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Inspector General

Office of the Inspector General

Pleasant Valley State Prison
Medical Inspection Results
Cycle 5

April 2019

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

Office of the Inspector General
PLEASANT VALLEY STATE PRISON
Medical Inspection Results
Cycle 5

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April 2019

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FOREWORD

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

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

In Cycle 5, for the first time, the OIG will be inspecting institutions delegated back to CDCR from the Receivership. There is no difference in the standards used for assessment of a delegated institution versus an institution not yet delegated. At the time of the Cycle 5 inspection of Pleasant Valley State Prison, the Receiver had delegated this institution back to CDCR (on July 31, 2017).

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

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EXECUTIVE SUMMARY

The OIG completed the Cycle 5 medical inspection of Pleasant Valley State Prison (PVSP) in December 2018. The vast majority of our inspection findings were based on PVSP's health care delivery between June 2017 and January 2018. Our policy compliance inspectors performed an onsite inspection in November 2017. After reviewing the institution's health care delivery, our case review clinicians performed an onsite inspection in May 2018 to follow up on their findings.

OVERALL RATING:

Inadequate

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

Our clinician team reviewed 46 cases that contained 725 patient-related events. Our compliance team tested 88 policy questions by observing PVSP's processes and examining 393 patient records and 1,071 data points. We distilled the results from both the case review and compliance testing into 13 health care indicators and have listed the individual indicators and ratings applicable for this institution in the *PVSP Executive Summary Table* on the following page. Of these 13 indicators, OIG inspectors rated one *proficient*, 6 *adequate,* and 6 *inadequate*. Our experts made a considered and measured opinion that the overall quality of health care at PVSP was ***inadequate***.

PVSP Executive Summary Table

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

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

Expert Clinician Case Review Results

Our expert clinicians reviewed cases of patients with many medical needs and included a review of 725 patient care events.[1] The vast majority of our case review covered the period between June 2017 and January 2018. As depicted on the executive summary table on page *iv*, we rated 10 of the 13 indicators applicable to PVSP. Of those ten applicable indicators, we rated one *proficient*, four *adequate*, and five *inadequate.* When determining the overall adequacy of care, we paid particular attention to the clinical nursing and provider quality indicators, as adequate health care staff can sometimes overcome suboptimal compliance (i.e., performance with processes and programs). However, the opposite is not true; inadequate health care staff cannot provide adequate care, even though the established processes and programs may be adequate. We identified inadequate medical care based on the risk of significant harm to the patient, not the actual outcome.

Program Strengths — Clinical

- The providers reported good morale and felt well-supported by the medical leadership.
- PVSP continued to complete laboratory and radiology tests in accordance with the providers' orders.
- As long as staff correctly ordered appointments, the institution properly scheduled patients to see providers or nurses timely.

Program Weaknesses — Clinical

- PVSP nurses and providers demonstrated poor emergency care. They repeatedly made errors that placed patients at increased risk of harm, and in some cases those errors resulted in harm.
- Sick call performance at the institution worsened since Cycle 4. Sick call nurses frequently failed to make good assessments, intervene appropriately, or refer their patients to a provider.
- PVSP had severe problems with medication management that may have been related to the implementation of the new electronic health records system (EHRS). During this transition period, the institution had no pharmacist in charge (PIC). We found poor medication continuity in multiple areas, including transfers in, transfers out, hospital returns, and chronic medications. Some of the mediation lapses occurred when nurses sometimes failed to intervene for their patients who required medication renewal orders.

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

- Specialty services processes at PVSP were fragmented and unorganized. The lack of specialty services coordination resulted in the institution's inability to reliably track specialty appointments and properly retrieve specialty reports.

- PVSP had difficulty providing medical care seven days per week. When we asked about some of the lapses in the care we found during the weekends, PVSP staff said they could not accommodate any weekend provider care because of the lack of provider availability. Furthermore, we found that PVSP did not schedule its providers to work every weekday; the clinics typically lacked onsite provider coverage one or two customary workdays each week.

Compliance Testing Results

Of the 13 health care indicators applicable to PVSP, our compliance inspectors[2] evaluated 10. Of these, four were *proficient*, three were *adequate*, and three were *inadequate*. The vast majority of our compliance testing was of medical care that occurred between February 2017 and November 2017. There were 88 individual compliance questions within those ten indicators, generating 1,071 data points that tested PVSP's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[3] *Appendix A — Compliance Test Results* provides details for the 88 questions.

Program Strengths — Compliance

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

- The institution's nursing staff and providers did an excellent job of completing initial health assessments and evaluating patients admitted to specialized medical housing in a timely manner.

- The institution offered influenza vaccinations and provided colorectal cancer screenings to all sampled patients timely.

- PVSP nursing staff performed well with closely monitoring patients who were taking tuberculosis (TB) medications.

- Nursing staff at PVSP reviewed health care services request forms and conducted face-to-face encounters within required time frames.

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

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

- The institution's medical staff timely scanned non-dictated progress notes, initial health care screening forms, community hospital discharge reports, and requests for health care services into patients' electronic medical records.

Program Weaknesses — Compliance

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

- Clinicians at PVSP did not follow proper hand hygiene practices before or after patient encounters.

- Clinic examination rooms were missing essential core medical equipment and supplies, as well as properly calibrated equipment necessary to perform a comprehensive exam.

- Providers performed poorly with communicating diagnostic test results to patients.

- PVSP's pharmacy did not appropriately store refrigerated or non-refrigerated medications. Staff stored personal items in medication preparation areas, and medications were stored beyond manufacturers' guidelines.

Recommendations

The OIG recommends the following:

- The chief executive officer (CEO) should correct the review process of the Emergency Medical Response Review Committee (EMRRC); the EMRRC failed to identify problems with the institution's emergency response and care provided by providers and nurses in the triage and treatment center (TTA). PVSP needs a properly functioning EMRRC to identify and correct the institution's various lapses in emergency care.

- The CEO should address the numerous problems related to medications at PVSP by first improving the pharmacy's staffing levels. The pharmacist in charge (PIC) and the chief nursing executive (CNE) should then implement quality improvement measures to address the numerous problems with medication management we found during this inspection.

- The CNE and the PIC should correct and then monitor the medication transfer process to ensure medication continuity for patients transferring into and out of PVSP or returning from an outside hospital. During our inspection, we found serious problems with medication continuity in all transfer processes.

- The CNE should provide training to, and monitor, nurses in the receiving and release (R&R) and the TTA, as these nurses are the primary staff responsible for coordinating and ensuring

the continuity of care for patients in these areas. During our inspection, nurses in R&R and the TTA did not fulfill their responsibilities sufficiently.

- The CEO should revamp the specialty services processes to ensure PVSP staff coordinate their efforts to deliver appropriate specialty care. During our inspection, we found a lack of coordination, resulting in poor tracking of specialty appointments and sporadic performance with retrieving specialty reports at PVSP. The CEO and the CNE should also develop and implement a process that will ensure the institution's staff refer patients who refuse specialty services back to the primary provider for further evaluation.

- The chief medical executive (CME) should refine the current methods used to evaluate provider performance since we found problems with provider performance in the emergency setting and issues with superficial reviews of medical records.

Population-Based Metrics

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

With regard to immunization measures, PVSP scored higher than two, but lower than three health care plans for influenza immunizations for younger adults. No comparative data was available regarding vaccinations for older adults because PVSP did not have any patients 65 years of age or older at the time of inspection. Colorectal cancer screening scores were mixed, with the institution scoring higher than two health plans, matching the score of one health plan, and scoring lower than two other health plans.

PVSP may improve its scores for immunizations by reducing patient refusals through educating patients on the benefits of these preventive services.

INTRODUCTION

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

Pleasant Valley State Prison (PVSP) was the 31st medical inspection of Cycle 5. During the inspection process, the OIG assessed the delivery of medical care to patients using the primary clinical health care indicators applicable to the institution. The *Administrative Operations* indicator is secondary because it does not reflect the actual clinical care provided.

ABOUT THE INSTITUTION

Pleasant Valley State Prison (PVSP) opened in 1994, and is located in Coalinga, in Fresno County. The institution houses general population, minimum- to maximum-custody patients. PVSP operates six medical clinics where staff members handle non-urgent requests for medical services. PVSP also conducts screenings in its receiving and release (R&R) clinical area; treats patients needing urgent or emergency care in its triage and treatment area (TTA); and treats those requiring inpatient health services in its correctional treatment center (CTC). The institution primarily provides medical care for patients designated as low to medium medical risk; however, it does have a very small population of patients classified as high medical risk. California Correctional Health Care Services (CCHCS) has designated PVSP a "basic" health care institution, an institution located in a rural area away from tertiary care centers and specialty care providers whose services would likely be used frequently by higher-risk patients. PVSP's geographical location is in the western San Joaquin Valley, and the institution is one of two California prisons designated as a restricted area for patients who are at high risk for contracting coccidioidomycosis ("valley fever").

The institution received national accreditation from the Commission on Accreditation for Corrections in August 2016. This accreditation program is a professional peer review process based on national standards set by the American Correctional Association.

Based on staffing data we obtained from the institution as identified in the following *PVSP Health Care Staffing Resources* table as of November 2017 table, PVSP's average vacancy rate was approximately 3 percent.

PVSP Health Care Staffing Resources as of November 2017

	Executive Leadership*	Primary Care Providers	Nursing Supervisors	Nursing Staff**	Total
Authorized Positions	5.0	7.0	10.5	90.6	113.1
Filled by Civil Service	5.0	6.3	10.0	88.5	109.8
Vacant	0.0	0.7	0.5	2.1	3.3
Percent Filled by Civil Service	100.0%	90.0%	95.2%	97.7%	97.1%
Filled by Telemed	0.0	0.3	0.0	0.0	0.3
Percent Filled by Telemed	0.0%	4.3%	0.0%	0.0%	0.3%
Filled by Registry	0.0	0.0	0.0	4.02	4.0
Percent Filled by Registry	0.0%	0.0%	0.0%	4.4%	3.6%
Total Filled Positions	5.0	6.6	10.0	92.5	114.1
Total percentage Filled	100.0%	94.3%	95.2%	102.2%	100.9%
Appointments in last 12 Months	1.0	1.0	8.0	11.0	21.0
Redirected Staff	0.0	0.0	0.0	1.0	1.0
Staff on Extended Leave^	0.0	0.0	0.0	2.0	2.0
Adjusted Total: Filled Positions	5.0	6.6	10.0	89.5	111.1
Adjusted Total: percentage Filled	100.0%	94.3%	95.2%	98.8%	98.3%

* Executive Leadership includes Chief Physician & Surgeon.
** Nursing Staff includes Senior Psychiatric Technician/Psychiatric Technician.
^ In Authorized Positions.
Note: The OIG did not validate the PVSP Health Care Staffing Resources and Filled Positions data.

As of October 30, 2017, the Master Registry for PVSP showed that the institution had a total population of 2,842. Within that total population, 0.1 percent was designated as high medical risk, Priority 1 (High 1), and 0.2 percent was designated as high medical risk, Priority 2 (High 2). Patients' assigned risk levels are based on the complexity of their required medical care related to their specific diagnoses, frequency of higher levels of care, age, and abnormal laboratory results and procedures. High 1 has at least two high-risk conditions; High 2 has only one. Patients at high medical risk are more susceptible to poor health outcomes than those at medium or low medical risk. Patients at high medical risk also typically require more health care services than do patients with lower assigned risk levels. The table below illustrates the breakdown of the institution's medical risk levels at the start of the OIG medical inspection.

PVSP Master Registry Data as of October 30, 2017

Medical Risk Level	Number of Patients	Percentage
High 1	2	0.1%
High 2	7	0.2%
Medium	1,114	39.2%
Low	1,719	60.5%
Total	**2,842**	**100.%**

OBJECTIVES, SCOPE, AND METHODOLOGY

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

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

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

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

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

CASE REVIEWS

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

Exhibit 1. Case Review Definitions

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

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

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

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

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

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

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

Patient Selection for Retrospective Case Reviews

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

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

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

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

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

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

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

Benefits and Limitations of Targeted Subpopulation Review

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

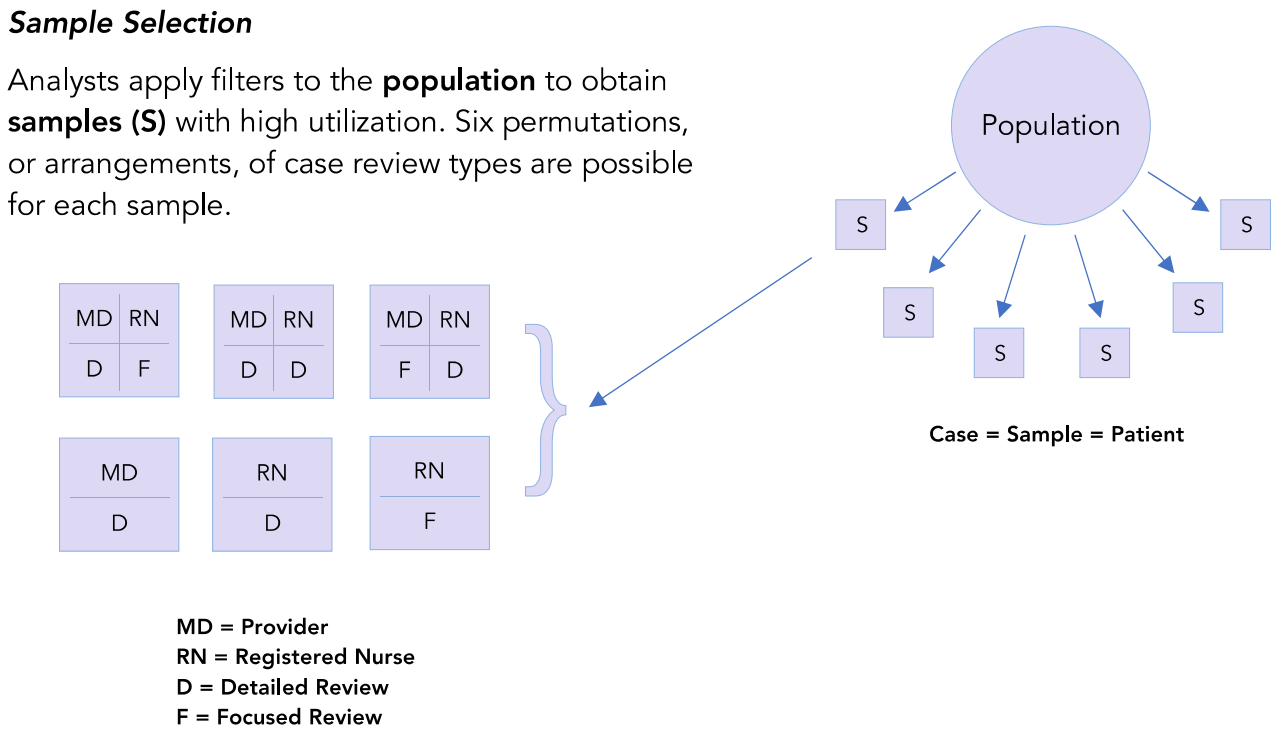
Since the targeted subpopulation does not represent the institution's general prison population, the OIG cautions against inappropriate extrapolation of medical *conditions* or *outcomes* from the retrospective case reviews to the general population. For example, if the high-risk diabetic patients reviewed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

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

Case Review Sampling Methodology

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

Chart 1. Case Review Sample Selection



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

Breadth of Case Reviews

As indicated in *Appendix B, Table B-1: PVSP Sample Sets*, the OIG clinicians evaluated medical records for 46 unique cases. *Appendix B, Table B-4: PVSP Case Review Sample Summary* clarifies that both nurses and physicians reviewed 16 of those cases, for 62 case reviews in total. Physicians performed detailed reviews of 22 cases, and nurses performed detailed reviews of

15 cases, totaling 37 detailed case reviews. Physicians and nurses also performed a focused review of an additional 25 cases. These reviews generated 725 case review events (*Appendix B, Table B-3: PVSP Event – Program*).

While the sample method specifically pulled only 3 chronic care cases, i.e., 3 diabetes cases (*Appendix B, Table B-1: PVSP Sample Sets*), the 46 unique cases sampled included 117 chronic care diagnoses, including one additional case with diabetes (for a total of 4) (*Appendix B, Table B-2: PVSP Chronic Care Diagnoses*). The OIG's sample selection tool allowed evaluation of many chronic care programs because the complex and high-risk patients selected from the different categories often had multiple medical problems. While the OIG did not evaluate every chronic disease or health care staff member, the OIG did assess for adequacy the overall operation of the institution's system and staff.

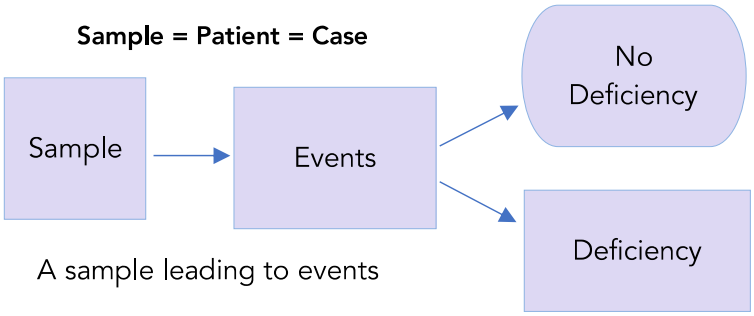
Case Review Testing Methodology

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

Chart 2. Case Review Testing and Deficiencies

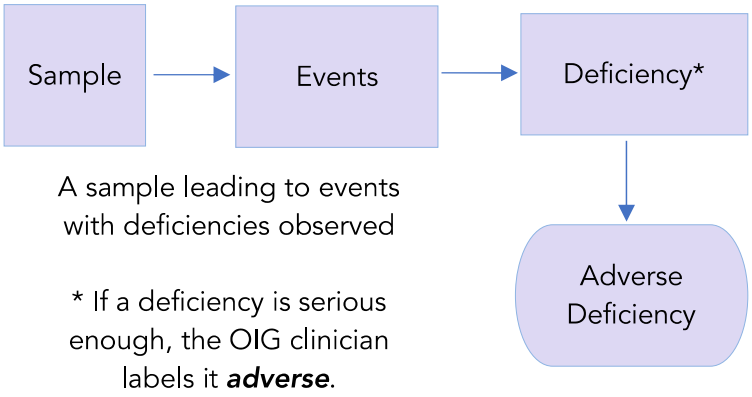
Case Review Testing

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



Deficiencies

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



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

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

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

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

COMPLIANCE TESTING

Sampling Methods for Conducting Compliance Testing

Our registered nurse inspectors obtained answers to 88 objective medical inspection test (MIT) questions designed to assess the institution's compliance with critical policies and procedures applicable to the delivery of medical care. To conduct most tests, inspectors randomly selected samples of patients for whom the testing objectives were applicable and reviewed their electronic medical records. In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed health records for 393 individual patients and analyzed specific transactions within their records for evidence that critical events occurred. Inspectors also reviewed management reports and meeting minutes to assess certain administrative operations. In addition, during the week of November 13, 2017, registered nurse field inspectors conducted a detailed onsite inspection of PVSP's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,071 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 PVSP's plant infrastructure, protocols for tracking medical appeals and local operating procedures, and staffing resources.

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

Scoring of Compliance Testing Results

After compiling the answers to the 88 questions for the ten indicators for which compliance testing was applicable, the OIG compliance team derived a score for each quality indicator by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Based on those results, the OIG assigned a rating to each quality indicator of *proficient* (greater than 85 percent), *adequate* (between 75 percent and 85 percent), or *inadequate* (less than 75 percent).

OVERALL QUALITY INDICATOR RATING FOR CASE REVIEWS AND COMPLIANCE TESTING

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

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

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

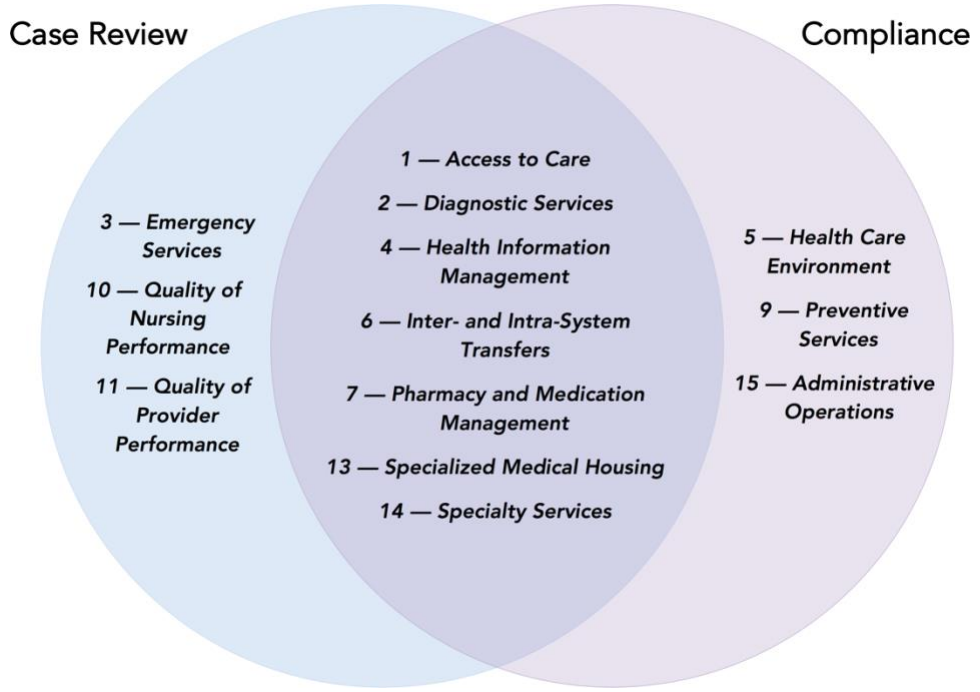
POPULATION-BASED METRICS

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

MEDICAL INSPECTION RESULTS

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

Chart 3. Inspection Indicator Review Distribution



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

Summary of Case Review Results: The clinical case review component assessed 10 of the 13 primary (clinical) indicators applicable to PVSP. Of these ten indicators, OIG clinicians rated one *proficient*, four *adequate,* and five *inadequate*.

The OIG physicians rated the overall adequacy of care for each of the 22 detailed case reviews they conducted. Of these 22 cases, one was *proficient*, 14 were *adequate*, and 7 were *inadequate*. In the 725 events reviewed, there were 145 deficiencies, 52 of which were considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

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

- In case 1, the patient with seizures transferred into PVSP. Even though the R&R nurse saw the patient during normal business hours, the nurse failed to timely notify a provider regarding the patient's seizure medications. The nurse also failed to ensure continuity of the patient's other essential medications. Partially due to the nurse's errors, the patient's medications lapsed, and he developed seizures two days after he arrived, requiring health care staff to send the patient to an outside emergency department (ED). We also discuss this case in the *Inter- and Intra-System Transfers* and the *Pharmacy and Medication Management* indicators.

- In case 2, staff found the patient unresponsive in his cell with shallow, slow breathing and critically low oxygen levels. The first medical responder (FMR) and subsequent health care staff failed to provide sufficient respiratory support. The nurse inappropriately administered low-flow oxygen instead of high-flow oxygen. When the patient arrived at the TTA, a nurse began high-flow oxygen, but the provider inexplicably changed the oxygen back to low-flow. None of the medical staff provided ventilation (assistance with breathing), even though the patient's oxygen levels remained critically low and the patient complained of difficulty with breathing. Fortunately, the patient recovered with no obvious signs of permanent injury after an outside hospitalization. We also discuss this case in the *Emergency Services* and the *Quality of Provider Performance* indicators.

- In case 3, the patient had risk factors for cardiac disease and developed chest pain. The patient was transported to the TTA, where staff made serious errors that placed the patient at risk of complications from delayed evaluation of chest pain. The TTA nurse did not follow chest pain protocol and did not administer nitroglycerin (medication to dilate arteries) or aspirin until 40 minutes after receiving the order from the on-call provider. The nurse did not insert an IV (intravenous access) until 109 minutes after the patient arrived. The provider failed to evaluate the patient promptly and delayed sending the patient, who may have been having a heart attack, to the ED for 90 minutes. Even after the provider ordered the nurse to transfer the patient to the ED, the nurse waited an additional 23 minutes before calling 9-1-1.

We also discuss this case in the *Emergency Services* and the *Quality of Provider Performance* indicators.

- In case 4, the patient overdosed on an unknown substance. The initial emergency response was appropriate with medical staff administering naloxone (a medication used to reverse opioid overdose temporarily) with good results. However, the on-call provider did not evaluate the patient properly. The patient needed more monitoring because he could have been in danger when the naloxone wore off. The patient also needed diagnostic testing to determine which drug he had taken and whether he had any metabolic imbalances from the overdose. Unfortunately, the provider failed to examine the patient, did not arrange the needed monitoring or testing, and inappropriately released the patient back to regular housing. The patient overdosed again two days later. We also discuss this case in the *Emergency Services* and the *Quality of Provider Performance* indicators.

- In case 6, the patient was unresponsive, not breathing, and without a pulse. Staff began CPR, but failed to call 9-1-1 until they transported the patient to the TTA 20 minutes later. This was a severe delay in calling 9-1-1. PVSP staff delayed advanced cardiovascular life support (ACLS) measures until offsite paramedics arrived. Unfortunately, the ACLS efforts were unsuccessful, and the patient died in the TTA. We also discuss this case in the *Emergency Services* indicator.

- In case 13, the patient was shivering, had a bad headache, was vomiting, and had elevated blood pressure and heart rate. The patient had warning signs and symptoms of a serious neurological condition, but the nurse did not recheck the patient's abnormal vital signs or contact a provider. Instead, the nurse ordered a routine provider follow-up appointment and sent the patient back to his housing unit with the unresolved symptoms. The following day, the patient submitted another sick call request for a recurring headache. The nurse found the patient with persistently elevated blood pressure and contacted a provider. The provider ordered the patient have another blood pressure check later that afternoon, but the nurses failed to do the check. On the third day, the patient developed a sudden loss of vision and had persistent vomiting, uncontrolled blood pressure, and an explosive headache. The provider intervened, examined the patient, and sent the patient to an offsite hospital. Hospital physicians diagnosed the patient with a bleeding brain aneurysm and performed extensive brain surgery to save his life. We also discuss this case in the *Quality of Nursing Performance* indicator.

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

1 — *ACCESS TO CARE*

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

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

For this indicator, the case review and compliance review processes yielded different results, with the case reviewers assigning an *adequate* rating and the compliance testing resulting in a *proficient* score. Although PVSP proficiently scheduled appointments when staff ordered appointments correctly, our case review clinicians found that the institution's staff did not reliably order appointments correctly and that those errors resulted in delays in care. Despite those delays, we determined the overall rating for this indicator was *adequate* because those delays were seldom clinically significant.

Case Review Results

The OIG clinicians reviewed 150 provider, nurse, specialty, and hospital events that required a follow-up appointment. There were 11 deficiencies relating to *Access to Care*¸ 7 of which were significant. The case review rating for this indicator was *adequate*.

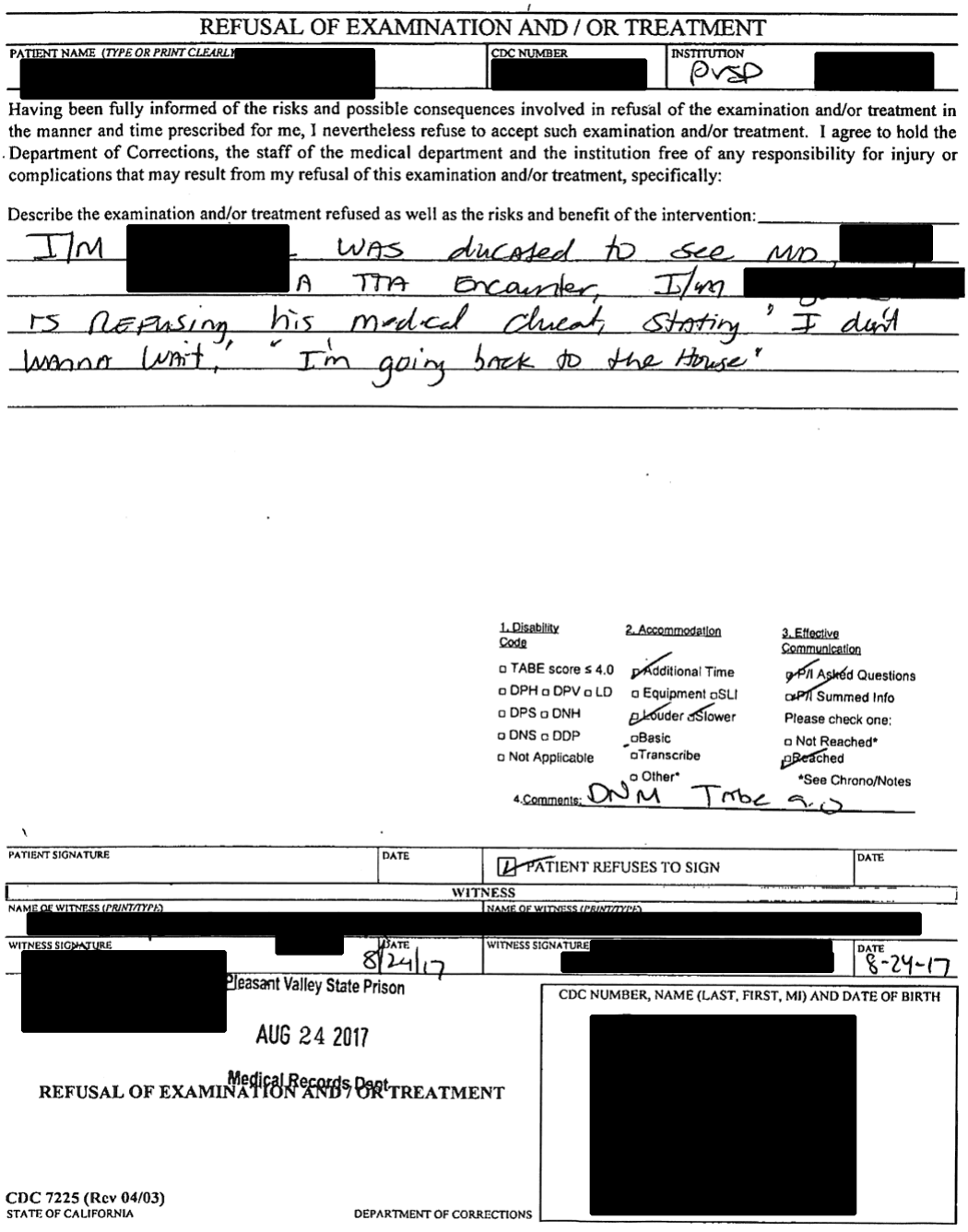
Provider Follow-up Appointments

We reviewed 68 provider encounters requiring a follow-up appointment with another provider. As long as medical staff entered orders for the requested appointments, the institution reliably scheduled them. However, medical staff errors resulted in some notable lapses:

- In case 1, the sick call nurse recorded the intention to refer the patient to the provider. When making a provider referral, CCHCS policy requires the nurse to choose a follow-up interval within 14 days and to complete and document that intervention. The nurse recorded the intent to refer the patient to the provider in 14 days, but failed to enter the order. The patient should have been seen in two weeks, but instead the patient had to wait a month to see the provider because of the nurse's error.

- In case 18, the patient refused an appointment for management of a serious left arm wound. Medical staff did not properly inform the patient of the recommended intervention (wound monitoring), or the consequences of his refusal (worsening infection and the cessation of wound care) (*Figure 1*, p. 18). The provider did not review the patient's medical condition

and failed to request any further follow-up. Because of these errors, the institution completely stopped caring for the patient's wound with no further monitoring.



REFUSAL OF EXAMINATION AND / OR TREATMENT

PATIENT NAME (TYPE OR PRINT CLEARLY) [redacted] | CDC NUMBER [redacted] | INSTITUTION PVSP [redacted]

Having been fully informed of the risks and possible consequences involved in refusal of the examination and/or treatment in the manner and time prescribed for me, I nevertheless refuse to accept such examination and/or treatment. I agree to hold the Department of Corrections, the staff of the medical department and the institution free of any responsibility for injury or complications that may result from my refusal of this examination and/or treatment, specifically:

Describe the examination and/or treatment refused as well as the risks and benefit of the intervention:

I/M [redacted] WAS directed to see MD [redacted] A TTA Encounter, I/M [redacted] IS REFUSING his medical check, stating "I don't wanna wait," "I'm going back to the House"

1. Disability Code
- ☐ TABE score ≤ 4.0
- ☐ DPH ☐ DPV ☐ LD
- ☐ DPS ☐ DNH
- ☐ DNS ☐ DDP
- ☐ Not Applicable

2. Accommodation
- ☑ Additional Time
- ☐ Equipment ☐ SLI
- ☑ Louder ☐ Slower
- ☐ Basic
- ☐ Transcribe
- ☐ Other*

3. Effective Communication
- ☑ P/I Asked Questions
- ☐ P/I Summed Info

Please check one:
- ☐ Not Reached*
- ☑ Reached

*See Chrono/Notes

4. Comments: DNM TTOC 9.0

PATIENT SIGNATURE [redacted] | DATE | ☑ PATIENT REFUSES TO SIGN | DATE

WITNESS

NAME OF WITNESS (PRINT/TYPE) [redacted] | NAME OF WITNESS (PRINT/TYPE) [redacted]

WITNESS SIGNATURE [redacted] | DATE 8/24/17 | WITNESS SIGNATURE [redacted] | DATE 8-24-17

Pleasant Valley State Prison

AUG 24 2017

Medical Records Dept

REFUSAL OF EXAMINATION AND / OR TREATMENT

CDC NUMBER, NAME (LAST, FIRST, MI) AND DATE OF BIRTH [redacted]

CDC 7225 (Rev 04/03)
STATE OF CALIFORNIA

DEPARTMENT OF CORRECTIONS

Figure 1: Refusal documentation for Case 18, which indicates staff failed inform the patient of the recommended intervention (wound monitoring) and the consequences of refusing the appointment (worsening wound infection and cessation of wound care).

RN Sick Call Access

In general, the 139 registered nurse (RN) sick call appointments we reviewed occurred timely. There was one minor deficiency:

- In case 39, the patient described pain in his body on a sick call request. CCHCS policy requires nurses to examine patients who describe symptoms on a sick call request within one business day to ensure prompt intervention if the patient had urgent medical needs. The nurse saw the patient one day late.

Provider Follow-up After Specialty Services

We reviewed 11 specialty service encounters requiring a provider follow-up visit and found all occurred timely.

Intra-System Transfers / Reception Center

We reviewed the cases of eight patients who transferred into PVSP and needed a provider encounter. Most patients we reviewed were seen timely. We identified only one deficiency:

- In case 25, the patient transferred into PVSP. The nurse ordered a provider intake referral within 30 days, but the appointment was never scheduled.

Follow-up After Hospitalization

We reviewed four cases in which patients required a provider follow-up visit following a hospital discharge. We found one minor deficiency:

- In case 19, the patient returned from the hospital after an evaluation for chest pain. CCHCS policy requires these patients to be seen within five calendar days by their primary care providers. The nurse erroneously entered a six-day appointment order and the patient was seen one day late.

Follow-up After Urgent or Emergent Care

We reviewed nine TTA encounters that required a provider follow-up appointment and identified deficiencies in the following cases:

- In case 14, the TTA nurse evaluated the patient for dizziness when standing. The nurse contacted the on-call provider, who ordered a one-day follow-up appointment for the patient. The nurse erroneously entered a three-day appointment request.

- In case 18, the patient was seen in the TTA for abdominal pain. The provider requested a one-day follow-up appointment to exclude a serious disorder, such as appendicitis. However, the provider erroneously entered a three-day appointment request.

Specialized Medical Housing

We reviewed eight specialized medical housing admissions that required provider follow-up visits. All admissions occurred timely without deficiencies.

Specialty Access and Follow-up

We reviewed 11 specialty service visits that required a specialty consultant appointment and provider follow-up visit. We found two deficiencies, both of which were significant:

- In case 21, the ophthalmologist advised a two-month follow-up appointment for the patient. The appointment did not occur.

- In case 39, the patient refused a cardiology consultation and stress test and wished to be rescheduled. The specialty nurse failed to refer the patient back to his provider to reorder the services. Because of this error, the provider did not re-evaluate the patient for his cardiac condition, and no further cardiac services were scheduled.

We also discuss performance in this area in the *Specialty Services* indicator.

Diagnostic Results Follow-up

We reviewed 40 diagnostic encounters that required the provider follow up with the patient after an abnormal result. All occurred timely without a deficiency.

Clinician Onsite Inspection

Our inspection period included the institution's transition to the EHRS. Following implementation of the EHRS, nurses and providers were required to enter orders for follow-up appointments. Unfamiliarity with the new processes in the EHRS may have contributed to some of the errors we found during our inspection.

When asked about the one-day follow-up appointments ordered as three-day follow-up appointments, PVSP staff explained that the one-day follow-up appointments could not have been ordered because the appointments would have fallen on a weekend. Those types of appointments needed to wait until the following Monday because PVSP could not provide medical care over the weekend. The OIG does not agree with PVSP's practice of delaying medical care on the weekends for patients with acute medical problems. The institution schedules onsite nurses 24 hours per day, 7 days per week. At least one PVSP provider is on-call at all times to return to the institution to see patients when needed.

We also found the management of patients after they refused services to be potentially problematic. When staff did not provide sufficient information for patients to make informed decisions, the providers did not always make appropriate interventions to minimize their patients' risk of harm. Within CDCR institutions, medical staff usually intervene in these

situations by ordering follow-up appointments. PVSP staff did not intervene in cases 18 and 39, as we described previously.

Case Review Conclusion

In general, PVSP performed well with scheduling as long as staff ordered appointments in the EHRS correctly. However, we found that staff did not consistently order these appointments properly due to several reasons. These reasons included unfamiliarity with the EHRS, and the intent to avoid scheduling care that fell on weekends. Nonetheless, most patients received care promptly, and we rated this indicator *adequate.*

Compliance Testing Results

The institution performed in the *proficient* range, with a score of 87.4 percent in the *Access to Care* indicator. The following tests earned scores in the *proficient* range:

- Nurses reviewed 29 of 30 sampled health care services request forms (CDCR Form 7362) on the same day they were received (96.7 percent). Nursing staff failed to document the date and time one patient's request form was received and reviewed (MIT 1.003).

- For 27 of 29 sampled patients who submitted health care services request forms (93.1 percent), nurses completed a face-to-face encounter with the patient within one business day of reviewing the service request form. For two patients, nurses did not document a complete progress note (MIT 1.004).

- PVSP provided follow-up appointments timely for all eight applicable patients whom nurses referred to a provider and for whom the provider subsequently ordered a follow-up appointment (MIT 1.006).

- PVSP offered 21 of 22 applicable patients a follow-up appointment with a provider within five days of discharge from a community hospital (95.5 percent). The institution provided one patient's follow-up appointment one day late (MIT 1.007).

- Patients had access to health care services request forms at all six housing units inspected (MIT 1.101).

Two tests received scores in the *adequate* range:

- We reviewed recent appointments for 25 sampled patients with chronic care conditions. The institution provided follow-up appointments to 19 of the 25 patients (76.0 percent). The institution provided follow-up appointments for five patients from 2 to 91 days late. The institution did not provide a follow-up appointment for one other patient (MIT 1.001).

- Among 12 health care services request forms sampled, from which nursing staff referred the patient for a provider appointment, the institution provided ten patients a timely appointment (83.3 percent). The institution provided one patient's appointment 28 days late. One other patient's appointment was not documented properly (MIT 1.005).

The OIG inspectors found room for improvement in the following two tests:

- Among 25 sampled patients who transferred into PVSP from other institutions and who were referred to a provider based on the nurse's initial health care screening, 17 patients (68.0 percent) received timely provider appointments. The institution provided four patients their provider appointments from one to 13 days late. The institution provided three other patients' provider appointments from 24 to 59 days late. One other patient did not receive a provider appointment, but was seen by a nurse instead (MIT 1.002).

- The institution provided timely follow-up appointments with a provider to 17 of the 23 patients sampled who had received a high-priority or routine specialty service (73.9 percent). The institution provided five patients' follow-up appointments from one to 11 days late. One other patient did not receive a follow-up appointment with a provider at all (MIT 1.008).

2 — *DIAGNOSTIC SERVICES*

Case Review Rating:
Proficient
Compliance Score:
Inadequate (56.9%)
Overall Rating:
Adequate

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

For this indicator, the case review and compliance review processes yielded different results, with the case reviewers assigning a *proficient* rating and the compliance testing resulting in an *inadequate* score. Compliance testing showed providers regularly failed to review and sign radiology reports, and had difficulty communicating test results to patients timely. However, our case reviewers found that providers correctly acted on the test results and that their failure to communicate the results to patients did not place patients at significant risk of harm. We determined the overall rating for this indicator was *adequate*.

Case Review Results

We reviewed 97 diagnostic events and found four deficiencies related to health information management, one of which was significant. Overall, we found PVSP improved its performance in the *Diagnostic Services* indicator compared to Cycle 4; PVSP performed all tests as ordered and had fewer deficiencies. The case review rating for this indicator was *proficient*.

Test Completion

All laboratory and radiology tests were performed in accordance with providers' orders.

Health Information Management

In all four deficiencies we identified, the provider did not sign the diagnostic reports. For three of the four deficiencies, the provider was aware of the results. The only significant error we found, in which the provider did not review the report and was unaware of the results, was in the following case:

- In case 17, the patient's abnormal chest X-ray was not reviewed or signed by the provider. Fortunately, the care of the patient was not affected by this error.

Clinician Onsite Inspection

According to PVSP leadership, implementing the EHRS contributed to the improvement of diagnostic services at the institution. Since our inspection covered the period during which PVSP transitioned to the EHRS, the institution's leadership also attributed some of the remaining deficiencies to incomplete staff training in the new system. Health care staff were optimistic future deficiencies would improve since EHRS training opportunities in these areas had been addressed.

Case Review Conclusion

PVSP performed well with regard to *Diagnostic Services*, and the indicator rating was thus *proficient*.

Compliance Testing Results

The institution received an *inadequate* compliance score of 56.9 percent in the *Diagnostic Services* indicator, which encompasses radiology, laboratory, and pathology services. For clarity, we discuss each type of diagnostic service separately below:

Radiology Services

- The institution timely provided radiology services to all ten sampled patients (MIT 2.001). PVSP providers then timely reviewed and signed the corresponding radiology test reports for two of the ten patients (20.0 percent). Providers reviewed two patients' reports 2 and 15 days late. For the other six patients, providers did not review the patients' reports at all (MIT 2.002). Providers also timely communicated radiology report results to five of the ten patients (50.0 percent). Providers communicated report results to three patients from two to six days late. The provider communicated the results 161 days late to one other patient. For one final patient, the provider did not communicate the results at all (MIT 2.003).

Laboratory Services

- The institution timely provided laboratory services to nine of ten sampled patients (90.0 percent). The institution did not provide the laboratory service on the scheduled date as specified by the provider to one patient (MIT 2.004). PVSP providers then timely reviewed eight of the ten resulting laboratory services reports (80.0 percent). Providers reviewed two reports one and 24 days late (MIT 2.005). For the timely communication of results to patients, PVSP scored zero. Providers communicated the results to two patients 9 and 41 days late, and did not communicate the results at all to one patient. Providers did not specify the type of tests in their written communication to seven other patients (MIT 2.006).

Pathology Services

- The institution timely retrieved the final pathology report for six of ten sampled patients (60.0 percent). The institution retrieved two patients' final reports one and 41 days late. The institution did not retrieve final pathology reports at all for two other patients (MIT 2.007). PVSP providers timely reviewed and signed the pathology results for seven of eight sampled patients (87.5 percent). For one patient, the provider signed the report five days late (MIT 2.008). In addition, providers timely communicated the final pathology results to only two of the eight patients (25.0 percent). Providers communicated the final results to two patients 5 and 70 days late. The provider did not specify the type of tests in his written communication to one patient. Providers did not communicate the final results at all to three patients (MIT 2.009).

3 — *EMERGENCY SERVICES*

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

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

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

Case Review Results

We reviewed 18 cases in which patients required urgent or emergent care. These cases yielded 25 urgent/emergent events and 24 deficiencies in various aspects of emergency care. Twelve deficiencies were significant and occurred in cases 2, 3, 4, 5, 6, 8, 14, 15, and 18. Due to the strong pattern of problematic emergency care, we rated this indicator *inadequate*.

Emergency Response

The institution's emergency response staff had great difficulty providing appropriate basic life support and often failed to activate 9-1-1 when indicated as noted in the following cases:

- In case 2, the unresponsive patient had shallow and slow breathing, and critically low oxygen levels. The first medical responder and subsequent health care staff failed to provide sufficient respiratory support. The nurse inappropriately administered low-flow oxygen instead of high-flow oxygen. When the patient arrived at the TTA, a nurse began high-flow oxygen, but the provider inexplicably changed the oxygen back to low-flow. No medical staff provided ventilation (assistance with breathing) even though the patient's oxygen levels remained critically low and the patient complained of difficulty breathing. Fortunately, the patient recovered with no obvious signs of permanent injury after an outside hospitalization.

- In case 3, the patient with risk factors for cardiac disease developed chest pain. The patient arrived at the TTA, where staff made serious errors in his care. The nurse did not follow chest pain protocol, failing to administer nitroglycerin (medication to dilate arteries) or aspirin until 40 minutes after receiving the order from the on-call provider. The nurse did not insert an IV (intravenous access) until 109 minutes after the patient arrived. The provider

did not evaluate the patient promptly and delayed sending the patient, who may have been having a heart attack, to the ED for 90 minutes. Even after the provider ordered the nurse to transfer the patient to the ED, the nurse waited an additional 23 minutes before calling 9-1-1. This placed the patient at risk of complications from the delayed evaluation of chest pain.

- In case 4, the patient overdosed on an unknown substance. The initial emergency response was appropriate with medical staff administering naloxone with good results. However, the on-call provider did not evaluate the patient properly. The patient needed more monitoring because he could have been in danger when the naloxone wore off. The patient also needed diagnostic testing to determine which drug the patient had taken and whether he had any metabolic imbalances from the overdose. Unfortunately, the provider failed to examine the patient, did not arrange the needed monitoring or testing, and inappropriately released the patient back to regular housing. The patient overdosed again two days later.

- In case 5, the patient overdosed on heroin and was unconscious. First medical responders began CPR because the patient had no pulse and was in respiratory distress. The nurse incorrectly administered low-flow oxygen through the bag-valve-mask resuscitator. The nurse should have administered high-flow oxygen in this situation. Fortunately, the patient did not appear to suffer any harm from this error, and staff successfully resuscitated him.

- In case 6, the patient was unresponsive, not breathing, and without a pulse. Staff began CPR, but failed to call 9-1-1 until they transported the patient to the TTA 20 minutes later, a severe delay. PVSP staff delayed advanced cardiovascular life support (ACLS) measures until outside paramedics arrived. Unfortunately, the ACLS efforts were unsuccessful, and the patient died in the TTA.

- In case 8, the unresponsive patient had a self-inflicted leg wound. PVSP staff failed to call 9-1-1. Despite resuscitative measures, the patient died in the TTA due to the amount of blood lost.

Provider Performance

Consistent with PVSP's designation as a basic care institution, we reviewed relatively few medical emergencies during the case review period. Most providers managed these encounters via telephone consultation with the TTA nurse. Emergency provider performance at PVSP was unreliable; we found six provider deficiencies, four of which were significant. As we noted previously, providers made critical errors during the emergency responses in cases 2, 3, and 4. Poor emergency provider performance is also illustrated in the case below:

- In case 15, the patient developed abdominal pain and bloody vomiting. The provider saw the patient in the TTA and appropriately referred him to an outside ED. Unfortunately, the provider gave the patient Toradol (a non-steroidal pain injection), which can increase the risk of stomach bleeding. Because the patient already complained of vomiting blood, this

pain medication was contraindicated. Fortunately, no harm came to the patient from the provider's error.

Nursing Performance

We found emergency nursing performance unreliable. As we previously noted, nurses made critical errors during the emergency responses in cases 2, 3, 5, 6, and 8. PVSP nurses demonstrated patterns of assessment and intervention errors that increased their patients' risk of harm. We found substandard nursing care in the following cases:

- In case 1, the nurse evaluated the patient urgently for seizures, but did not determine if the patient had urinary incontinence.

- In case 2, nurses failed to assess if the patient had responded to the second dose of naloxone. While in the TTA, nurses failed to monitor the patient's level of consciousness for 37 minutes and never checked the patient's blood pressure.

- In case 3, the nurse did not reassess the patient's chest pain during the last 83 minutes the patient was in the TTA.

- In case 17, the nurse did not reassess whether the patient's chest pain had improved at the time of his release from the TTA.

- In case 18, the TTA nurse evaluated the patient for an arm wound, but did not assess the skin integrity or describe the wound's size or appearance.

Nursing Documentation

Documentation is a serious responsibility, and nurses should include specific details of the care provided, information conveyed to the patient, and the outcomes of the interventions. Nurses did not meet this responsibility in several cases. The first medical responder and TTA RN notes were missing or incomplete in the following cases:

- In case 4, the first medical responder did not document the administration of two doses of naloxone to which the patient had responded.

- In case 6, staff found the patient unresponsive and with various injuries to the head and face. The nurses recorded different timelines of the emergency care, recorded an incorrect type of oxygen mask used, and entered two different dosages of medication administered. The nurses also failed to document the injuries observed on the patient.

- In case 7, the nurses did not document the amount of oxygen applied and the time the provider arrived in the TTA.

Emergency Medical Response Review Committee

We reviewed several Emergency Medical Response Review Committee (EMRRC) minutes. The EMRRC did not identify the poor emergency responses, the poor provider and nurse performances, or the inaccurate nursing documentation that we identified in our review.

Clinician Onsite Inspection

The TTA had two examination rooms with gurneys and medical supplies, and a third room with a crash cart and an AED (automated external defibrillator). The rooms were equipped for cardiac monitoring and emergency care. Two nurses staffed the TTA each shift, and a provider was also present during the day shifts. The nurses were familiar with the chest pain protocol and could recount the required processes. Nurses also processed patients returning from the hospital and offsite specialty services. According to TTA staff, when they receive specialty reports, they inform the provider and then scan the report into the electric medical record. The TTA supervisor and staff reported positive morale.

Case Review Conclusion

PVSP medical staff performed poorly with regard to *Emergency Services*. Medical staff often failed to provide appropriate life support for patients with medical emergencies. Staff provided insufficient respiratory support and delayed calling 9-1-1. Both providers and nurses were responsible for these critical errors. Furthermore, the EMRRC failed to identify important lapses in care in these cases. Compared to Cycle 4, PVSP significantly declined in its quality of emergency services. We rated this indicator *inadequate*.

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4 — *HEALTH INFORMATION MANAGEMENT*

Case Review Rating:
Adequate
Compliance Score:
Proficient
(85.3%)
Overall Rating:
Adequate

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

For this indicator, the case review and compliance review processes yielded different results, with the case reviewers assigning an *adequate* rating and the compliance testing resulting in a *proficient* score. Our case review testing found frequent problems with the institution's handling of specialty reports. The institution failed to retrieve specialty reports or retrieved them late. Fortunately, despite these problems, providers usually addressed the specialty recommendations appropriately. Because the institution had room for improvement in this area, we determined that the overall rating for this indicator was *adequate*.

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

Case Review Results

We reviewed 743 events and found 20 deficiencies related to health information management. Of those 20 deficiencies, 2 were significant. Although we identified some deficiency patterns, patient care was unhindered in most cases. As a result, we rated this indicator *adequate*.

Hospital Records

We reviewed ten hospital or ED transfers. PVSP usually retrieved, scanned, and reviewed hospital records timely. There was one significant deficiency:

- In case 3, the patient received care from an outside ED for chest pain. PVSP staff failed to retrieve or review the outside ED physician report, placing the patient who was already at high risk of cardiovascular disease at further risk of a lapse in care.

Specialty Services

We reviewed 37 specialty services encounters and identified 12 deficiencies. PVSP had difficulty retrieving specialty reports on time, and providers often failed to sign those reports. The institution did not retrieve specialty reports timely or at all in cases 8, 15, 17, 29, and 41. The providers failed to sign specialty reports in cases 8 and 20. Fortunately, most providers reviewed important specialty recommendations when they became available and communicated these with their patients, even when they failed to sign the reports. We discuss these findings further in the *Specialty Services* indicator.

Diagnostic Reports

PVSP did very well with its handling of diagnostic reports. We reviewed 97 events and identified four deficiencies. Compared to Cycle 4, PVSP showed similar deficiency patterns related to providers not signing the reports prior to the reports being scanning into medical records. We found only one significant deficiency, which we also discuss in the *Diagnostic Services* indicator.

Urgent/Emergent Records

Most deficiencies in this category resulted from poor nursing documentation, which we also discuss in the *Emergency Services* indicator. In addition to the problems we already discussed, we also found errors in the following cases:

- In case 2, the provider recorded that the patient required three doses of naloxone, but the medical record showed no evidence the third dose was ordered or administered.
- In case 4, the first medical responder did not record the administration of two doses of naloxone.
- In case 6, the medical records staff incorrectly scanned a TTA record into the EHRS as a CTC encounter and used the incorrect date.

Scanning Performance

As in Cycle 4, we identified a pattern of minor deficiencies with misfiled and mislabeled documents (cases 6, 13, 17, 20, and 35).

Legibility

After implementation of the EHRS, legibility at the institution improved. We did not have any significant difficulty with document legibility.

Clinician Onsite Visit

PVSP had recently implemented the EHRS, prior to the start of our inspection; therefore, we attribute some deficiencies to incomplete EHRS training. According to medical records staff, providers were automatically notified of newly available reports through the EHRS message center. However, we found a pattern in which providers did not sign their reports. Twelve of the 37 deficiencies related to specialty services. The institution delegated much of the specialty report workflow to many different staff, and this fragmentation contributed to many missing or delayed reports.

Case Review Conclusion

PVSP performed sufficiently with managing health information following the EHRS implementation. However, we did find repeated problems with the institution's processing of specialty reports. We rated this indicator *adequate*.

Compliance Testing Results

The institution scored in the *proficient* range with a score of 85.3 percent in the *Health Information Management* indicator. The following tests were *proficient*:

- PVSP timely scanned eight non-dictated progress notes, initial health screening forms, and requests for health care services into the patients' electronic medical records (MIT 4.001).

- PVSP timely scanned community hospital discharge reports into patients' medical records for all 20 sampled patients (MIT 4.004).

Two tests received *adequate* scores:

- PVSP scored 79.2 percent in its labeling and filing of documents scanned into patients' electronic medical records. For this test, the OIG bases its score on 24 mislabeled or misfiled documents; the institution mislabeled five documents (MIT 4.006).

- Providers reviewed 17 of 22 hospital discharge reports within three calendar days of the patient's discharge (77.3 percent). Providers reviewed four discharge reports from one to six days late. For one final report, the provider did not review it at all (MIT 4.007).

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

- The institution timely scanned 14 of 20 sampled specialty service consultant reports into the patients' electronic health records (70.0 percent). The institution scanned six other specialty reports from 2 to 22 days late (MIT 4.003).

5 — *HEALTH CARE ENVIRONMENT*

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

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(53.9%)

Overall Rating:
Inadequate

Compliance Testing Results

PVSP earned an *inadequate* compliance score of 53.9 percent in the *Health Care Environment* indicator. The institution received scores in the *inadequate* range in the following seven tests:

- In only six of ten clinics inspected, clinical health care staff ensured that reusable invasive and non-invasive medical equipment was properly sterilized or disinfected (60.0 percent). In the other four clinics, one or more of the following deficiencies were identified: clinical staff failed to mention disinfecting the examination table prior to the start of a shift as part of their daily protocol; clinical staff failed to describe the proper sterilization process of reusable medical equipment; the clinic stored previously sterilized medical equipment beyond the indicated shelf life; and clinical staff did not replace the disposable paper on the examination table between patient encounters (*Figure 2*) (MIT 5.102).

Figure 2: Expired medical supplies

- We observed clinician encounters with patients in ten clinics. Clinicians followed good hand hygiene practices in six clinics (60.0 percent). At four other clinic locations, clinicians failed to wash their hands before and after patient contact (MIT 5.104).

- Health care staff at four of the ten clinics followed proper protocols to mitigate exposure to bloodborne pathogens and contaminated waste (40.0 percent). Six other clinics did not have puncture-resistant containers in examination rooms for medical staff to discard expended needles and sharps (MIT 5.105).

- The non-clinic bulk medical supply storage areas did not meet the supply management process or support the needs of the medical health care program. Medical supplies were stored directly on the floor. As a result, the institution scored zero on this test (MIT 5.106).

- Only three of the ten clinics inspected followed adequate medical supply storage and management protocols (30.0 percent). In the seven other clinics, one or more of the following deficiencies were identified: clinics stored medical supplies beyond manufacturers' guidelines; medical supplies were inappropriately stored together with personal items and germicidal wipes; personal food items were stored long term in the bulk medical supply room; and medical supply cabinets were disorganized and their contents not clearly identifiable (*Figure 3*) (MIT 5.107).

Figure 3: Personal belongings and food stored in the same area as medical supplies

- Only two of ten clinic locations (20.0 percent) maintained core equipment or other essential supplies necessary to conduct comprehensive examinations in their examination rooms and common clinic areas. In eight other clinic locations, deficiencies in equipment and supplies included one or more of the following: a demarcation line for the Snellen eye examination chart was missing; there were no hemoccult cards and developer; a nebulization unit did not have current calibration stickers or was missing; an oto-ophthalmoscope was missing; there were no disposable paper covers for examination tables; there were no biohazard waste durable receptacles or labeled plastic bags; tongue depressors were missing; and the weight scale, AED, and pulse oximeters were missing current calibration stickers (MIT 5.108).

- Only five of ten clinic examination rooms observed (50.0 percent) had appropriate space, configuration, supplies, and equipment to allow clinicians to perform a proper clinical examination. Five other clinics had one or more of the following deficiencies: examination room furniture was in disrepair; the examination room did not have adequate space to perform patient examinations; and clinical areas did not have portable screens to provide visual privacy (MIT 5.110).

Three tests received scores in the *adequate* range:

- Eight of the ten clinic locations inspected (80.0 percent) had operable sinks and sufficient quantities of hand hygiene supplies in the examination areas. One clinic's examination room

did not have antiseptic soap. Another clinic's patient restroom did not have antiseptic soap or disposable hand towels (MIT 5.103).

- Clinic common areas at seven of the nine clinics (77.8 percent) had environments conducive to providing medical services. In two other clinics, the location of triage stations compromised patients' auditory privacy (MIT 5.109).

- We examined emergency medical response bags (EMRBs) and crash carts to determine if the institution staff inspected them daily and inventoried them monthly, and whether they contained all essential items. At six of the eight applicable clinical locations (75.0 percent), EMRBs and crash carts were compliant. At two locations, staff did not inventory the minimum levels of medical supplies in the crash carts (MIT 5.111).

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

- Staff appropriately disinfected, cleaned, and sanitized all ten sampled clinics (MIT 5.101).

Non-Scored Results

We gathered information to determine if the institution maintained its physical infrastructure in a manner that supported health care management's ability to provide timely or adequate health care. We do not score this question.

- When we interviewed health care managers, they had no concerns about the facility's infrastructure or its effect on the staff's ability to provide adequate health care. However, at the time of our medical inspection, PVSP had several significant infrastructure projects under way. These projects included increasing space at four yards, renovation of specialty clinics, and creating new space for the ambulatory surgical unit, TTA, pharmacy, and laboratory. These projects were started in the summer of 2016, and the institution estimated that they would be complete by the spring of 2019 (MIT 5.999).

6 — *INTER- AND INTRA-SYSTEM TRANSFERS*

Case Review Rating:
Inadequate
Compliance Score:
Adequate
(83.8%)
Overall Rating:
Inadequate

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

For this indicator, the case review and compliance review processes yielded different results, with the case reviewers assigning an *inadequate* rating and the compliance testing resulting in an *adequate* score. Our case review testing found pervasive problems with the continuity of care for patients transferring into and out of PVSP, as well as for those patients returning from a community hospital. Lapses in care due to these problems were common and increased the risk of patient harm. Therefore, we determined that the overall rating for this indicator was *inadequate*.

Case Review Results

We reviewed 25 inter- and intra-system transfer cases, including information from both the sending and receiving institutions. These included 12 hospitalization and outside emergency room cases, each resulting in a transfer back to the institution. We found 20 deficiencies, of which 8 were significant (cases 1, 3, 13, 14, 15, 27, and 28). The case review rating for this indicator was *inadequate.*

Transfers In

When a new patient transfers into the institution, the R&R nurse should review any pending appointments and notify the primary care team of the new arrival. The primary care team provider should discuss the new patient in the morning huddle and schedule the follow-up appointment with the provider and the nurse care coordinator. The provider should also reconcile

and order appropriate medications. We reviewed six transfer-in cases and found several problems with the transfer-in process:

- In case 1, the patient with a history of seizures transferred into PVSP. Even though the R&R nurse saw the patient during normal business hours, the nurse failed to timely notify a provider regarding the patient's seizure medications. The nurse also failed to ensure continuity of the patient's other essential medications. Partially due to the nurse's errors, the patient experienced a lapse in medication continuity and developed seizures two days after he arrived, requiring health care staff to send the patient to an outside ED. We also discuss this case in the *Pharmacy and Medication Management* indicator.

- In case 6, the patient returned to the institution from an outside court appointment. The patient should have received his prescribed medication when he arrived. The nurse erroneously recorded that the patient was still outside the institution and failed to administer the medication.

- In case 25, the patient arrived at PVSP and should have received a routine provider appointment within 30 days of arrival. This appointment did not occur within the required time frame.

Transfers Out

When a patient transfers out of the institution to another CDCR institution, the R&R nurse should review the patient transfer summary, perform a face-to-face evaluation to ensure the patient is stable for transfer, ensure that the patient has a five-day supply of medications, record all pending appointments, and ensure that the patient's durable medical equipment travels with the patient. We reviewed seven transfer-out cases and identified four deficiencies:

- In case 1, the R&R nurse did not record the patient's pending need for special shoes or the patient's history of seizures.

- In cases 13 and 27, the R&R nurse did not send the patients with a supply of their medications when transferring them to other institutions.

- In case 28, the R&R nurse did not record why the patient needed his arm sling or the patient's activity restrictions.

Hospitalizations

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

The TTA nurse evaluates patients returning from the community hospital and consults with a provider after reviewing patient hospital discharge recommendations for follow-up care. We reviewed 12 of these events and found 12 deficiencies. The following are examples of the problems we found with the hospital-return process:

- In case 3, the physician's report from the outside ED was not retrieved or reviewed.

- In case 13, the patient returned from the hospital after being treated for bleeding in the brain. PVSP staff did not administer his hospital-recommended medications until three days after he returned. This was a significant lapse in medication continuity.

- In case 14, the patient returned from the hospital after being treated for gastrointestinal bleeding. The hospital physician recommended that the patient stop taking aspirin, a blood thinner that can cause intestinal bleeding. Although the provider discontinued the medication, the nurse did not instruct the patient to stop taking the aspirin. The patient continued taking the medication for three weeks. Fortunately, the patient did not suffer any harm. We also discuss this case in the *Quality of Nursing Performance* indicator.

- In case 15, the patient returned from the hospital and did not receive the newly recommended medication until two days after he returned. The patient was also on several chronic medications and did not receive them until one and two months later.

- In case 16, the patient returned from the hospital with a recommendation to continue antibiotics. The patient missed an antibiotic dose the day after he returned, increasing the risk for infection complications.

- In case 28, the patient returned from the hospital with a pacemaker. The hospital provider called the institution to transmit discharge instructions, which included a cardiology follow-up appointment two weeks after hospital discharge. When the patient returned from the hospital, the provider failed to order the cardiology follow-up appointment, which did not occur.

Clinician Onsite Inspection

The R&R was sufficiently staffed, with a nurse assigned to each shift. The R&R nurse appeared knowledgeable about the transfer processes and reported that staff evaluated newly arrived patients and sent the patients to the TTA if their conditions warranted further intervention. The nurse also stated that the clinic's primary care teams scheduled required follow-up appointments. According to the nurse, if the patients did not bring their medications with them the morning of their transfer, the nurses would transfer the patients to other institutions without their medications. When this problem occurred, the R&R nurse would notify the receiving institution of the missing medications. Furthermore, the nurse explained, the PVSP pharmacy routinely did

not provide the required five-day supply of medications for patients transferring out of the institution.

The TTA nurse reported that staff in the TTA evaluated patients returning from the outside hospital or ED. The nurse would call the outside facility to obtain the discharge report if the facility failed to send it with the patient. If the TTA nurse could not get the report, then it became the responsibility of medical records staff to obtain the missing report. Regarding medications, the nurse notified a provider, who was then responsible for ordering all the patient's medications. The TTA nurse might order a follow-up appointment for a patient in the EHRS, but the clinic's primary care team was responsible for discussing the patient in the morning huddles and scheduling the follow-up appointment at that time. According to the nurse, the institution did not have any on-call pharmacists on the weekends, so the nurses were often incapable of administering new medications until the pharmacist returned during regular business hours.

Case Review Conclusion

The institution demonstrated fundamental problems with many aspects of the transfer process. PVSP had difficulty ensuring medication continuity for patients transferring into the institution. When patients transferred to other CDCR institutions, PVSP's nurses often did not list important medical information on the transfer forms, and the nurses reported that they regularly failed to provide the required five-day supply of medications needed to ensure medication continuity. For patients returning from an outside hospital, a variety of errors occurred, including poor medication continuity, insufficient nurse assessment and education, and inconsistent health information transmittal. We discussed these issues with the institution's nursing administrative team, who acknowledged the findings. Because of these various problems that increased the risk of patient harm, we rated this indicator *inadequate*.

Compliance Testing Results

The institution scored in the *adequate* range for this indicator, with a score of 83.8 percent, with *proficient* scores on the following tests:

- Nursing staff completed an initial health screening form on the same day the patient arrived for 24 of 25 patients who transferred into PVSP from another CDCR institution (96.0 percent). For one patient, nursing staff did not document the patient's weight (MIT 6.001).

- The nursing staff timely completed the assessment and disposition sections of the screening form for all 25 patients (MIT 6.002).

- We inspected the transfer packages of two patients who were transferring out of the facility to determine whether the packages included required medications and support documentation. Both transfer packages were compliant (MIT 6.101).

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

- Nursing staff timely delivered or administered medications to eight of the ten patients who transferred into PVSP with an existing medication order that required its administration at the next dosing interval after the patients' arrival (80.0 percent). For two patients, nursing staff delivered or administered their medications two and three days late (MIT 6.003).

One test received an *inadequate* score:

- For 6 of 14 sampled patients who transferred out of PVSP to another CDCR institution (42.9 percent), nursing staff documented their pending specialty service appointments on the patients' health care transfer forms. For six other patients, nursing staff did not document their pending appointments on the transfer forms. For the remaining two patients, nursing staff did not complete a health care transfer form (MIT 6.004).

7 — *PHARMACY AND MEDICATION MANAGEMENT*

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(63.1%)
Overall Rating:
Inadequate

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

Case Review Results

We evaluated 69 events related to medications and found 29 deficiencies. We identified 18 significant lapses in medication delivery. The case review rating for this indicator was *inadequate.*

Medication Continuity

The institution demonstrated a pattern of delays or failures in refilling chronic medications, obtaining new medications following hospitalization, and sending medications with the patient when transferring to another institution. We found these deficiencies in cases 5, 6, 19, 27, and in the following cases:

- In case 1, the patient with a history of seizures transferred into PVSP. The R&R nurse failed to timely notify a provider regarding the patient's medications, contributing to the lapse in medication continuity. The following day, the provider ordered the seizure medications to begin the same day, but PVSP did not follow the provider's orders and failed to provide the patient with the medications. On the third day after the patient arrived at PVSP, the patient developed seizures and had to be sent to an outside ED. We also discussed this case in the *Inter- and Intra-System Transfers* indicator.

- In case 3, the patient requested refills of his high-cholesterol, allergy, and asthma medications. The patient received one of the medications one month late and did not receive the other medications at all.

- In case 13, the patient had bleeding in his brain and was hospitalized. When the patient returned to PVSP, staff admitted him to the CTC, but failed to obtain the medications recommended by the hospital. The patient did not receive the medications until three days later. Staff discharged the patient back to regular housing. The patient did not receive his

gout medication until a month later. When the patient transferred to another CDCR institution, the pharmacy failed to send a five-day supply of his medications with him.

- In case 14, the patient requested refills of calcium-vitamin D (prescribed to control tremors from other mental health medications), asthma inhalers, and antacid medications. He received the calcium-vitamin D 12 days late and an inhaler 9 days late. The patient did not receive the other inhaler and antacid medication.

- In case 15, the patient returned from the hospital and received his new medication two days late. Also, the TTA nurse failed to obtain an order for the patient's chronic blood pressure medication, and the patient did not receive it until a month later. On another occasion, the medication nurse noted the blood pressure medication was unavailable but did not ask the pharmacy to dispense it. The patient did not receive the blood pressure medication until the following month.

- Also in case 15, the provider reordered an essential antifungal medication for the patient's chronic coccidioidomycosis (valley fever) infection. The pharmacist canceled the order and did not notify the provider. The patient did not receive the medication, which was a significant lapse in care.

Medication Administration

The nurses usually administered medications timely. However, when a prescribed medication expired or was not available, the nurses failed to contact the provider to renew the medication or the pharmacy to dispense the medication, resulting in a break in medication continuity. Also, medication nurses failed to administer medications or record the medications they gave to patients in cases 1, 4, 5, 6, 14, and 16. The nurse erroneously administered an extra dose of the patient's medications twice in case 19.

Clinician Onsite Inspection

PVSP implemented the EHRS during the OIG inspection period. Inadequate training on the new system resulted in providers being unaware of their responsibility to assure medication continuity upon patients' returning to PVSP. Nurses also failed to ensure medication continuity by neglecting to obtain critical medication orders or administer essential medications during the transitions of care that occur when patients transfer into or out of the institution. Furthermore, PVSP had no PIC for several months. This absence may have also contributed to PVSP's poor medication performance during this crucial EHRS transition time. When our clinicians visited PVSP in May 2018, the pharmacy department remained understaffed, and there was no weekend pharmacist available to help resolve any medication issues, even urgent or emergent ones.

Case Review Conclusion

PVSP performed poorly in several areas of *Pharmacy and Medication Management*. Medication continuity was poor for PVSP patients who transferred into or out of the institution and for those patients who returned from an outside hospital. Also, nurses failed to ensure medication continuity for patients by failing to obtain necessary medication orders or intervening when medications were not available. The pharmacy also failed to dispense needed medications, especially on the weekends when there was no pharmacist available. We rated this indicator *inadequate*.

Compliance Testing Results

The institution received an *inadequate* compliance score of 62.8 percent in the *Pharmacy and Medication Management* indicator. For discussion purposes below, this indicator is divided into three sub-indicators: medication administration, observed medication practices and storage controls, and pharmacy protocols.

Medication Administration

In this sub-indicator, the institution received an *adequate* score of 76.7 percent. One test earned a score in the *proficient* range:

- Nursing staff administered medications without interruption to 23 of 25 applicable patients who transferred from one housing unit to another (92.0 percent). For two patients, nursing staff did not document the reason for the patient's refusal of the medication (MIT 7.005).

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

- Nursing staff timely administered or delivered newly ordered medications to 20 of the 25 sampled patients (80.0 percent). For four patients, nursing staff administered their medications one day late. For one final patient, nursing staff did not administer the medication at all (MIT 7.002).

Two tests earned scores in the *inadequate* range:

- Nursing staff timely administered chronic care medications to 10 of 15 applicable patients (66.7 percent). For two patients, nursing staff delivered keep-on-person (KOP) medications two days late. For three other patients, PVSP replenished multiple supplies of chronic care medications in a shorter duration than normal. In addition, for three of the six patients who did not receive timely mediations, the institution did not make available KOP medications at least one business day prior to exhaustion (MIT 7.001).

- The institution timely provided newly ordered medications to 15 of 22 applicable patients (68.2 percent). For five patients, nursing staff did not administer one to two doses of their

medications. For another patient, PVSP had his ordered medication available three days late. For one final patient, the provider did not order his medications within eight hours of his arrival to the institution (MIT 7.003).

Observed Medication Practices and Storage Controls

The institution received an *inadequate* score of 60.0 percent in this sub-indicator. The following tests scored in the *inadequate* range:

- The institution properly employed security controls over narcotic medications in four of the seven applicable clinic and medication line locations where narcotics were stored (57.1 percent). At three clinics, the narcotics logbook showed that a controlled substance inventory was not performed by two licensed nursing staff on multiple occasions (MIT 7.101).

- PVSP safely stored non-refrigerated, non-narcotic medications in only two of the eight applicable clinic and medication line storage locations (25.0 percent). In six other locations, one or more of the following deficiencies were observed: the medication area lacked a designated area for return-to-pharmacy medications; oral and topical medications were not properly separated when stored; medication rooms and cabinets were disorganized; multi-use medication was not labeled with the date it was opened; medication was stored beyond its expiration date; and the pharmacist did not perform an inventory of crash cart medication within the last 30 days (MIT 7.102).

- Non-narcotic refrigerated medications were properly stored at four of the nine applicable clinic and medication line storage locations (44.4 percent). In five other locations, one or more of the following deficiencies were observed: staff did not complete temperature logbooks; refrigerator temperatures were not kept within an acceptable range; the medication area lacked a designated area for return-to-pharmacy refrigerated medications; and medications were stored beyond manufacturers' guidelines (MIT 7.103).

- Only three of six inspected medication preparation and administration areas demonstrated appropriate administrative controls and protocols (50.0 percent). At two other locations, medication nurses did not always ensure patients swallowed direct observation therapy (DOT) medications. One other medication line location did not have sufficient outdoor cover to protect patients waiting to receive their medications from heat or inclement weather (MIT 7.106).

One test received an *adequate* score:

- Nursing staff at five of the six sampled medication preparation and administration locations (83.3 percent) followed proper hand hygiene and contamination control protocols during the

medication preparation and administrative processes. At one location, not all nursing staff washed or sanitized their hands before reapplying gloves (MIT 7.104).

One test received a *proficient* score:

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

Pharmacy Protocols

PVSP received an *inadequate* score of 56.0 percent in this sub-indicator. The institution earned *inadequate* scores in the tests below:

- In its main pharmacy, PVSP did not properly store non-refrigerated medication, and medication boxes were stored directly on the floor of the pharmacy. In addition, personal beverages belonging to staff were kept in the medication preparation areas, resulting in a score of zero for this test (MIT 7.108).

- The main pharmacy did not properly store refrigerated or frozen medications. The pharmacy stored medications beyond manufacturers' guidelines, resulting in a score of zero for this test (MIT 7.109).

The following test received an *adequate* score:

- The institution's PIC followed required protocols for 20 of the 25 medication error reports and monthly statistical reports reviewed (80.0 percent). For five medication error reports, the PIC completed corresponding medication error follow-up reports from one to 36 days late (MIT 7.111).

The following tests were *proficient*:

- In its main pharmacy, the institution followed general security, organization, and cleanliness management protocols (MIT 7.107).

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

Non-Scored Tests

- In addition to our testing of reported medication errors, we follow up on any significant medication errors found during compliance testing to determine whether PVSP properly identified and reported errors. We provide those results for information purposes only. At PVSP, we did not find any applicable medication errors (MIT 7.998).

- We interviewed patients housed in isolation units to determine whether they had immediate access to their prescribed KOP rescue inhalers and nitroglycerin medications. Three of four applicable patients interviewed indicated they had access to their rescue medications. One patient indicated that he did not have his inhaler with him. Upon notification, PVSP took timely action to replace the patient's inhaler (MIT 7.999).

8 — *PRENATAL AND POST-DELIVERY SERVICES*

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

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

Case Review Rating:
Not Applicable
Compliance Score:
Not Applicable

Overall Rating:
Not Applicable

9 — *PREVENTIVE SERVICES*

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

Case Review Rating:
Not Applicable
Compliance Score:
Proficient
(88.2%)
Overall Rating:
Proficient

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

Compliance Testing Results

The institution scored in the *proficient* range for this indicator at 88.2 percent. The following four tests were in the *proficient* range:

- Nursing staff performed monthly or weekly monitoring for all 12 patients who were taking tuberculosis (TB) medications (MIT 9.002).
- During the most recent influenza season, the institution timely provided or offered all 25 patients an influenza vaccination (MIT 9.004).
- The institution offered annual colorectal cancer screenings to 24 of 25 applicable patients (96.0 percent). One patient did not have a normal colonoscopy and was not offered a colorectal cancer screening within the previous 12 months (MIT 9.005).
- We tested whether the institution offered vaccinations for influenza, pneumonia, and hepatitis to patients who suffered from chronic care conditions. The institution offered or provided 14 of 15 applicable patients vaccinations (93.3 percent). For one patient, there was no evidence he was offered hepatitis A and B vaccinations (MIT 9.008).

Two tests received *adequate* scores:

- We sampled 30 patients at PVSP to determine whether they received a TB screening within the last year and during the month of their birth; 23 of the 30 patients sampled (76.7 percent) timely received the screening. For seven patients, the institution did not conduct the TB screening in the patient's birth month (MIT 9.003).
- The institution timely transferred 17 of 20 patients (85.0 percent) who were deemed at high risk for contracting the coccidioidomycosis infection, and identified as medically restricted and ineligible to reside at PVSP. The institution transferred the remaining three patients out of PVSP from 18 to 53 days late (MIT 9.009).

One test was *inadequate*:

- Nursing staff timely administered TB medications to 8 of the 12 applicable patients (66.7 percent). For three patients, nursing staff did not administer their medications at the provider-scheduled interval dates. For the remaining patient, nursing staff administered the wrong dosage for one of the patient's TB medications (MIT 9.001).

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10 — *QUALITY OF NURSING PERFORMANCE*

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

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

Case Review Results

We reviewed 241 nursing encounters, 148 of which were in the outpatient setting. Most outpatient nursing encounters were for sick call requests, walk-in visits, and nurse follow-up appointments. In all, we identified 60 deficiencies related to nursing care performance, 14 of which were significant. The most important nurse deficiencies we found were in emergency services, sick call, and transfers. We rated the *Nursing Performance* indicator *inadequate.*

Nursing Sick Call

We found widespread problems with the nursing sick call performance at PVSP. When sick call nurses assessed their patients, they often made poor or incomplete assessments. They also did not consistently intervene correctly or timely refer sick patients to a provider. We found one or more deficiencies with nursing sick call performance in cases 1, 3, 13, 14, 15, 29, 30, 31, 34, 35, 36, 38, 40, and 41. The following are a few examples of poor nursing sick call performance:

- In case 13, the patient was shivering, had a bad headache, was vomiting, and had elevated blood pressure and heart rate. The patient had warning signs and symptoms of an impending or current serious neurological condition, but the nurse did not recheck the patient's abnormal vital signs or contact a provider. Instead, the nurse ordered a routine provider follow-up appointment and sent the patient back to his housing unit with the unresolved symptoms. The following day, the patient submitted another sick call request for a recurring headache. The nurse found the patient with persistently elevated blood pressure and contacted a provider. The provider ordered the patient another blood pressure check later

that afternoon, but the nurses failed to do the check. On the third day, the patient developed a sudden loss of vision and had persistent vomiting, uncontrolled blood pressure, and an explosive headache. The provider intervened, examined the patient, and sent the patient to an offsite hospital. Hospital physicians diagnosed the patient with a bleeding brain aneurysm and performed extensive life-saving surgery.

- In case 29, the patient had fallen the day before and had a swollen, discolored, and painful knee. The nurse did not notify the provider of the patient's fall. Also, the nurse did not offer the patient any education for fall prevention or offer an assistive device to minimize the risk of another fall. Furthermore, the nurse failed to record a time frame for the provider referral or whether the patient was using a brace or a cane. The nurse's errors placed the patient at further risk of injury. Fortunately, a provider saw the patient three days later.

- In case 36, the patient submitted a sick call request for worsening chills, cough, fatigue, and night sweats. The nurse should have made a same-day or urgent referral to a provider, but instead made a routine referral. Fortunately, the provider was able to diagnose and treat the patient's valley fever, and the delay did not result in harm.

- In case 40, the patient fell in his cell and submitted a sick call request for a severe headache. The sick call nurse did not inquire as to how or why the patient fell or attempt to determine if the patient may have had a seizure or other condition that could have precipitated the fall.

Outpatient Nursing

Aside from the sick call, we found that nurses occasionally neglected to perform some tasks or made poor decisions. Examples of these errors included failing to provide sufficient wound care or to notify a provider when their patients required medical expertise. PVSP can use the following examples for quality improvement:

- In case 14, the patient returned from a hospitalization for gastrointestinal bleeding and saw the nurse. The nurse did not review the hospital report or the primary provider's hospital follow-up progress note. The nurse was unaware of the patient's recent medication changes. The nurse did not discuss with a provider the plan to stop certain important medications to prevent bleeding recurrence. We also discuss this case in the *Inter- and Intra-System Transfers* indicator.

- In case 12, on two occasions, the provider ordered blood pressure checks once a day. For both orders, nurses failed to check the patient's blood pressure multiple times.

Wound care errors occurred in cases 16, 44, and the following case:

- In case 18, the patient saw the nurse for a draining wound on his arm. The nurse described the wound with five open, draining areas, and a foul smell. The nurse cleaned and dressed the wound, but did not notify the nursing supervisor, the TTA nurse, or a provider of the

severity of the wound. This clinical decision by the nurse placed the patient at risk for further complications. The next day, the patient had to be sent to the hospital for a rapidly spreading bacterial skin infection.

- In case 19, the patient was being treated for a wound infection with antibiotics. The nurse evaluated the patient's wound and discovered that the wound was worsening. The nurse did not notify the nurse supervisor or the provider of the changes in the wound's condition, resulting in a delay in care. Fortunately, a provider examined the wound the following day and sent the patient to an offsite hospital because the wound was not responding to antibiotics.

We also found that PVSP nurses did not provide sufficient patient education in cases 3, 6, 29, 33, and 38, and made documentation errors in cases 5, 29, and 41.

Urgent/Emergent Care

We reviewed 25 urgent or emergent encounters and found 10 nursing deficiencies, 6 of which were significant. The emergency nursing performance at PVSP was unreliable. We found errors made by first medical responders and TTA nurses that increased the patients' risk of harm. Refer to the *Emergency Services* indicator for additional details regarding nursing performance in this area.

Care Management

In each clinic, PVSP nurse supervisors assigned a licensed vocational nurse (LVN) as a care coordinator. For chronic care management, the care coordinators were supposed to monitor the CCHCS patient registry, identify patients with poorly controlled chronic conditions, ensure appropriate follow-up appointments were made, and provide education on chronic conditions to patients. We found scant evidence of effective chronic care management, as we did not see any such interventions for chronic care patients in the cases we reviewed.

Specialty Services

PVSP nurses usually provided sufficient care for patients in need of specialty services. We reviewed 18 nursing encounters related to specialty services and found five deficiencies, two of which were significant. Refer to the *Specialty Services* indicator for more details.

Specialized Medical Housing

The institution's nurses provided high-quality care for patients in the CTC. We reviewed 77 nursing encounters in the CTC and found only two minor deficiencies. Refer to the *Specialized Medical Housing* indicator for more information regarding nursing performance in this area.

Inter-and Intra-System Transfers

PVSP nurses performed poorly with patients transferring into or out of the institution, and for patients returning to PVSP from an offsite hospital. For patients transferring into PVSP, nurses did not ensure medication continuity. For patients transferring out of PVSP, nurses did not sufficiently record the patients' needs or send the patients with a sufficient supply of medications. For patients returning to PVSP from an offsite hospital, nurses again often failed to ensure medication continuity. Refer to the *Inter and Intra-System Transfers* indicator for additional details.

Clinician Onsite Inspection

We visited several clinical areas and interviewed various nursing staff, including registered nurses, medication nurses, provider support nurses, and care coordinators. During the time of our clinicians' onsite visit, PVSP's CTC was closed due to construction and repairs. In the short-term restricted housing unit, we interviewed a psychiatric technician. The sick call nurse saw five to nine patients on an average day. According to the nurses, there was no backlog for nurse appointments. All the staff interviewed said they communicated with their nursing supervisors daily. Overall, they reported positive morale at PVSP.

Case Review Conclusion

In the cases we reviewed, PVSP nurses performed well in the CTC and functioned satisfactorily in specialty services. However, we found poor and unreliable nurse performance in emergency services, sick call, care management, transfers, and hospital returns. Because nurse performance in those areas increased the risk of patient harm, we rated the *Quality of Nursing Performance* indicator *inadequate*.

11 — *QUALITY OF PROVIDER PERFORMANCE*

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

OIG physicians alone assess provider care. There is no compliance testing component associated with this quality indicator.

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

Case Review Results

We reviewed 22 cases which yielded 172 medical provider encounters. We identified 21 deficiencies related to provider performance, 8 of which were significant. Most deficiencies occurred in emergency care, a vital area of importance. For the 22 in-depth cases reviewed, we assigned the following ratings: one *proficient*, 14 *adequate,* and 7 *inadequate*. The case review rating for the *Quality of Provider Performance* indicator was *inadequate*.

Assessment and Decision-Making

The institution's providers demonstrated frequent errors in assessment and decision-making with respect to urgent or emergent situations. These errors often increased the risk of lapses in care and patient harm. We found these errors in cases 1, 12, 15, 21, 38, and in the following cases:

- In case 2, the patient had a critically low oxygen level during an emergency situation. When the patient arrived at the TTA, the provider inappropriately ordered the nurses to change the oxygen delivery to a less efficient method and to decrease the amount of oxygen delivered to the patient, even though the patient had persistent and severely low oxygen levels. With oxygen levels this low, the provider's errors placed the patient at elevated risk for irreversible brain and organ damage. Fortunately, the errors did not appear to result in any permanent harm. We also discussed this case in the *Emergency Services* indicator.

- In case 3, the patient was at high risk for cardiac disease and developed symptoms suggestive of a heart attack. The provider delayed sending the patient to the ED for 90 minutes, increasing the risk of irreversible heart damage and other cardiac complications. We also discussed this case in the *Emergency Services* indicator.

- In case 4, the patient overdosed on an unknown substance. The initial emergency response was appropriate with medical staff administering naloxone with good results. However, the on-call provider did not evaluate the patient properly. The patient required more monitoring because he could have been in danger when the naloxone wore off. The patient also needed diagnostic testing to determine which drug he had taken and whether he had any metabolic

imbalances from the overdose. Unfortunately, the provider failed to examine the patient, did not arrange the needed monitoring or testing, and inappropriately released the patient back to regular housing. The patient overdosed again two days later. We also discussed this case in the *Emergency Services* indicator.

- In case 13, the provider failed to examine a patient with severely elevated blood pressure and symptoms suggestive of a hypertensive emergency. This error increased the patient's risk of stroke and other complications.

Review of Records

Providers also did not always review their patients' medical records with sufficient depth or detail. We found this frequent error in cases 3, 12, 18, and the following cases:

- In case 21, the patient had chronic eye problems after having multiple surgeries and returning from an ophthalmology appointment. The provider did not review the patient's record and did not know the patient did not have a needed ophthalmology follow-up appointment scheduled. The provider did not order the follow-up appointment, placing the patient at risk for a lapse in care.

- In case 28, the patient returned to PVSP from the hospital with recommendations to see a cardiologist in two weeks because he recently had a pacemaker implanted. The provider did not sufficiently review the records and failed to order the cardiology follow-up appointment. The cardiology appointment did not occur.

- In case 38, the nurse referred the patient for a two-week provider appointment for knee pain. The provider failed to review the patient's medical record, did not address the reason for the appointment, and did not review the X-ray of the patient's knee, which had been performed for this issue.

Chronic Care

To reduce the risk for both acute and long-term complications of chronic health problems, such as diabetes mellitus, hypertension, and hyperlipidemia, it is important that providers both identify and appropriately manage these conditions. At PVSP, we found that providers usually performed acceptably in these areas, but needed to exercise more diligence when patients refused their appointments:

- In case 18, staff discharged the patient from the TTA after treating him for a chronic, non-healing wound. When the patient refused his initial provider follow-up appointment, the staff failed to provide the information needed for him to make an informed decision. After this error, the provider failed to review the patient's medical record, determine a safe follow-up interval, or order a follow-up appointment. The patient's care lapsed; the patient received no further appointments during our review period.

Specialty Services

We reviewed 37 specialty services encounters at PVSP. Providers usually referred their patients appropriately to specialists and saw their patients when they returned. However, providers did not always review their patients' medical records correctly:

- In case 12, the patient returned from an offsite specialty appointment during which the specialist used a camera to examine the patient's stomach and intestines, and to obtain a biopsy. During the patient's follow-up appointment, the provider neglected to review the patient's medical record and did not address the biopsy result. Fortunately, the biopsy did not show any cancer.

Emergency Care

The institution's providers performed poorly with emergency care and contributed to multiple occurrences wherein staff placed patients at undue risk of harm. Refer to the *Emergency Services* indicator for more details.

Specialized Medical Housing

We reviewed seven cases in which patients received care in the specialized housing unit. Provider care was usually sufficient in this area.

Clinician Onsite Inspection

PVSP physician leaders reported that although recent staffing was sufficient to maintain access to care, they needed to ask providers to minimize taking any time off from their work to avoid appointment backlogs. According to PVSP leadership, it would be difficult to continue to sustain this work pressure on the institution's providers. Even more problematic was the possibility of having two or three additional provider vacancies in the near future. The institution's leadership indicated that it would be difficult to recruit new providers to PVSP because of its remote location. In addition, PVSP is located in an area endemic to valley fever, and new providers might not be willing to expose themselves to this additional health risk.

Morale was high at the institution. Most providers enjoyed working at PVSP and reported feeling supported by their leadership. Most providers enjoyed a four-day, ten-hour work week to balance the long commute from their homes. The majority of providers expressed the opinion that the health care system at PVSP worked well, but that improvements could be made in obtaining pathology reports quicker. Providers also commented that emergency transports were occasionally delayed because of insufficient custody support.

Case Review Conclusion

The institution's providers gave inconsistent quality of care to their patients. In emergency services, providers performed poorly and placed their patients at undue risk of harm.

Furthermore, providers frequently demonstrated poor decision-making skills and often did not review their patients' medical records satisfactorily. Compared to Cycle 4, we found that providers' emergency care, decision-making, and record review had regressed. We rated the *Quality of Provider Performance* indicator *inadequate*.

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12 — *RECEPTION CENTER ARRIVALS*

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

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

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

13 — *SPECIALIZED MEDICAL HOUSING*

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

Case Review Rating:
Adequate
Compliance Score:
Proficient
(92.5%)
Overall Rating:
Adequate

For this indicator, the case review and compliance review processes yielded different results, with the case reviewers assigning an *adequate* rating and the compliance testing resulting in a *proficient* score. Because the compliance tests in this indicator do not sufficiently reflect the quality of patient care, we relied on the case review rating for the overall rating of this indicator. Our case reviewers found sporadic problems with nursing care, as well as occasional medication discontinuity. We determined that the overall rating for this indicator was *adequate*.

Case Review Results

We reviewed eight patients who received care in the CTC. The patients were admitted for various reasons, including wound care, post-operative care, and intravenous antibiotic therapy. We reviewed 81 events, which included 30 provider and 30 nursing encounters. We identified five deficiencies, only one of which was significant. Case reviewers rated this indicator *adequate.*

Provider Performance

The CTC cases we reviewed were of patients who had straightforward medical problems, such as a simple wound infection or simply needed close observation. Providers performed appropriately and delivered satisfactory care. Providers regularly evaluated and managed their CTC patients correctly.

Nursing Performance

The institution's nurses provided efficient and well-coordinated nursing care. Nurses conducted daily patient assessments, reported the status of daily living activities, provided wound care, re-assessed patients after the administration of pain medication, implemented provider orders, and documented patient refusals. We found two minor nursing deficiencies:

- In case 4, the nurse did not record the appearance of the patient's scalp laceration or the removal of the staples.

- In case 19, the patient was assigned to an isolation room. The nurse failed to make a care plan that addressed goals to prevent infections of the patient's intravenous site and wound, as well as the psychosocial environmental challenges for the patient.

Medication Management

The institution's nurses usually administered medications appropriately in the CTC. We found only one deficiency in this area:

- In case 5, CTC nurses missed administering a dose of antibiotic medication for one day. Lapses in antibiotic administration can place patients at risk for worsening infections and other complications.

Clinician Onsite Inspection

At the time of our clinicians' onsite visit to PVSP, the CTC had been closed since March 2018 due to needed repairs for a leaky roof. It was unknown when the CTC would reopen. PVSP had sent its CTC patients to other CDCR institutions' CTCs. Because PVSP's CTC was closed, the institution was able to place its CTC nursing staff in other units, such as the TTA, R&R, and the nurse sick-call lines for cross-training. The CTC nurses we interviewed appreciated the additional training, expressed positive morale, and felt supported by their supervisors.

Case Review Conclusion

In general, patients at PVSP were medically straightforward and did not have complex needs. PVSP staff members were able to meet their CTC patients' needs without difficulty. The occasional lapses in care we found did not increase the risk of harm to patients. Our case reviewers rated this indicator *adequate.*

Compliance Testing Results

The institution received a *proficient* compliance score of 92.5 percent in this indicator. Four tests earned scores in the *proficient* range:

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

- Providers evaluated nine out of the ten patients sampled within 24 hours of admission to the CTC (90.0 percent). The provider evaluated one patient 104 minutes late (MIT 13.002).

- We observed the working order of sampled call buttons in CTC patient rooms and found all working properly. According to staff members we interviewed, custody officers and clinicians were able to expeditiously access patients' locked rooms when emergent events occurred (MIT 13.101).

One test was *adequate*:

- PVSP's providers timely completed their Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes at required three-day intervals for eight of ten sampled patients (80.0 percent). Providers completed their SOAPE notes one day late for two patients. Also, for one of these two patients, the provider did not document a complete SOAPE note (MIT 13.003).

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14 — *SPECIALTY SERVICES*

Case Review Rating:
Adequate
Compliance Score:
Adequate
(80.6%)
Overall Rating:
Adequate

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

Case Review Results

We reviewed 73 events related to *Specialty Services*, which included 46 specialty consultations and procedures. We found 17 deficiencies in this category, 3 of which were significant. The case review rating for this indicator was *adequate*.

Access to Specialty Services

PVSP usually had no problem with providing timely access to specialty services. We found only one scheduling deficiency:

- In case 21, the patient had a complex retinal eye disease. The consulting eye doctor requested a two-month follow-up appointment for the patient, however, the appointment did not occur.

Health Information Management

PVSP staff had room for improvement in retrieving specialty reports. We found specialty reports that were retrieved late or not at all. While these deficiencies did not result in harm, they did increase the risk of lapses in care. These deficiencies occurred in cases 8, 17, 29, and the following cases:

- In case 15, the infectious disease report was not retrieved in a timely manner. The specialist recommended decreasing the dose of antibiotic medication. The specialty recommendations did not reach the primary provider until nine days after the patient's appointment.

- In case 41, the magnetic resonance imaging (MRI) report and infectious disease recommendations were unavailable for provider review when the patient saw his regular provider six days after the procedure and consultation.

In addition, providers failed to sign specialty reports in cases 8 and 20.

Nursing Performance

Nurses performed well in assessing patients, reviewing specialty reports, and documenting encounters. However, when specialty reports were not immediately available, nurses failed to obtain the report or inform the specialty clinic staff to follow up on the missing reports. PVSP's management confirmed it was the responsibility of the nurses to retrieve specialists' recommendations and transmit them to the primary provider when patients returned from offsite specialty appointments. The following case illustrates a deficiency in this area:

- In case 15, as noted previously, the telemedicine specialist recommended reducing the dosage of an important antibiotic for the patient. However, the telemedicine nurse who was present during the visit did not transmit the recommendation to the provider. This error contributed to the delay in decreasing the dosage of the patient's medication.

We also found two significant nursing deficiencies that also contributed to delays in medical care in the following cases:

- In case 20, the patient was scheduled for an urgent eye surgery. The surgery was delayed for three days because the nurse failed to ensure the patient did not eat breakfast the day of the surgery. The patient could not have anesthesia with a full stomach, so the surgery had to be postponed.

- In case 39, the patient was scheduled for an important cardiac stress test to evaluate the patient's risk of coronary artery disease. When the patient refused the test, the nurse did not refer the patient back to the primary provider to determine if or when the test should be rescheduled.

Provider Performance

The institution's providers usually referred their patients to appropriate specialists within safe time frames. When specialty reports were available, the providers usually reviewed the reports timely and acted on them correctly.

Clinician Onsite Inspection

We noted the specialty services process at PVSP was fragmented and uncoordinated. No one was responsible for coordinating efforts to ensure adequate tracking of the operation from start to finish. When we inquired about the patient who refused the cardiology test (case 39), PVSP's health care staff claimed that a follow-up appointment was not scheduled because the provider did not request one. However, we found no evidence that health care staff notified the provider of the patient's refusal or that the provider was aware of the refusal. The institution should ensure that providers review the refusals of these important medical appointments. In addition, we found many incomplete retrievals of consultation reports because the institution's staff did not sufficiently track specialty reports.

Case Review Conclusion

Providers referred patients to specialists appropriately. The institution scheduled and completed most specialty services timely. When patients returned from specialty appointments, nurses usually assessed these patients correctly. However, we found multiple problems with the institution's inability to retrieve specialty reports timely and consistently. When specialty recommendations were unavailable, nurses often failed to retrieve those recommendations and transmit them to the primary provider. At PVSP, no one was assigned to coordinate or oversee the entire specialty services process, which contributed to some of these problems. Compared to Cycle 4, PVSP's performance in this area had significantly regressed. Nonetheless, most patients still received the specialty care they needed. The deficiencies we found did not place the patients at serious risk of harm. We rated the *Specialty Services* indicator *adequate*.

Compliance Testing Results

The institution received an *adequate* compliance score of 80.6 percent in this indicator, with the following three tests scoring in the *proficient* range:

- The institution provided high-priority specialty services appointments within 14 days of the provider's order to 14 of 15 patients sampled (93.3 percent). The institution provided one patient's specialty services appointment three days late (MIT 14.001).

- PVSP provided routine specialty services appointments to 14 of 15 patients sampled within 90 days of the provider's order (93.3 percent). PVSP provided one patient's routine specialty services appointment 27 days late (MIT 14.003).

- PVSP's health care management timely denied providers' specialty services requests for all 20 patients sampled (MIT 14.006).

Two tests scored in the *adequate* range:

- Providers timely received and reviewed the high-priority specialists' reports for 11 of the 14 applicable patients (78.6 percent). One patient's report was received 21 days late. Another patient's report was received and reviewed one day late. Finally, the institution did not scan one remaining patient's high-priority specialty report into the patient's electronic medical record (MIT 14.002).

- When an institution approves or schedules a patient for specialty services appointments and then transfers the patient to another institution, policy requires that the receiving institution ensure a patient's appointment occurs timely. At PVSP, 15 of the 20 patients who transferred from another institution (75.0 percent) received their specialty services appointments within the required time frame. The institution provided previously approved services to the remaining five patients from 7 to 72 days late (MIT 14.005).

Two tests earned *inadequate* scores:

- Providers timely received and reviewed specialists' reports following routine specialty service appointments for 7 of the 14 sampled patients (50.0 percent). For three patients, the provider reviewed their reports five to nine days late. For another two patients, the institution did not scan the specialty reports into the patients' electronic medical records. For another patient, the institution received the report 33 days late. For one final patient, the provider did not indicate review by dating and initialing the report (MIT 14.004).

- Among 19 applicable patients who had a specialty service denied by PVSP's health care management, 14 of them (73.7 percent) received timely notification of the denied service. For three patients, the denials were communicated one to four days late. For the two remaining patients, the providers did not communicate their denials at all. (MIT 14.007).

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15 — *ADMINISTRATIVE OPERATIONS (SECONDARY)*

Case Review Rating:
Not Applicable
Compliance Score:
Adequate
(81.3%)
Overall Rating:
Adequate

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

Compliance Testing Results

The institution received an *adequate* score of 81.3 percent in this indicator, with several tests earning *proficient* scores:

- The institution timely processed patient medical appeals in 11 of 12 months reviewed (91.7 percent). For one month, 25 percent of medical appeals were overdue (MIT 15.001).

- PVSP's Quality Management Committee (QMC) met monthly, evaluated program performance, and acted when management identified areas for improvement opportunities (MIT 15.003).

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

- The OIG inspected incident package documentation for 12 emergency medical responses reviewed by PVSP's EMRRC during the prior six-month period; all 12 sampled packages complied with policy (MIT 15.005).

- Based on a sample of ten second-level medical appeals, the institution's responses addressed all the patients' appealed issues (MIT 15.102).

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

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

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

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

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

One test earned an *adequate* score:

- PVSP's Local Governing Body (LGB) met quarterly and exercised responsibility for the quality management of patient health care in three of the four prior quarters (75.0 percent). In the second quarter, PVSP did not timely approve the LGB meeting minutes dated June 1, 2017 (MIT 15.006).

Four tests earned scores in the *inadequate* range:

- The institution did not meet the emergency response drill requirements for the most recent quarter for one of its three watches, resulting in a score of 66.7 percent. The institution's first-watch drill package did not contain a Crime/Incident Report (CDCR Form 837) as required by CCHCS policy (MIT 15.101).

- PVSP had three patient deaths occur during our sample test period. Medical staff reviewed and timely submitted the initial Inmate Death Report (CDCR Form 7229A or 7229B) to CCHCS' Death Review Unit for two patient deaths, resulting in a score of 66.7 percent. For one patient's death, the institution failed to provide sufficient evidence that the CDCR Form 7229B was submitted timely (MIT 15.103).

- We inspected records from September 2017 for five nurses to determine if their nursing supervisors properly completed monthly performance reviews. We identified the following deficiencies: the supervisor did not discuss the review results with the subordinate nurse for four nurses, and the supervisor's review did not summarize aspects that were well done or needing improvement for all five nurses. As a result, the institution scored zero for this test (MIT 15.104).

- Of the 12 nurses PVSP hired within the last year, 11 received a timely new employee orientation training. One nurse received this orientation 52 days late. As a result, the institution scored zero for this test (MIT 15.111).

Non-Scored Results

- We gathered non-scored data regarding the CCHCS Death Review Committee (DRC) completing its death review reports. Three unexpected (Level 1) deaths occurred during our review period. CCHCS policy requires the DRC to complete its death review summary report within 60 calendar days from the date of death for Level 1 deaths and submit these reports to the institution's CEO within seven calendar days thereafter. While one death review report was completed timely, the DRC completed two other reports 19 and 46 days late and submitted them to PVSP's CEO 29 and 30 days late thereafter. For the third death, CCHCS completed the review timely, but was 11 days late sending the report to the CEO (MIT 15.998).

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

RECOMMENDATIONS

The OIG recommends the following:

- The CEO should correct the review process of the EMRRC; the EMRRC failed to identify problems with the institution's emergency response and care provided by providers and nurses in the TTA. PVSP needs a properly functioning EMRRC to identify and correct the institution's various lapses in emergency care.

- The CEO should address the numerous problems related to medications at PVSP by first improving the pharmacy's staffing levels. The PIC and the CNE should then implement quality improvement measures to address the numerous problems with medication management we found during this inspection.

- The CNE and the PIC should correct and then monitor the medication transfer process to ensure medication continuity for patients transferring into and out of PVSP or returning from an outside hospital. During our inspection, we found serious problems with medication continuity in all transfer processes.

- The CNE should provide training to, and monitor, nurses in the R&R area and the TTA, as these nurses are the primary staff responsible for coordinating and ensuring the continuity of care for patients in these areas. During our inspection, nurses in R&R and the TTA did not fulfill their responsibilities sufficiently.

- The CEO should revamp the specialty services processes to ensure PVSP staff coordinate their efforts to deliver appropriate specialty care. During our inspection, we found a lack of coordination, resulting in poor tracking of specialty appointments and sporadic performance with retrieving specialty reports at PVSP. The CEO and the CNE should also develop and implement a process that will ensure the institution's staff refer patients who refuse specialty services back to the primary provider for further evaluation.

- The CME should refine the current methods used to evaluate provider performance since we found problems with provider performance in the emergency setting and issues with superficial reviews of medical records.

POPULATION-BASED METRICS

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

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

Methodology

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

Comparison of Population-Based Metrics

For Pleasant Valley State Prison, nine HEDIS measures were selected and are listed in the following *PVSP Results Compared to State and National HEDIS Scores* table. Multiple health plans publish their HEDIS performance measures at the state and national levels. The OIG has provided selected results for several health plans in both categories for comparative purposes.

Results of Population-Based Metric Comparison

Comprehensive Diabetes Care

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

When compared statewide, PVSP outperformed or matched Medi-Cal in all five diabetic measures. PVSP also outperformed Kaiser in four of the five diabetic measures. The institution scored lower than Kaiser with regard to diabetic eye exams. When compared nationally, PVSP outperformed Medicaid and commercial plans in all five diabetic measures. The institution scored lower than Medicare and the VA regarding diabetic eye exams.

Immunizations

Comparative data for immunizations was only fully available for the VA and partially available for Kaiser, commercial plans, Medicaid, and Medicare. With respect to administering influenza vaccinations to younger adults, PVSP outperformed Medicaid and commercial plans. The institution scored lower than Kaiser and the VA. No comparative data was presented regarding vaccinations for older adults, as PVSP's population of patients 65 years of age or older was zero at the time of inspection.

Cancer Screening

With respect to colorectal cancer screening, PVSP matched Kaiser North and outperformed commercial plans and Medicare. The institution scored lower than Kaiser South and the VA.

Summary

PVSP performed well with regard to population-based metrics in comparison to the other health care plans reviewed. The institution may improve its scores with immunizations by reducing patient refusals through patient education.

PVSP Results Compared to State and National HEDIS Scores

Clinical Measures	California					National		
	PVSP Cycle 5 Results[1]	HEDIS Medi-Cal 2017[2]	HEDIS Kaiser (No. CA) 2016[3]	HEDIS Kaiser (So. CA) 2016[3]	HEDIS Medicaid 2017[4]	HEDIS Com-mercial 2017[4]	HEDIS Medicare 2017[4]	VA Average 2016[5]
Comprehensive Diabetes Care								
HbA1c Testing (Monitoring)[6]	**100%**	87%	94%	94%	87%	91%	94%	99%
Poor HbA1c Control (>9.0%)[6, 7]	**13%**	38%	20%	23%	43%	33%	26%	18%
HbA1c Control (<8.0%)[6]	**81%**	52%	70%	63%	47%	56%	63%	-
Blood Pressure Control (<140/90)[6]	**88%**	63%	83%	83%	60%	62%	64%	76%
Eye Exams[6]	**57%**	57%	68%	81%	55%	54%	70%	89%
Immunizations								
Influenza Shots - Adults (18–64)	**49%**	-	56%	57%	39%	48%	-	52%
Influenza Shots - Adults (65+)[8]	**N/A**	-	-	-	-	-	71%	72%
Immunizations: Pneumococcal[8]	**N/A**	-	-	-	-	-	74%	93%
Cancer Screening								
Colorectal Cancer Screening	**79%**	-	79%	82%	-	62%	67%	82%

1. Unless otherwise stated, data was collected in November 2017 by reviewing medical records from a sample of PVSP's population of applicable patients. These random statistical sample sizes were based on a 95 percent confidence level with a 15 percent maximum margin of error.

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

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

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

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

6. For this indicator, the entire applicable PVSP 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 population did not contain any patients 65 years of age or older; therefore, this sample was omitted from the comparative analysis.

APPENDIX A — COMPLIANCE TEST RESULTS

Pleasant Valley State Prison Range of Summary Scores: 53.9% – 92.5%	
Indicator	**Compliance Score (Yes %)**
1 – ***Access to Care***	87.4%
2 – ***Diagnostic Services***	56.9%
3 – ***Emergency Services***	Not Applicable
4 – ***Health Information Management (Medical Records)***	85.3%
5 – ***Health Care Environment***	53.9%
6 – ***Inter- and Intra-System Transfers***	83.8%
7 – ***Pharmacy and Medication Management***	63.1%
8 – ***Prenatal and Post-Delivery Services***	Not Applicable
9 – ***Preventive Services***	88.2%
10 – ***Quality of Nursing Performance***	Not Applicable
11 – ***Quality of Provider Performance***	Not Applicable
12 – ***Reception Center Arrivals***	Not Applicable
13 – ***Specialized Medical Housing (OHU, CTC, SNF, Hospice)***	92.5%
14 – ***Specialty Services***	80.6%
15 – ***Administrative Operations***	81.3%

Reference Number	1 – *Access to Care*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
1.001	Chronic care follow-up appointments: Was the patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter?	19	6	25	76.0%	0
1.002	For endorsed patients received from another CDCR institution: If the nurse referred the patient to a provider during the initial health screening, was the patient seen within the required time frame?	17	8	25	68.0%	0
1.003	Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received?	29	1	30	96.7%	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?	27	2	29	93.1%	1
1.005	Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter?	10	2	12	83.3%	18
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?	8	0	8	100.0%	22
1.007	Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame?	21	1	22	95.5%	0
1.008	Specialty service follow-up appointments: Do specialty service primary care physician follow-up visits occur within required time frames?	17	6	23	73.9%	7
1.101	Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms?	6	0	6	100.0%	0
Overall percentage:					**87.4%**	

Reference Number	2 – *Diagnostic Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
2.001	Radiology: Was the radiology service provided within the time frame specified in the provider's order?	10	0	10	100.0%	0
2.002	Radiology: Did the primary care provider review and initial the diagnostic report within specified time frames?	2	8	10	20.0%	0
2.003	Radiology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	5	5	10	50.0%	0
2.004	Laboratory: Was the laboratory service provided within the time frame specified in the provider's order?	9	1	10	90.0%	0
2.005	Laboratory: Did the primary care provider review and initial the diagnostic report within specified time frames?	8	2	10	80.0%	0
2.006	Laboratory: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	0	10	10	0.0%	0
2.007	Pathology: Did the institution receive the final diagnostic report within the required time frames?	6	4	10	60.0%	0
2.008	Pathology: Did the primary care provider review and initial the diagnostic report within specified time frames?	7	1	8	87.5%	2
2.009	Pathology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	2	6	8	25.0%	2
Overall percentage:					**56.9%**	

3 – *Emergency Services*

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

Reference Number	4 – *Health Information Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated healthcare documents (provider progress notes) scanned within 3 calendar days of the patient encounter date?	8	0	8	100.0%	0
4.002	Are dictated/transcribed documents scanned into the patient's electronic health record within five calendar days of the encounter date?	Not Applicable				
4.003	Are High-Priority specialty notes (either a Form 7243 or other scanned consulting report) scanned within the required time frame?	14	6	20	70.0%	0
4.004	Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge?	20	0	20	100.0%	0
4.005	Are medication administration records (MARs) scanned into the patient's electronic health record within the required time frames?	Not Applicable				
4.006	During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files?	19	5	24	79.2%	0
4.007	For patients discharged from a community hospital: Did the preliminary hospital discharge report include key elements and did a primary care provider review the report within three calendar days of discharge?	17	5	22	77.3%	0
Overall percentage:					**85.3%**	

Reference Number	5 – *Health Care Environment*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
5.101	Are clinical health care areas appropriately disinfected, cleaned, and sanitary?	10	0	10	100.0%	0
5.102	Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	6	4	10	60.0%	0
5.103	Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	8	2	10	80.0%	0
5.104	Does clinical health care staff adhere to universal hand hygiene precautions?	6	4	10	60.0%	0
5.105	Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	4	6	10	40.0%	0
5.106	Warehouse, Conex and other non-clinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program?	0	1	1	0.0%	0
5.107	Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	3	7	10	30.0%	0
5.108	Do clinic common areas and exam rooms have essential core medical equipment and supplies?	2	8	10	20.0%	0
5.109	Do clinic common areas have an adequate environment conducive to providing medical services?	7	2	9	77.8%	1
5.110	Do clinic exam rooms have an adequate environment conducive to providing medical services?	5	5	10	50.0%	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	75.0%	2
Overall percentage:					**53.9%**	

Reference Number	6 – *Inter- and Intra-System Transfers*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
6.001	For endorsed patients received from another CDCR institution or COCF: Did nursing staff complete the initial health screening and answer all screening questions on the same day the patient arrived at the institution?	24	1	25	96.0%	0
6.002	For endorsed patients received from another CDCR institution or COCF: When required, did the RN complete the assessment and disposition section of the health screening form; refer the patient to the TTA, if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening?	25	0	25	100.0%	0
6.003	For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption?	8	2	10	80.0%	15
6.004	For patients transferred out of the facility: Were scheduled specialty service appointments identified on the patient's health care transfer information form?	6	8	14	42.9%	0
6.101	For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents?	2	0	2	100.0%	8
Overall percentage:					**83.8%**	

Reference Number	*7 – Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.001	Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows?	10	5	15	66.7%	10
7.002	Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames?	20	5	25	80.0%	0
7.003	Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames?	15	7	22	68.2%	0
7.004	For patients received from a county jail: Were all medications ordered by the institution's reception center provider administered, made available, or delivered to the patient within the required time frames?	Not Applicable				
7.005	Upon the patient's transfer from one housing unit to another: Were medications continued without interruption?	23	2	25	92.0%	0
7.006	For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption?	Not Applicable				
7.101	All clinical and medication line storage areas for narcotic medications: Does the Institution employ strong medication security over narcotic medications assigned to its clinical areas?	4	3	7	57.1%	3
7.102	All clinical and medication line storage areas for non-narcotic medications: Does the Institution properly store non-narcotic medications that do not require refrigeration in assigned clinical areas?	2	6	8	25.0%	2
7.103	All clinical and medication line storage areas for non-narcotic medications: Does the institution properly store non-narcotic medications that require refrigeration in assigned clinical areas?	4	5	9	44.4%	1
7.104	Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes?	5	1	6	83.3%	4
7.105	Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients?	6	0	6	100.0%	4
7.106	Medication preparation and administration areas: Does the Institution employ appropriate administrative controls and protocols when distributing medications to patients?	3	3	6	50.0%	4
7.107	Pharmacy: Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and satellite pharmacies?	1	0	1	100.0%	0

Reference Number	7 – *Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.108	Pharmacy: Does the institution's pharmacy properly store non-refrigerated medications?	0	1	1	0.0%	0
7.109	Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications?	0	1	1	0.0%	0
7.110	Pharmacy: Does the institution's pharmacy properly account for narcotic medications?	1	0	1	100.0%	0
7.111	Does the institution follow key medication error reporting protocols?	20	5	25	80.0%	0
Overall percentage:					**62.8%**	

8 – *Prenatal and Post-Delivery Services*

The institution had no female patients, so this indicator was not applicable.

Reference Number	9 – *Preventive Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
9.001	Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed?	8	4	12	66.7%	0
9.002	Patients prescribed TB medication: Did the institution monitor the patient monthly for the most recent three months he or she was on the medication?	12	0	12	100.0%	0
9.003	Annual TB Screening: Was the patient screened for TB within the last year?	23	7	30	76.7%	0
9.004	Were all patients offered an influenza vaccination for the most recent influenza season?	25	0	25	100.0%	0
9.005	All patients from the age of 50 - 75: Was the patient offered colorectal cancer screening?	24	1	25	96.0%	0
9.006	Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy?	Not Applicable				
9.007	Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy?	Not Applicable				
9.008	Are required immunizations being offered for chronic care patients?	14	1	15	93.3%	10
9.009	Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	17	3	20	85.0%	0
Overall percentage:					**88.2%**	

10 – *Quality of Nursing Performance*

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

11 – *Quality of Provider Performance*

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

12 – *Reception Center Arrivals*

The institution had no reception center, so this indicator was not applicable.

Reference Number	13 – *Specialized Medical Housing*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient on the day of admission, or within eight hours of admission to CMF's Hospice?	10	0	10	100.0%	0
13.002	For CTC and SNF only: Was a written history and physical examination completed within the required time frame?	9	1	10	90.0%	0
13.003	For OHU, CTC, SNF, and Hospice: Did the primary care provider complete the Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes on the patient at the minimum intervals required for the type of facility where the patient was treated?	8	2	10	80.0%	0
13.101	For OHU and CTC only: Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter patient's cells?	1	0	1	100.0%	0
Overall percentage:					**92.5%**	

Reference Number	14 – *Specialty Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	Did the patient receive the high priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service?	14	1	15	93.3%	0
14.002	Did the primary care provider review the high priority specialty service consultant report within the required time frame?	11	3	14	78.6%	1
14.003	Did the patient receive the routine specialty service within 90 calendar days of the primary care provider order or Physician Request for Service?	14	1	15	93.3%	0
14.004	Did the primary care provider review the routine specialty service consultant report within the required time frame?	7	7	14	50.0%	1
14.005	For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames?	15	5	20	75.0%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	20	0	20	100.0%	0
14.007	Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame?	14	5	19	73.7%	1
Overall percentage:					**80.6%**	

Reference Number	15 – *Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.001	Did the institution promptly process inmate medical appeals during the most recent 12 months?	11	1	12	91.7%	0
15.002	Does the institution follow adverse / sentinel event reporting requirements?	Not Applicable				
15.003	Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified?	6	0	6	100.0%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	1	0	1	100.0%	0
15.005	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	12	0	12	100.0%	0
15.006	For institutions with licensed care facilities: Does the Local Governing Body (LGB), or its equivalent, meet quarterly and exercise its overall responsibilities for the quality management of patient health care?	3	1	4	75.0%	0
15.101	Did the institution complete a medical emergency response drill for each watch and include participation of health care and custody staff during the most recent full quarter?	2	1	3	66.7%	0
15.102	Did the institution's second level medical appeal response address all of the patient's appealed issues?	10	0	10	100.0%	0
15.103	Did the institution's medical staff review and submit the initial inmate death report to the Death Review Unit in a timely manner?	2	1	3	66.7%	0
15.104	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	0	5	5	0.0%	0
15.105	Are nursing staff who administer medications current on their clinical competency validation?	10	0	10	100.0%	0
15.106	Are structured clinical performance appraisals completed timely?	7	0	7	100.0%	0
15.107	Do all providers maintain a current medical license?	9	0	9	100.0%	0
15.108	Are staff current with required medical emergency response certifications?	2	0	2	100.0%	1
15.109	Are nursing staff and the Pharmacist-in-Charge current with their professional licenses and certifications, and is the pharmacy licensed as a correctional pharmacy by the California State Board of Pharmacy?	6	0	6	100.0%	1

Reference Number	15 – *Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.110	Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	1	0	1	100.0%	0
15.111	Are nursing staff current with required new employee orientation?	0	1	1	0.0%	0
Overall percentage:					**81.3%**	

APPENDIX B — CLINICAL DATA

Table B-1: PVSP Sample Sets

Sample Set	Total
Death Review/Sentinel Events	3
Diabetes	3
Emergency Services – CPR	2
Emergency Services – Non-CPR	3
High Risk	3
Hospitalization	5
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	18
Specialty Services	3
	46

Table B-2: PVSP Chronic Care Diagnoses

Diagnosis	Total
Anemia	2
Arthritis/Degenerative Joint Disease	5
Asthma	7
COPD	3
Cardiovascular Disease	1
Chronic Pain	20
Cirrhosis/End-Stage Liver Disease	1
Coccidioidomycosis	8
Diabetes	4
Gastroesophageal Reflux Disease	10
Gastrointestinal Bleed	1
Hepatitis C	17
Hyperlipidemia	5
Hypertension	11
Mental Health	14
Rheumatological Disease	1
Seizure Disorder	5
Thyroid Disease	2
	117

Table B-3: PVSP Event – Program

Diagnosis	Total
Diagnostic Services	96
Emergency Care	38
Hospitalization	37
Intra-System Transfers In	11
Intra-System Transfers Out	6
Outpatient Care	389
Specialized Medical Housing	78
Specialty Services	70
	725

Table B-4: PVSP Review Sample Summary

	Total
MD Reviews Detailed	22
MD Reviews Focused	0
RN Reviews Detailed	15
RN Reviews Focused	25
Total Reviews	62
Total Unique Cases	46
Overlapping Reviews (MD & RN)	16

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

Pleasant Valley State Prison

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Access to Care			
MIT 1.001	Chronic Care Patients (25)	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • **Randomize**
MIT 1.002	Nursing Referrals (25)	OIG Q: 6.001	• See ***Intra-system Transfers***
MITs 1.003–006	Nursing Sick Call (5 per clinic) (30)	MedSATS	• Clinic (each clinic tested) • Appointment date (2–9 months) • **Randomize**
MIT 1.007	Returns from Community Hospital (22)	OIG Q: 4.007	• See ***Health Information Management (Medical Records)*** (returns from community hospital)
MIT 1.008	Specialty Services Follow-up (30)	OIG Q: 14.001 & 14.003	• See ***Specialty Services***
MIT 1.101	Availability of Health Care Services Request Forms (6)	OIG onsite review	• Randomly select one housing unit from each yard
Diagnostic Services			
MITs 2.001–003	Radiology (10)	Radiology Logs	• Appointment date (90 days–9 months) • **Randomize** • Abnormal
MITs 2.004–006	Laboratory (10)	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • **Randomize** • Abnormal
MITs 2.007–009	Pathology (10)	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • **Randomize**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Health Information Management (Medical Records)			
MIT 4.001	Timely Scanning (8)	OIG Qs: 1.001, 1.002, & 1.004	• Non-dictated documents • 1st 10 IPs MIT 1.001, 1st 5 IPs MITs 1.002, 1.004
MIT 4.002	(0)	OIG Q: 1.001	• Dictated documents • First 20 IPs selected
MIT 4.003	(20)	OIG Qs: 14.002 & 14.004	• Specialty documents • First 10 IPs for each question
MIT 4.004	(20)	OIG Q: 4.007	• Community hospital discharge documents • First 20 IPs selected
MIT 4.005	(0)	OIG Q: 7.001	• MARs • First 20 IPs selected
MIT 4.006	(5)	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.007	Returns From Community Hospital (22)	Inpatient claims data	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • **Randomize** (each month individually) • First 5 patients from each of the 6 months (if not 5 in a month, supplement from another, as needed)
Health Care Environment			
MIT 5.101–105 MIT 5.107–111	Clinical Areas (10)	OIG inspector onsite review	• Identify and inspect all onsite clinical areas.
Inter- and Intra-System Transfers			
MIT 6.001–003	Intra-System Transfers (25)	SOMS	• Arrival date (3–9 months) • Arrived from (another CDCR facility) • Rx count • **Randomize**
MIT 6.004	Specialty Services Send-Outs (14)	MedSATS	• Date of transfer (3–9 months) • **Randomize**
MIT 6.101	Transfers Out (10)	OIG inspector onsite review	• R&R IP transfers with medication

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Pharmacy and Medication Management			
MIT 7.001	Chronic Care Medication (25)	OIG Q: 1.001	*See* ***Access to Care*** • At least one condition per patient—any risk level • **Randomize**
MIT 7.002	New Medication Orders (25)	Master Registry	• Rx count • **Randomize** • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns from Community Hospital (22)	OIG Q: 4.007	• See ***Health Information Management (Medical Records)*** *(returns from community hospital)*
MIT 7.004	RC Arrivals – Medication Orders *(N/A at this institution)*	OIG Q: 12.001	• See ***Reception Center Arrivals***
MIT 7.005	Intra-Facility Moves (25)	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • **Randomize**
MIT 7.006	En Route (0)	SOMS	• Date of transfer (2–8 months) • Sending institution (another CDCR facility) • **Randomize** • NA/DOT meds
MITs 7.101–103	Medication Storage Areas (varies by test)	OIG inspector onsite review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–106	Medication Preparation and Administration Areas (varies by test)	OIG inspector onsite review	• Identify and inspect onsite clinical areas that prepare and administer medications
MITs 7.107–110	Pharmacy (1)	OIG inspector onsite review	• Identify & inspect all onsite pharmacies
MIT 7.111	Medication Error Reporting (25)	Monthly medication error reports	• All monthly statistic reports with Level 4 or higher • Select a total of 5 months
MIT 7.999	Isolation Unit KOP Medications (4)	Onsite active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in isolation units
Prenatal and Post-Delivery Services			
MIT 8.001–007	Recent Deliveries *(N/A at this institution)*	OB Roster	• Delivery date (2–12 months) • **Most recent** deliveries (within date range)
	Pregnant Arrivals *(N/A at this institution)*	OB Roster	• Arrival date (2–12 months) • **Earliest** arrivals (within date range)

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Preventive Services			
MITs 9.001–002	TB Medications (12)	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • **Randomize**
MIT 9.003	TB Evaluation, Annual Screening (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • Birth Month • **Randomize**
MIT 9.004	Influenza Vaccinations (25)	SOMS	• Arrival date (at least 1 year prior to inspection) • **Randomize** • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening (25)	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • **Randomize**
MIT 9.006	Mammogram *(N/A at this institution)*	SOMS	• Arrival date (at least 2 yrs prior to inspection) • Date of birth (age 52–74) • **Randomize**
MIT 9.007	Pap Smear *(N/A at this institution)*	SOMS	• Arrival date (at least three yrs prior to inspection) • Date of birth (age 24–53) • **Randomize**
MIT 9.008	Chronic Care Vaccinations (25)	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • **Randomize** • Condition must require vaccination(s)
MIT 9.009	Valley Fever (20)	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • **All**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Reception Center Arrivals			
MITs 12.001–008	RC *(N/A at this institution)*	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • **Randomize**
Specialized Medical Housing			
MITs 13.001–004	CTC (10)	CADDIS	• Admit date (1–6 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • **Randomize**
MIT 13.101	Call Buttons CTC (all)	OIG inspector onsite review	• Review by location
Specialty Services			
MITs 14.001–002	High-Priority (15)	MedSATS	• Approval date (3–9 months) • **Randomize**
MITs 14.003–004	Routine (15)	MedSATS	• Approval date (3–9 months) • Remove optometry, physical therapy or podiatry • **Randomize**
MIT 14.005	Specialty Services Arrivals (20)	MedSATS	• Arrived from (other CDCR institution) • Date of transfer (3–9 months) • **Randomize**
MIT 14.006–007	Denials (19)	InterQual	• Review date (3–9 months) • **Randomize**
	(1)	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • **Randomize**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Administrative Operations			
MIT 15.001	Medical Appeals (all)	Monthly medical appeals reports	• Medical appeals (12 months)
MIT 15.002	Adverse/Sentinel Events (0)	Adverse/sentinel events report	• Adverse/sentinel events (2–8 months)
MITs 15.003–004	QMC Meetings (6)	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.005	EMRRC (12)	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.006	LGB (4)	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills (3)	Onsite summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	2nd Level Medical Appeals (10)	Onsite list of appeals/closed appeals files	• Medical appeals denied (6 months)
MIT 15.103	Death Reports (3)	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.104	RN Review Evaluations (5)	Onsite supervisor periodic RN reviews	• RNs who worked in clinic or emergency setting six or more days in sampled month • **Randomize**
MIT 15.105	Nursing Staff Validations (10)	Onsite nursing education files	• On duty one or more years • Nurse administers medications • **Randomize**
MIT 15.106	Provider Annual Evaluation Packets (7)	Onsite provider evaluation files	• All required performance evaluation documents
MIT 15.107	Provider licenses (9)	Current provider listing (at start of inspection)	• Review all

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

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

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Administrative Operations			
MIT 15.110	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations (all)	Onsite listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 15.111	Nursing Staff New Employee Orientations (all)	Nursing staff training logs	• New employees (hired within last 12 months) •
MIT 15.998	Death Review Committee (3)	OIG summary log - deaths	• Between 35 business days & 12 months prior • CCHCS death reviews

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

April 9, 2019

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

Dear Mr. Wesley:

The Office of the Receiver has reviewed the draft report of the Office of the Inspector General (OIG) Medical Inspection Results for Pleasant Valley State Prison (PVSP) conducted from November 2017 to May 2018. California Correctional Health Care Services (CCHCS) acknowledges the OIG findings.

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

Sincerely,

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

cc: Clark Kelso, Receiver
Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
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Stephen Tseng, M.D., Chief of Medical Inspections, OIG
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Misty Polasik, Staff Services Manager I, OIG