test both administered and read timely?	1	19	20	5.00%	0
12.008	**For inmate-patients received from a county jail:** Was a Coccidioidomycosis (Valley Fever) skin test offered, administered, and read timely?	4	2	6	66.67%	14
	Overall Percentage:				**74.52%**	

Reference Number	*Specialized Medical Housing (OHU, CTC, SNF, Hospice)*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	**For all higher level care facilities:** Did the registered nurse complete an initial assessment of the inmate-patient on the day of admission, or within eight hours of admission to CMF's Hospice?	10	0	10	100%	0
13.002	**For OHU, CTC, and SNF only:** Did the primary care provider for OHU or attending physician for CTC & SNF evaluate the inmate-patient within 24 hours of admission?	10	0	10	100%	0
13.003	**For OHU, CTC, and SNF only:** Was a written history and physical examination completed within 72 hours of admission?	10	0	10	100%	0
13.004	**For all higher level care facilities:** Did the primary care provider complete the Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes on the inmate-patient at the minimum intervals required for the type of facility where the inmate-patient was treated?	10	0	10	100%	0
13.101	**For OHU and CTC Only:** Do inpatient areas either have a properly working call system in its OHU, CTC & GACH or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter inmate-patient's cells?	1	0	1	100%	0
	Overall Percentage:				**100%**	

Reference Number	*Specialty Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	Did the inmate-patient receive the high-priority specialty service within 14 calendar days of the PCP order?	13	2	15	86.67%	0
14.002	Did the PCP review the high-priority specialty service consultant report within three business days after the service was provided?	14	1	15	93.33%	0
14.003	Did the inmate-patient receive the routine specialty service within 90 calendar days of the PCP order?	14	1	15	93.33%	0
14.004	Did the PCP review the routine specialty service consultant report within three business days after the service was provided?	14	1	15	93.33%	0
14.005	**For endorsed inmate-patients received from another CDCR institution:** If the inmate-patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames?	8	7	15	53.33%	1
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	20	0	20	100%	0
14.007	Following the denial of a request for specialty services, was the inmate-patient informed of the denial within the required time frame?	12	7	19	63.16%	1
	Overall Percentage:				**83.31%**	

Reference Number	*Internal Monitoring, Quality Improvement, and Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.001	Did the institution promptly process inmate medical appeals during the most recent 12 months?	12	0	12	100%	0
15.002	Does the institution follow adverse/sentinel event reporting requirements?	Not applicable				0
15.003	Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified?	0	6	6	0.00%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	0	1	1	0.00%	0
15.005	For each initiative in the Performance Improvement Work Plan (PIWP), has the institution performance improved or reached the targeted performance objective(s)?	2	6	8	25.00%	0
15.006	For institutions with licensed care facilities: Does the local governing body (LGB), or its equivalent, meet quarterly and exercise its overall responsibilities for the quality management of patient health care??	4	0	4	100%	0
15.007	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	0	12	12	0.00%	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	33.33%	0
15.102	Did the institution's second level medical appeal response address all of the inmate-patient's appealed issues?	10	0	10	100%	0
15.103	Did the institution's medical staff review and submit the initial inmate death report to the Death Review Unit in a timely manner?	3	1	4	75.00%	0
15.996	**For Information Purposes Only:** Did the CCHCS Death Review Committee submit its inmate Death Review Summary to the institution timely?	Information Only				
15.997	**For Information Purposes Only:** Identify the institution's protocols for tracking medical appeals.	Information Only				
15.998	**For Information Purposes Only:** Identify the institution's protocols for implementing health care local operating procedures (LOPs).	Information Only				
15.999	**For Information Purposes Only:** Identify the institution's health care staffing resources.	Information Only				
	Overall Percentage:				**48.14%**	

Reference Number	*Job Performance, Training, Licensing, and Certifications*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
16.001	Do all providers maintain a current medical license?	12	0	12	100%	0
16.101	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	1	4	5	20.00%	0
16.102	Are nursing staff who administer medications current on their clinical competency validation?	10	0	10	100%	0
16.103	Are structured clinical performance appraisals completed timely?	1	10	11	9.10%	0
16.104	Are staff current with required medical emergency response certifications?	3	0	3	100%	0
16.105	Are nursing staff and the pharmacist-in-charge current with their professional licenses and certifications?	5	0	5	100%	0
16.106	Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	1	0	1	100%	0
16.107	Are nursing staff current with required new employee orientation?	1	0	1	100%	0
	Overall Percentage:				**78.64%**	

APPENDIX B—CLINICAL DATA

Table B-1: NKSP Sample Sets	
Sample Set	**Total**
Anticoagulation	3
Death Review/Sentinel Events	1
Diabetes	4
Emergency Services—CPR	3
Emergency Services— Non-CPR	5
CTC/OHU	4
High Risk	5
Hospitalization	5
Intra-System Transfers-in	3
Intra-System Transfers-out	3
RN Sick Call	30
Specialty Services	5
Reception Center Transfers	5
	76

Table B-2: NKSP Chronic Care Diagnoses	
Diagnosis	**Total**
Anemia	3
Anticoagulation	5
Arthritis/Degenerative Joint Disease	4
Asthma	7
COPD	2
Cancer	4
Cardiovascular Disease	7
Chronic Kidney Disease	1
Chronic Pain	6
Cirrhosis/End-Stage Liver Disease	4
Coccidioidomycosis	2
Deep Vein Thrombosis/Pulmonary Embolism	3
Diabetes	14
Gastroesophageal Reflux Disease	15
Gastrointestinal Bleed	3
HIV	2
Hepatitis C	21
Hyperlipidemia	16
Hypertension	30
Mental Health	8
Seizure Disorder	6
	163

Table B-3: NKSP Event—Program	
Program	**Total**
Diagnostic Services	292
Emergency Care	78
Hospitalization	60
Intra-System Transfers-in	20
Intra-System Transfers-out	20
Outpatient Care	497
Reception Center Care	47
Specialized Medical Housing	170
Specialty Services	81
	1,265

Table B-4: NKSP Case Review Sample Summary	
	Total
MD Reviews Detailed	30
MD Reviews Focused	0
RN Reviews Detailed	20
RN Reviews Focused	44
Total Reviews	94
Total Unique Cases	76
Overlapping Reviews (MD & RN)	18

APPENDIX C—COMPLIANCE SAMPLING METHODOLOGY

North Kern State Prison			
Quality Indicator	**Sample Category (number of patients)**	**Data Source**	**Filters**
Access to Care	Chronic Care (30—Basic Level) (40—Inter Level)	Master Registry	• Chronic care conditions (at least one condition per inmate-patient—any risk level) • **Randomize**
	Nursing Sick Call (5 per clinic) (minimum of 30)	MedSATS	• Clinic (each clinic tested) • Appt. date (2–9 months) • **Randomize**
	Returns from Community Hospital (30)	Inpatient Claims Data	• See ***Health Information Management (Medical Records)*** *(returns from community hospital)*
Diagnostic Services	Radiology (10)	Radiology Logs	• Appt. Date (90 days–9 months) • **Randomize** • Abnormal
	Laboratory (10)	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • **Randomize** • Abnormal
	Pathology (10)	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • **Randomize**
Health Information Management (Medical Records)	Timely Scanning (20 each)	OIG Qs: 1.001, 1.002, 1.006, & 9.004	• Non-dictated documents • First 5 inmate-patients selected for each question
		OIG Q: 1.001	• Dictated documents • First 20 inmate-patients selected
		OIG Qs: 14.002 & 14.004	• Specialty documents • First 10 inmate-patients selected for each question
		OIG Q: 4.008	• Community hospital discharge documents • First 20 inmate-patients selected for the question
		OIG Q: 7.001	• MARs • First 20 inmate-patients selected
	Legible Signatures and Review (40)	OIG Qs: 4.008, 6.001/6.002, 7.001, 12.001/12.002, & 14.002	• First 8 inmates sampled • One source document per inmate-patient
	Complete and Accurate Scanning	Documents for any tested inmate	• Any incorrectly scanned eUHR document identified during OIG eUHR file review, e.g., mislabeled, misfiled, illegibly scanned, or missing
	Returns from Community Hospital (30)	Inpatient Claims Data	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • **Randomize** (each month individually) • First 5 inmate-patients from each of the 6 months (if not 5 in a month, supplement from another, as needed)

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
Health Care Environment	Clinical Areas (number varies by institution)	OIG Inspector Onsite Review	• Identify and inspect all onsite clinical areas.
Inter- and Intra-System Transfers	Intra-System transfers (30)	SOMS	• Arrival date (3–9 months) • Arrived from (another CDCR facility) • Rx count • **Randomize**
	Specialty Service Send-outs (20)	MedSATS	• Date of Transfer (3–9 months) • **Randomize**
Pharmacy and Medication Management	Chronic Care Medication (30—Basic Level) (40—Inter Level)	OIG Q: 1.001	*See* ***Access to Care*** • (At least one condition per inmate-patient—any risk level) • **Randomize**
	New Medication Orders (30—Basic Level) (40—Inter Level)	Master Registry	• Rx Count • **Randomize** • Ensure no duplication of inmate-patients tested in chronic care medications
	Intra-Facility moves (30)	MAPIP Transfer Data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (high–low)–*inmate-patient must have NA/DOT meds to qualify for testing* • **Randomize**
	En Route (10) *N/A at this institution*	SOMS	• Date of transfer (2–8 months) • Sending institution (another CDCR facility) • **Randomize** • Length of stay (minimum of 2 days) • NA/DOT meds
	Returns from Community Hospital (30)	*Inpatient Claims Data*	• See ***Health Information Management (Medical Records)*** *(returns from community hospital)*
	Medication Preparation and Administration Areas	OIG Inspector Onsite Review	• Identify and inspect onsite clinical areas that prepare and administer medications
	Pharmacy	OIG Inspector Onsite Review	• Identify and inspect onsite pharmacies
	Medication Error Reporting	OIG Inspector Review	• Any medication error identified during OIG eUHR file review, e.g., case reviews and/or compliance testing
Prenatal and Post-delivery Services	Recent Deliveries (5) *N/A at this institution*	OB Roster	• Delivery date (2–12 months) • **Most recent** deliveries (within date range)
	Pregnant Arrivals (5) *N/A at this institution*	OB Roster	• Arrival date (2–12 months) • **Earliest** arrivals (within date range)

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
Preventive Services	Chronic Care Vaccinations (30—Basic Level) (40—Inter Level) *Not all conditions require vaccinations*	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per inmate-patient—any risk level) • **Randomize** • Condition must require vaccination(s)
	INH (all applicable up to 30)	Maxor	• Dispense date (past 9 months) • Time period on INH (at least a full 3 months) • **Randomize**
	Colorectal Screening (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • **Randomize**
	Influenza Vaccinations (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • **Randomize** • Filter out inmate-patients tested in chronic care vaccination sample
	TB Code 22, annual TST (15)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (22) • **Randomize**
	TB Code 34, annual screening (15)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (34) • **Randomize**
	Mammogram (30) *N/A at this institution*	SOMS	• Arrival date (at least 2 years prior to inspection) • Date of birth (age 52–74) • **Randomize**
	Pap Smear (30) *N/A at this institution*	SOMS	• Arrival date (at least three years prior to inspection) • Date of birth (age 24–53) • **Randomize**
	Valley Fever (number will vary)	Cocci Transfer Status Report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • **All**
Reception Center Arrivals	RC (20)	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • **Randomize**
Specialized Medical Housing	OHU, CTC, SNF, Hospice (10 per housing area)	CADDIS	• Admit date (1–6 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • **Randomize**

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
Specialty Services Access	High-Priority (10)	MedSATS	• Appt. date (3–9 months) • **Randomize**
	Routine (10)	MedSATS	• Appt. date (3–9 months) • Remove optometry, physical therapy or podiatry • **Randomize**
	Specialty Service Arrivals (20)	MedSATS	• Sending institution • Date of transfer (3–9 months) • Sent to (another CDCR facility) • **Randomize**
	Denials (20)* **Ten InterQual* *Ten MARs*	InterQual	• Review date (3–9 months) • **Randomize**
		IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • **Randomize**
Internal Monitoring, Quality Improvement, and Administrative Operations	Medical Appeals (all)	Monthly Medical Appeals Reports	• Medical appeals (12 months)
	Adverse/Sentinel Events (5)	Adverse/Sentinel Events Report	• Adverse/sentinel events (2–8 months)
	QMC Meetings (12)	Quality Management Committee Meeting Minutes	• Meeting minutes (12 months)
	Performance Improvement Plans (12)	Performance Improvement Work Plan	• Performance Improvement Work Plan with updates (12 months)
	Local Governing Body (12)	Local Governing Body Meeting Minutes	• Meeting minutes (12 months)
	EMRRC (6)	EMRRC Meeting Minutes	• Meeting minutes (6 months)
	Medical Emergency Response Drills (3)	OIG Inspector Onsite Review	• Most recent full quarter • Each watch
	2nd Level Medical Appeals (10)	OIG Inspector Onsite Review	• Medical appeals denied (6 months)
	Death Reports (10)	OIG Inspector Onsite Review	• Death reports (12 months)
	Local Operating Procedures (all)	OIG Inspector Onsite Review	• Review all

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
Job Performance and Training, Licensing, and Certifications	RN Review Evaluations (5)	OIG Inspector Onsite Review	• Current Supervising RN reviews
	Nursing Staff Validations (10)	OIG Inspector Onsite Review	• Review annual competency validations • **Randomize**
	Provider Annual Evaluation Packets (all)	OIG Inspector Onsite Review	• All required performance evaluation documents

	Medical Emergency Response Certifications (all)	OIG Inspector Onsite Review	• All staff
			  ○ Providers (ACLS)
			  ○ Nursing (BLS/CPR)
			  ○ Custody (CPR/BLS)

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

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

October 15, 2015

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

Dear Mr. Barton:

The purpose of this letter is to inform you that the Office of the Receiver has reviewed the draft report of the Office of the Inspector General (OIG) Medical Inspection Results for North Kern State Prison (NKSP) conducted from April 2015 to June 2015. California Correctional Health Care Services (CCHCS) acknowledges all OIG findings.

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

Sincerely,

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

cc: Clark Kelso, Receiver
Diana Toche, Undersecretary, California Department of Corrections and Rehabilitation
Richard Kirkland, Chief Deputy Receiver
Jared Goldman, Counsel to the Receiver
Roy Wesley, Chief Deputy Inspector General, OIG
Christine Berthold, Deputy Inspector General, Senior, OIG
Scott Heatley, M.D., Ph.D., CCHP, Chief Physician and Surgeon, OIG
Roscoe Barrow, Chief Counsel, Receiver's Office of Legal Affairs, CCHCS
R. Steven Tharratt, M.D., MPVM, FACP, Director, Health Care Operations, CCHCS
Yulanda Mynhier, Director, Health Care Policy and Administration, CCHCS
Renee Kanan, M.D., Chief Quality Officer, Quality Management, CCHCS
Ricki Barnett, M.D., Deputy Director, Medical Services, CCHCS
Cheryl Schutt, R.N., Deputy Director, Nursing Services Branch, CCHCS
Christopher Podratz, Regional Health Care Executive, Region III
Felix Igbinosa, M.D., Regional Deputy Medical Executive, Region III
Steven Jones, Regional Nursing Executive, Region III