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California Substance Abuse Treatment Facility and State Prison at Corcoran Medical Inspection Results, Cycle 4

January 2017

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Office of the Inspector General
CALIFORNIA SUBSTANCE ABUSE TREATMENT FACILITY AND STATE PRISON AT CORCORAN
Medical Inspection Results
Cycle 4

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EXECUTIVE SUMMARY

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

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

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

The OIG performed its Cycle 4 medical inspection at SATF from February to April 2016. The inspection included in-depth reviews of 81 inmate-patient files conducted by clinicians, as well as reviews of documents from 447 inmate-patient files, covering 93 objectively scored tests of compliance with policies and procedures applicable to the delivery of medical care. The OIG assessed the case review and compliance results at SATF using 14 health care quality indicators applicable to the institution, made up of 12 primary clinical indicators and 2 secondary administrative indicators. To conduct clinical case reviews, the OIG employs a clinician team consisting of a physician and a registered nurse consultant, while compliance testing is done by a team of deputy inspectors general and registered nurses trained in monitoring medical policy compliance. Of the 12 primary indicators, 7 were rated by both case review clinicians and compliance inspectors, 3 were rated by case review clinicians only, and 2 were rated by compliance inspectors only; both secondary indicators were rated by compliance inspectors only. See the *Health Care Quality Indicators* table on page *ii*. Based on that analysis, OIG experts made a considered and measured overall opinion that the quality of health care at SATF was ***adequate***.

Health Care Quality Indicators

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

Overall Assessment: Adequate

Overall Assessment Rating:

Adequate

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

Clinical Case Review and OIG Clinician Inspection Results

The clinicians' case reviews sampled patients with high medical needs and included a review of 1,772 patient care events.[1] Of the 12 primary indicators applicable to SATF, 10 were evaluated by clinician case review; 8 were *adequate*, and 2 were *inadequate.* When determining the overall adequacy of care, the OIG paid particular attention to the clinical nursing and provider quality indicators, as adequate health care staff can sometimes overcome suboptimal processes and programs. However, the opposite is not true; inadequate health care staff cannot provide adequate care, even though the established processes and programs onsite may be adequate. The OIG clinicians identify inadequate medical care based on the risk of significant harm to the patient, not the actual outcome.

Program Strengths — Clinical

- SATF implemented a morning report program in which the provider on call updated the other medical providers about important events, including those involving patients seen in the treatment and triage area (TTA), patients sent to a community hospital, and patients transferred from other prisons. This arrangement enhanced communication among the provider team members.

- The chief medical executive instructed providers that all scheduled patients should be seen on the day they were scheduled. This was in addition to urgent evaluations and referrals from the nurses' lines. The two mid-level providers were deployed as needed to assist assigned clinic providers. As a result, SATF reported no provider appointment backlogs.

- Providers interviewed during the onsite visit uniformly expressed a high morale and team spirit.

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

- SATF informed the OIG clinicians of the implementation of the LACE (length of stay, acuity, comorbidities, and emergency department) assessment tool for patients returning from a higher level of care. This significantly reduced the 30-day hospital readmission rate, from approximately 11 percent to 3 percent. To ensure implementation of discharge recommendations, the primary provider and the clinic nurse evaluated all patients at high risk for readmission within one business day.

Program Weaknesses — Clinical

- Nursing staff did not always timely respond with appropriate action when they assessed patients during sick call encounters or when they assessed patients who arrived in the TTA with potentially urgent conditions.

- Patients in the CTC were not always seen as required every 72 hours. In addition, superficial assessments, inadequate review of records, and the lack of continuity of patient care led to many questionable management decisions. These errors compounded when the providers used cloned notes.

- Numerous errors in medication administration, interruptions in continuity of administration of medications, and pharmacy errors were noted in the CTC, transfer process, and the other outpatient settings.

Compliance Testing Results

Of the 14 health care indicators applicable to SATF, compliance inspectors evaluated 11.[2] There were 93 individual compliance questions within those 11 indicators, generating 1,371 data points, testing SATF's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[3] Those 93 questions are detailed in *Appendix A — Compliance Test Results*. The institution's inspection scores in the 11 applicable indicators ranged from 51.7 percent to 95 percent, with the secondary (administrative) indicator *Internal Monitoring, Quality Improvement, and Administrative Operations* receiving the lowest score, and the secondary (administrative) indicator *Job Performance, Training, Licensing, and Certifications* receiving the highest. Of the nine primary indicators applicable to compliance testing, the OIG rated five *adequate* and four *inadequate.* Of the two secondary indicators, which involve administrative health care functions, one was rated *proficient* and the other, *inadequate.*

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

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

Program Strengths — Compliance

As the *SATF Executive Summary Table* on page *viii* indicates, none of the institution's compliance ratings were *proficient*, scoring above 85 percent, in the primary indicators. However, one secondary (administrative) compliance rating, *Job Performance, Training, Licensing, and Certifications*, was *proficient*.

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

- Patients had a standardized process to obtain and submit forms for health care services, and nursing staff timely reviewed those requests and completed face-to-face visits with patients.
- Non-dictated progress notes, Initial Health Screening forms (CDCR Form 7277), Health Care Services Request forms (CDCR Form 7362), specialty service documents, and community hospital discharge documents were timely scanned into patients' electronic Unit Health Record (eUHR).
- Nurses timely delivered or administered all prescribed medications to patients who suffered with chronic care conditions.
- All patients sampled were timely offered an influenza vaccination for the most recent influenza season.
- Nurses timely completed initial assessments for sampled patients who were admitted to the CTC.
- Patients timely received high-priority and routine specialty service appointments.

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

- SATF promptly processed patients' initial medical appeals and addressed all appealed issues when responding to patients' second-level medical appeals.
- All providers received timely and complete clinical performance appraisals.
- All nursing staff hired within the most recent year timely received new employee orientation training, and nursing staff who administered medications possessed current clinical competency validations.

Program Weaknesses — Compliance

The institution received ratings of *inadequate*, scoring below 75 percent, in the following four primary indicators: *Health Information Management (Medical Records)*, *Pharmacy and Medication Management*, *Preventive Services*, and *Specialty Services.* The institution also received an *inadequate* score in the secondary administrative indicator *Internal Monitoring, Quality Improvement, and Administrative Operations*.

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

- Providers did not conduct timely appointments with patients who were referred to them by nursing staff upon their transfer to SATF from other institutions, or with those who required a follow-up visit after receiving a specialty service.

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

- Patients who transferred into SATF from other institutions, those who were in transit to another institution and were temporarily housed at SATF, and those who transferred from one housing unit to another did not receive their medications without interruption. Also, patients taking tuberculosis medications did not always timely receive their medication or the required monitoring.

- In most clinic and medication line locations, nursing staff did not employ strong security controls over narcotics.

- Nursing staff failed to follow appropriate protocols when administering medications to patients.

- Patients who suffered with chronic care conditions did not always receive required immunizations.

- When the institution denied provider requests for specialty services, the denials were not timely processed and providers did not timely meet with the patients to discuss alternate treatment strategies.

- The institution did not provide timely specialty service appointments to patients who transferred into SATF from other institutions with previously approved or scheduled appointments.

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

- Both Emergency Medical Response Review Committee incident review packages and emergency response drill packages lacked required documentation.

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

SATF Executive Summary Table

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

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

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

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

Population-Based Metrics

In general, SATF performed adequately as measured by population-based metrics. In three of the five comprehensive diabetes care measures, SATF outperformed other State and national organizations. This included Medi-Cal as well as Kaiser Permanente (typically one of the highest-scoring health organizations in California), Medicaid, Medicare, commercial entities, and the United States Department of Veterans Affairs (VA). The institution scored lower than Kaiser, statewide, in one measure and lower than both Kaiser, Southern California, and the VA in another measure.

With regard to immunization measures, SATF outperformed other entities for administering influenza vaccinations. SATF timely offered all sampled patients their required influenza immunizations, but many patients refused the offers, which negatively affected the institution's score. For administering pneumococcal immunizations, the institution's rate was higher than Medicare's but lower than the VA's.

The institution's rate for administering colorectal cancer screenings to older adults was significantly lower than Kaiser's and the VA's, but was slightly higher than commercial entities' rate and matched Medicare's. Again, patient refusals influenced the institution's performance in this measure.

Overall, SATF's performance demonstrated by population-based metrics indicated that comprehensive diabetes care, immunizations, and cancer screenings were adequate in comparison to other State and national health care organizations.

INTRODUCTION

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

The California Substance Abuse Treatment Facility and State Prison at Corcoran (SATF) was the 21st medical inspection of Cycle 4. During the inspection process, the OIG assessed the delivery of medical care to patients for 12 primary clinical health care indicators and 2 secondary administrative health care indicators applicable to the institution. It is important to note that while the primary quality indicators represent the clinical care being provided by the institution at the time of the inspection, the secondary quality indicators are purely administrative and are not reflective of the actual clinical care provided.

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

ABOUT THE INSTITUTION

The California Substance Abuse Treatment Facility and State Prison at Corcoran (SATF) operates as a high-medium-security and maximum-security institution for general population inmates. The institution runs 11 medical clinics where staff members address routine requests for medical services. SATF also conducts patient screenings in its receiving and release (R&R) clinical area, treats inmates needing urgent or emergency care in its triage and treatment area (TTA), and treats those requiring inpatient health services in the correctional treatment center (CTC). It has been designated a "basic care institution." Basic care institutions are located in rural areas away from tertiary care centers and specialty care providers whose services are likely to be used frequently by higher-risk patients. Basic care institutions have the capability to provide limited specialty medical services and consultation for a generally healthy inmate-patient population.

On January 28, 2016, the institution received national accreditation from the Commission on Accreditation for Corrections. This accreditation program is a professional peer review process based on national standards set by the American Correctional Association.

Based on staffing data the OIG obtained from the institution, SATF's overall vacancy rate among medical managers, primary care providers, nursing supervisors, and non-supervisory nurses was 15 percent in January 2016. As indicated in the table below, SATF had 145.5 budgeted health care positions, of which 123 were filled. Based on its authorized and filled positions, the institution reported 22.5 vacant positions, with the highest vacancy percentages among primary care providers and non-supervisory nurses. SATF had three vacant provider positions and 18 vacant nursing staff positions; one other staff nurse had been redirected from clinical work. However, the institution had three additional certified nurse assistants working in the CTC whose positions were funded under the institution's "blanket" resources.[4] The chief executive officer (CEO) reported that as of January 2016, there were two staff members under CDCR disciplinary review, both of whom were still working in a clinical setting.

SATF Health Care Staffing Resources as of January 2016

	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff		Totals	
Description	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Authorized Positions	4	3%	14	10%	13.5	9%	114	78%	145.5	100%
Filled Positions	4	100%	11	79%	12	89%	96	84%	123	85%
Vacancies	0	0%	3	21%	1.5	11%	18	16%	22.5	15%
Recent Hires (within 12 months)	0	0%	1	9%	5	42%	21	22%	27	22%
Staff Utilized from Registry	0	0%	0	0%	0	0%	0	0%	0	0%
Redirected Staff (to Non-Patient Care Areas)	0	0%	0	0%	0	0%	1	1%	1	1%
Staff on Long-Term Medical Leave	0	0%	0	0%	0	0%	11	11%	11	9%

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

[4] Blanket resources are those available to the institution from salary savings related to authorized positions that are not currently filled. At management's discretion, blanket resources can be used to temporarily redirect funds from one unit within the institution to another.

As of January 25, 2016, the Master Registry for SATF showed that the institution had a total population of 5,423. Within that total population, 3 percent were designated as high medical risk, Priority 1 (High 1), and approximately 8 percent were designated as high medical risk, Priority 2 (High 2). Patients' assigned risk levels are based on the complexity of their required medical care related to their specific diagnoses, frequency of higher levels of care, age, and abnormal labs and procedures. High 1 has at least two high-risk conditions; High 2 has only one. Patients at high medical risk are more susceptible to poor health outcomes than those at medium or low medical risk. Patients at high medical risk also typically require more health care services than do patients with lower assigned risk levels. The chart below illustrates the breakdown of the institution's medical risk levels at the start of the OIG medical inspection.

SATF Master Registry Data as of January 25, 2016

Medical Risk Level	# of Inmate-Patients	percentage
High 1	165	3%
High 2	420	8%
Medium	2,982	55%
Low	1,856	34%
Total	**5,423**	**100%**

Commonly Used Abbreviations

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

OBJECTIVES, SCOPE, AND METHODOLOGY

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

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

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

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

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

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

CASE REVIEWS

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

PATIENT SELECTION FOR RETROSPECTIVE CASE REVIEWS

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

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

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

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

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

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

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

BENEFITS AND LIMITATIONS OF TARGETED SUBPOPULATION REVIEW

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

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

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

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

CASE REVIEWS SAMPLED

As indicated in *Appendix B, Table B–1: SATF Sample Sets*, the OIG clinicians evaluated medical charts for 81 unique inmate-patients. *Appendix B, Table B–4: SATF Case Review Sample Summary*, clarifies that both nurses and physicians reviewed charts for 20 of those patients, for 101 reviews in total. Physicians performed detailed reviews of 30 charts, and nurses performed detailed reviews of 20 charts, totaling 50 detailed reviews. For detailed case reviews, physicians or nurses looked at all encounters occurring in approximately six months of medical care. Nurses also performed a limited or focused review of medical records for an additional 51 inmate-patients. These generated 1,772 clinical events for review (*Appendix B, Table B–3: SATF Event—Program*). The inspection tool provides details on whether the encounter was adequate or had significant deficiencies, and identifies deficiencies by programs and processes to help the institution focus on improvement areas.

While the sample method specifically pulled only 5 chronic care patient records, i.e., 3 diabetes patients and 2 anticoagulation patients (*Appendix B, Table B–1: SATF Sample Sets*), the 81 unique inmate-patients sampled included patients with 248 chronic care diagnoses, including 17 additional patients with diabetes (for a total of 20) and one additional anticoagulation patient (for a total of 3) (*Appendix B, Table B–2: SATF Chronic Care Diagnoses*). The OIG's sample selection tool allowed evaluation of many chronic care programs because the complex and high-risk patients selected from the different categories often had multiple medical problems. While the OIG did not evaluate every chronic disease or health care staff member, the overall operation of the institution's system and staff were assessed for adequacy. The OIG's case review methodology and sample size matched other qualitative research. The empirical findings, supported by expert statistical consultants, showed adequate conclusions after 10 to 15 charts had undergone full clinician review. In qualitative statistics, this phenomenon is known as "saturation." The OIG asserts that the physician sample size of 30 detailed reviews certainly far exceeds the saturation point necessary for an adequate qualitative review. With regard to reviewing charts from different providers, the case review is not intended to be a focused search for poorly performing providers; rather, it is focused on how the system cares for those patients who need care the most. Nonetheless, while not sampling cases by each provider at the institution, the OIG inspections adequately review most providers. Providers would only escape OIG case review if institutional management successfully mitigated patient risk by having the more poorly performing providers care for the less complicated, low-utilizing, and lower-risk patients. The OIG's clinicians concluded that the case review sample size was more than adequate to assess the quality of services provided.

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

COMPLIANCE TESTING

SAMPLING METHODS FOR CONDUCTING COMPLIANCE TESTING

From February 2016 to April 2016, deputy inspectors general and registered nurses attained answers to 93 objective medical inspection test (MIT) questions designed to assess the institution's compliance with critical policies and procedures applicable to the delivery of medical care. To conduct most tests, inspectors randomly selected samples of inmate-patients for whom the testing objectives were applicable and reviewed their electronic unit health records. In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed health records for 447 individual inmate-patients and analyzed specific transactions within their records for evidence that critical events occurred. Inspectors also reviewed management reports and meeting minutes to assess certain administrative operations. In addition, during the week of February 8, 2016, field inspectors conducted a detailed onsite inspection of SATF's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,371 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 SATF's plant infrastructure, protocols for tracking medical appeals and local operating procedures, and staffing resources.

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

SCORING OF COMPLIANCE TESTING RESULTS

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

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

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

After compiling the answers to the 93 questions, the OIG derived a score for each primary and secondary quality indicator identified above by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Based on those results, the OIG assigned a rating to each quality indicator of *proficient* (greater than 85 percent), *adequate* (between 75 percent and 85 percent), or *inadequate* (less than 75 percent).

DASHBOARD COMPARISONS

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

OVERALL QUALITY INDICATOR RATING FOR CASE REVIEWS AND COMPLIANCE TESTING

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

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

POPULATION-BASED METRICS

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

MEDICAL INSPECTION RESULTS

PRIMARY (CLINICAL) QUALITY INDICATORS OF HEALTH CARE

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

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

Summary of Case Review Results: The clinical case review component assessed 10 of the 12 primary (clinical) indicators applicable to SATF. Of these 10 indicators, OIG clinicians rated none *proficient*, 8 *adequate*, and 2 *inadequate*.

The OIG physicians rated the overall adequacy of care for each of the 30 detailed case reviews they conducted. Of these 30 cases, 2 were *proficient*, 20 were *adequate*, and 8 were *inadequate*. In the 1,772 events reviewed, there were 461 deficiencies, of which 87 were of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

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

There was one adverse event identified in the case reviews at SATF:

- In case 15, a provider incorrectly ordered an immediate-action formulation of morphine for a cancer patient, instead of the delayed action formulation. This placed the patient at risk of significant harm from a medication overdose.

Summary of Compliance Results: The compliance component assessed 9 of the 12 primary (clinical) indicators applicable to SATF. Of these nine indicators, inspectors rated none *proficient*, five *adequate*, and four *inadequate*. The results of those assessments are summarized within this section of the report. The test questions used to assess compliance for each indicator are detailed in *Appendix A*.

ACCESS TO CARE

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

Case Review Rating:
Adequate
Compliance Score:
Adequate
(80.3%)

Overall Rating:
Adequate

Case Review Results

The OIG clinicians reviewed 1,268 provider, nurse, specialty care, and hospital discharge encounters, and identified 43 deficiencies relating to access to care. Five of these were significant and placed the patient at risk of serious harm. However, overall, patients had adequate access to address their health care needs; therefore, the OIG clinicians rated this indicator *adequate*.

RN Sick Call Access

Nursing staff at SATF generally collected and reviewed health care services request forms in a timely manner, and most patients with routine medical conditions were appropriately scheduled for nurse clinic visits on the next business day.

RN Follow-up Appointments

- In case 9, the patient, with recurrent leg infections, was not scheduled to return to see the RN as ordered. This was a significant deficiency.

Access to Specialty Services

- In case 21, the specialty evaluation ordered by the provider did not take place.

Follow-up After Specialty Consultation

Most patients were seen by their providers in a timely manner following specialty consultations, with the following exception:

- In case 12, a timely specialty clinic follow-up was not scheduled as ordered by the provider. This was a significant deficiency.

Follow-up After TTA Evaluation

Patients evaluated in the TTA are often given appointments to be reevaluated by their primary provider. This did not occur as ordered in cases 16 and 64.

Follow-up After Hospitalization

Patients were seen by their providers in a timely manner following discharge from a higher level of care.

Specialized Medical Housing

The CTC providers did not always see patients at least once every 72 hours as required by CCHCS policy (cases 7, 9, 15, 19, 22, and 31).

- In case 19, while in the CTC, this patient was seen by a provider after an interval of 10 days. This was a significant deficiency.

Diagnostics

Two significant deficiencies were noted:

- In case 10, laboratory tests were not performed as ordered by the provider for a patient with chronic liver disease whose dose of diuretics (water pills) had been increased.

- In case 35, laboratory tests were not performed as ordered for the patient, a new arrival to the institution who had a history of lip and skin cancer.

Clinician Onsite Inspection

At SATF, 11 percent of the inmates were high-risk or complex patients. This is despite CCHCS classifying SATF as a basic institution; basic institutions typically house mostly low-risk patients because of their remote location from referral hospitals, among other reasons.

SATF did require that providers see all scheduled patients. The medical clinics had no backlogs. However, with only one optometrist, there was a backlog for this service.

The RN and the provider reviewed sick call requests received during the morning huddle. Patients returning from higher levels of care were seen by the clinic RN on the following business day; this was followed by a visit with the provider on the same day, if necessary.

The clinics had LVN care coordinators who were responsible for population management and preventive screening.

Clinician Summary

Generally, patients at SATF had adequate access to health care for their needs. The few deficiencies were related to failure to schedule patients to be seen by a provider or to schedule follow-up, specialty evaluation, or laboratory testing as ordered by the provider. Patients in the CTC were not always seen within intervals required by CCHCS policy.

Compliance Testing Results

The institution performed in the *adequate* range in the *Access to Care* indicator with a compliance score of 80.3 percent, and scored in the *proficient* range in the following test areas:

- Inspectors sampled 50 Health Care Services Request forms (CDCR Form 7362) submitted by patients across all facility clinics. Nursing staff reviewed all 50 service request forms on the same day they were received (MIT 1.003).

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

- Nursing staff timely completed 48 of 50 face-to-face encounters with patients (96 percent). One nursing face-to-face encounter was late by one day, and the nursing assessment documentation was incomplete in another encounter (MIT 1.004).

In the following test areas, SATF scored in the *adequate* range:

- Of the six patients whom nursing staff referred to a provider and for whom the provider subsequently ordered a follow-up appointment, five (83 percent) received their follow-up appointment timely. One patient received the ordered follow-up appointment seven days late (MIT 1.006).

- The OIG reviewed recent appointments for 30 patients with chronic care conditions; 24 of the patients (80 percent) received timely routine appointments. Two patients' appointments occurred 3 and 17 days late, three patients' appointments occurred between one and three months late, and one patient's appointment occurred more than five months late (MIT 1.001).

- Of the 30 sampled patients who had been discharged from a community hospital, 24 (80 percent) received a timely provider follow-up appointment. Six provider follow-up appointments were one to five days late (MIT 1.007).

- Among 14 service request forms sampled on which nursing staff referred the patient for a provider appointment, 11 patients (79 percent) received a timely appointment. One provider appointment was 50 days late, and two appointments were not held at all (MIT 1.005).

The following test areas received scores in the *inadequate* range:

- Inspectors sampled 28 patients who received a specialty service; 19 of them (68 percent) received a timely follow-up appointment with a provider. Seven patients received appointments 6 to 20 days late, and two patients did not receive a follow-up appointment with a provider (MIT 1.008).

- Of the 30 patients sampled who transferred into SATF from other institutions and were referred to a provider for a routine appointment based on nursing staff's initial health care screening, only 11 were seen timely (37 percent). For 18 patients, appointments were held between one and 36 days late. For one patient, there was no evidence a provider appointment occurred (MIT 1.002).

Recommendations

No specific recommendations.

DIAGNOSTIC SERVICES

Case Review Rating:
Adequate
Compliance Score:
Adequate
(76.7%)

Overall Rating:
Adequate

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

Case Review Results

The OIG clinicians reviewed 190 diagnostic events and found 15 deficiencies, of which four were significant. The most common deficiency, in 5 of the 15 instances, was failure to schedule a test ordered by a provider (cases 8, 10, 16, 28, and 35). The OIG clinicians rated this indicator *adequate*. Significant deficiencies in cases 10 and 35 are also discussed in the *Access to Care* indicator.

- In case 69, the patient was paralyzed in both legs and had recurrent urinary tract infections. A urine specimen was collected three days after the provider ordered a urine culture. Further, an improper specimen was submitted, so the requested test could not be performed. The provider who reviewed this report erroneously informed the patient that the test result was normal and that no follow-up was required. Both these deficiencies were significant.

While providers reviewed most laboratory test results in a timely manner, delays occurred in eight instances (cases 12, 15, 19, 20, 22, 28, 31, and 69). These delays, however, did not have an adverse effect on the patient's health.

Specimens for urine or stool tests were not submitted by the nursing staff in a timely manner, or not at all, in two instances (cases 19 and 69).

Clinician Onsite Inspection

Due to logistic problems, SATF patients could not have onsite urgent or same day laboratory testing processed. Patients needing these services were transported to a community hospital.

Clinician Summary

In general, SATF performed well with regard to diagnostic services, and the indicator rating was thus *adequate*.

Compliance Testing Results

The institution received an *adequate* compliance score of 76.7 percent in the *Diagnostic Services* indicator, which encompasses radiology, laboratory, and pathology services. For clarity, each type of diagnostic service is discussed separately below:

Radiology Services

- The institution provided timely radiology services for nine of ten patients sampled (90 percent); one patient received his radiology service one day late. Providers timely reviewed the diagnostic services reports for nine patients (90 percent); for one patient, the provider failed to initial and date the report. For all ten patients, the test results were timely communicated to the patients (MIT 2.001, 2.002, 2.003).

Laboratory Services

- Among the ten laboratory services sampled, eight (80 percent) were timely performed. One patient received services ten days late; for another patient, the order was not located in the eUHR; therefore, inspectors could not determine if the service was performed timely. Providers timely reviewed all ten sampled laboratory reports and timely communicated the results to patients (MIT 2.004, 2.005, 2.006).

Pathology Services

- SATF timely received the final pathology report for nine of ten patients sampled (90 percent); one report was five days late. Providers documented evidence of their review of the reports by initialing and dating them for only one of the ten patients (10 percent). Providers timely communicated the final pathology results to only three of the ten patients (30 percent), communicating the results to four patients between one and 20 days late, and entirely failing to communicate the results to three other patients (MIT 2.007, 2.008, 2009).

Recommendation

The OIG recommends that SATF develop a system for expedited transportation and processing for urgent or same-day laboratory specimens.

EMERGENCY SERVICES

Case Review Rating:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

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

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

Case Review Results

The OIG clinicians reviewed 86 urgent/emergent events and found 18 deficiencies, of which four were considered significant (cases 10, 15, 21, and 23). The OIG inspectors rated *Emergency Services* at SATF *adequate*.

Provider Performance

Most of the events reviewed occurred in the TTA, sometimes after regular working hours or during weekends when a provider was not physically present in the TTA. Deficiencies in this setting included the following:

- In case 10, the provider did not order an analgesic for a patient in severe pain with an umbilical hernia.
- In cases 9, 10, and 17, the physician on call did not complete a telephone consultation note.
- In case 15, after evaluating a patient with severe abdominal pain, rectal bleeding, and low blood pressure, the provider should have ordered more emergent transportation to a higher level of care. The patient left the TTA nearly two and one-half hours after he arrived there.

Only one of the four significant deficiencies related to provider care; it occurred when the provider personally evaluated a patient in the TTA:

- In case 10, the provider failed to perform an abdominal examination on a patient with abdominal pain, nausea, and vomiting.

With the exception of the instances above, provider performance in the TTA was adequate.

Nursing Performance

The emergency services provided by SATF nursing staff were adequate, and nurses generally responded timely in emergent medical response events. However, three of the four significant deficiencies found in emergency services were in nursing care:

- In case 15, the TTA nurse and provider assessed the patient with dizziness, low blood pressure, abdominal tenderness, and rectal pain and bleeding. Although the patient's blood pressure continued to decrease, an intravenous line was not inserted until an hour after his arrival in the TTA. There was a 45-minute time period during which the nurse did not document the status of the patient or the nursing care provided to the patient prior to his transfer to a community hospital.

- In case 21, the patient arrived in the TTA by wheelchair and was assessed by the nurse for reported chest pain and loss of consciousness after experiencing dizziness while making his bed. There was a delay of about one hour in contacting the provider, and a delay of 25 minutes in calling 9-1-1 for an ambulance after the provider gave the order to send the patient out for higher-level evaluation. The nurse noted the patient had chest pain when he arrived in the TTA, but did not reassess the patient's pain level during the remainder of his stay in the TTA prior to transport to the hospital.

- In case 23, the patient with fever, headache, and difficulty swallowing was ordered an intravenous antibiotic and acetaminophen. Nursing staff made three attempts to insert an intravenous line that were not successful. Although there was no intravenous line access, the TTA nurse noted on the physician's order sheet that the antibiotic had been administered.

Emergency Medical Response Review Committee (EMRRC)

The EMRRC did not review code II hospital transfers (ambulance without sirens). During the onsite interview, the nurse administrators indicated that only code III urgent/emergent transfers were reviewed at SATF; they were not aware that policy required code II transfers be reviewed. Nurse administrators also discussed the SATF memorandum from the CME dated June 2010, titled "Emergency Medical Transfers," which gave custody staff 30 minutes to make arrangements for an emergency transport ambulance for code II transfers. However, the memorandum was rescinded by the CEO in December 2015, eliminating the allowance for a 30-minute delay; in cases 9, 10, and 21, providers ordered code II ambulance transfer, but it was delayed from 20 to 30 minutes.

Recommendations

No specific recommendations.

HEALTH INFORMATION MANAGEMENT (MEDICAL RECORDS)

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(68.9%)

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

In this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance testing resulting in an *inadequate* score. The OIG's internal review process considered the key factors that led to both results. Specifically, the compliance testing found that providers reviewed many hospital discharge reports from one to seven days late. However, the OIG case review clinicians concluded that SATF providers retrieved and reviewed hospital records timely but did not routinely initial and date them. Although both compliance testing and case review revealed many instances of improperly scanned and mislabeled documents, the medical inspection team concluded that these did not ultimately affect the medical services provided to patients at SATF. Therefore, case review's *adequate* finding was deemed to be the appropriate overall rating.

Case Review Results

The OIG clinicians identified 57 health information management deficiencies, of which 2 were significant. Most of the deficiencies occurred in the document scanning process. Based on the case reviews, the OIG clinicians rated this indicator *adequate*.

Hospital Records

SATF performed adequately with the retrieval and scanning of hospital and emergency room (ER) records. The OIG inspectors reviewed 40 encounters, among which there were three delays in obtaining records.

SATF providers routinely failed to initial and date the hospital and ER records. However, in most instances, discharge recommendations were implemented, suggesting that the providers had reviewed the records despite their failure to initial and date them.

Specialty Services

In five instances, specialty services reports were scanned into the eUHR before a provider reviewed them.

Specialty Services Reports

One significant health information management deficiency occurred in specialty services, and is also discussed in that indicator:

- In case 26, a Holter monitor report (heart rhythm study) was not retrieved or scanned into the eUHR.

Scanning Performance

Numerous errors were noted in the document scanning process. The most common errors were mislabeled and missing documents. One or more mislabeled documents were noted in cases 6, 7, 9, 11, 14, 15, 19, 22, 32, and 35. One or more missing documents were noted in cases 6, 7, 11, 15, 17, 18, 19, 21, 22, and 58. Three documents were misfiled, causing one significant deficiency:

- In case 10, the Physician Orders for Life Sustaining Treatment was not filed under the proper tab in the eUHR. The patient had given advance directives that he did not want cardiopulmonary resuscitation to be attempted. This important document should have been filed appropriately to be readily accessible by health care providers in an emergency setting. Additionally, two other records of a different patient had been scanned into the chart of this patient being reviewed. This error could have had undesirable consequences.

Legibility

Illegible notes pose a significant medical risk to patients, especially when other providers need to review the patient's records, or when the patient is transferred to a different health care team or to another institution. The OIG inspectors found sporadic instances of illegible notes and indistinguishable initials, signatures, or names.

Compliance Testing Results

SATF scored in the *inadequate* range in the *Health Information Management (Medical Records)* indicator, receiving a compliance score of 68.9 percent. SATF received an *inadequate* score in four areas, as discussed below:

- The institution scored zero in its labeling and filing of documents scanned into patients' eUHR files. Errors included documents that were mislabeled, filed under the wrong document category, or missing from the patient's file. Also, various medication records for two patients were scanned into other patients' files. For this test, once the OIG identifies 12 mislabeled or misfiled documents, the maximum points are lost and the resulting score is

zero. During the SATF medical inspection, inspectors identified a total of 21 documents with filing errors, 9 more than the maximum allowed (MIT 4.006).

- Among 30 sampled hospital discharge reports or treatment records for patients whom the institution sent to the hospital for a higher level of care, 18 (60 percent) were complete and reviewed by a SATF provider within three days of the patient's discharge. For 11 patients, providers reviewed the discharge reports from one to seven days late. For one other patient, the provider documented that the hospital discharge report was incomplete, but no evidence was found that any effort was made to obtain additional information (MIT 4.008).

- When the OIG reviewed various medical documents, including hospital discharge reports, Initial Health Screening forms (CDCR Form 7277), certain medication records, and specialty services reports, to ensure that clinical staff legibly documented their names on the forms, 20 of 32 samples (63 percent) were compliant. Nursing staff did not legibly sign nine documents, and providers did not legibly sign three documents (MIT 4.007).

- SATF timely scanned 14 of the 20 sampled medication administration records (MARs) into the patients' eUHRs (70 percent); six MARs were scanned from one to three days late (MIT 4.005).

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

- SATF staff timely scanned all 20 sampled specialty service consultant reports into the patient's eUHR file (MIT 4.003).

- Institution staff timely scanned 19 of 20 sampled initial health screening forms and health care service requests into patients' eUHRs within three calendar days of the patient encounter (95 percent). One document was scanned two days late (MIT 4.001).

- SATF timely scanned community hospital discharge reports or treatment records into the patient's eUHR for 19 of the 20 sampled reports (95 percent); one report scanned one day late (MIT 4.004).

Recommendations

No specific recommendations.

HEALTH CARE ENVIRONMENT

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

Case Review Rating:
Not Applicable
Compliance Score:
Adequate
(80.4%)

Overall Rating:
Adequate

Compliance Testing Results

The institution scored well in the *Health Care Environment* indicator, with an *adequate* score of 80.4 percent.

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

- Based on OIG's inspection of the institution's non-clinic storage area for bulk medical supplies, as well as responses from the warehouse manager and the CEO, the medical supply management process appropriately supported the needs of the medical health care program. As a result, SATF scored 100 percent on this test (MIT 5.106).

- All 14 clinics inspected followed adequate medical supply storage and management protocols in clinical areas (MIT 5.107).

- Thirteen of the 14 clinics (93 percent) had operable sinks and sufficient quantities of hand hygiene supplies. At one clinic, the inmate restroom was not supplied with antiseptic soap or disposable towels (MIT 5.103).

- At 13 of 14 clinics inspected (93 percent), proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste were followed. In one clinic, inspectors found biohazardous waste discarded in a regular trash receptacle (MIT 5.105).

- Good hand hygiene practice was followed in 13 of 14 observed clinics (93 percent). In one clinic, a clinician failed to wash his or her hands after an invasive surgical procedure and between patient encounters (MIT 5.104).

- Clinical health care staff at 12 of 13 applicable clinics (92 percent) ensured that reusable invasive and non-invasive medical equipment was properly sterilized or disinfected. The only exception was one clinic where the packaging for a reusable ear curette was not

appropriately date stamped; the packaging label showed no color change, indicating that it was not properly sterilized (MIT 5.102).

- Clinic common areas at 12 of the 14 clinics (86 percent) had an environment conducive to providing medical services. Two clinics lacked adequate auditory privacy for patients being seen in the common triage areas; in one of those clinics, insufficient counter space necessitated that nursing staff use a gurney as a table during medication administration (*Figure 1*) (MIT 5.109).

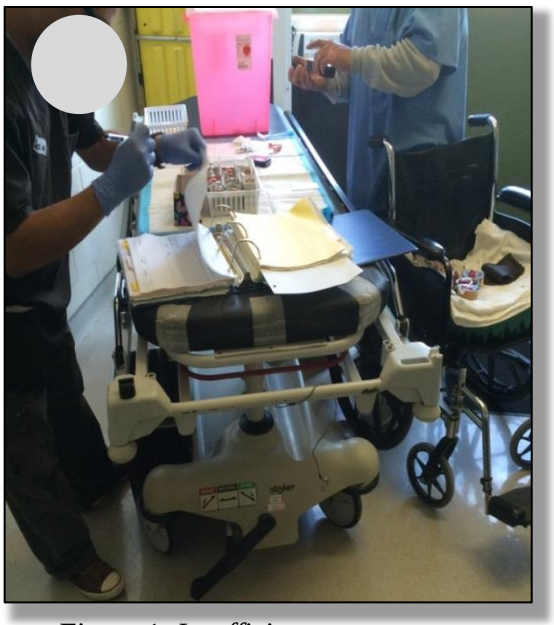

Figure 1: Insufficient counter space

The institution received an *adequate* score in the following area:

- Eleven of the 14 clinics (79 percent) were appropriately cleaned, disinfected, and sanitized; and the clinics' cleaning logs were appropriately completed. In the clinical areas of both administrative segregation facilities, floors were visibly dirty; according to an SRN, there was no process in place to ensure those areas were regularly cleaned. In another clinic, the supervisor signed the cleaning log prior to the inmate porter completing the work (MIT 5.101).

The institution received an *inadequate* compliance score in the following three areas:

- The OIG inspected various exam rooms in each of SATF's 14 clinics, observing patient encounters and interviewing clinical staff, to determine if they had appropriate space, configuration, supplies, and equipment to perform a proper clinical examination. The exam rooms or treatment spaces in only 9 of the 14 clinics (64 percent) were sufficient. Four clinics had exam tables with torn vinyl covers; one of those exam tables was in a location that made it unsuitable for a patient to lie fully extended. In two of those clinics, provider exam rooms had confidential medical documents designated for shredding in open containers that were visible and accessible to patients; staff explained that the documents were removed once a week for shredding, not daily as required. Also, the receiving and release (R&R) clinic was too small to perform basic exam functions (*Figure 2*) (MIT 5.110).

Figure 2: Inadequate exam space in the R&R clinic

- Only 8 of 14 clinics inspected (57 percent) met the OIG's compliance requirements for essential core medical equipment and supplies. Three clinics were lacking Snellen eye exam charts or distance markers. One clinic did not have a calibration sticker on the AED machine. One other clinic's two nebulizers did not have current calibration stickers and there were no nebulizer kits or tubing supplies in stock; that same clinic did not have a peak flow device and disposable mouth pieces, or a biohazard waste can; and the otoscope was in disrepair. In another clinic, the control solution for the glucometer had passed its expiration date. Finally, the R&R clinic was missing a nebulizer, a peak flow meter, a Snellen chart, and an oto-ophthalmoscope and tips (MIT 5.108).

- Inspectors examined emergency response bags to determine if they were inspected daily and inventoried monthly and whether they contained all essential items. Emergency response bags were compliant in only 3 of the 11 clinical locations where bags were stored (27 percent). In six of the deficient bags, the emergency oxygen tank was not fully charged. Also, one of the emergency bags was missing a nasal cannula, another was missing a CPR micro-mask and a blood pressure cuff, and in another, the glucose gel tubes had passed their expiration date. In three of the inspected clinics, there was no documentation indicating that an inventory of the bag had been completed in the previous 30 days (MIT 5.111).

Other Information Obtained from Non-Scored Areas

During its onsite inspection of SATF, the OIG gathered information to determine if the institution's physical infrastructure was maintained in a manner that supported health care managements' ability to provide timely and adequate health care. When OIG inspectors interviewed SATF's health care managers, they did not have any significant concerns about the existing infrastructure at the institution or its effect on staff's ability to provide adequate health care. The institution did have a process in place to identify and report infrastructure problems when they arose. As of November 2016, SATF had the following ongoing infrastructure improvement projects:

- The Health Facilities Improvement Project involves addition and renovation to various health care service areas. The five-phase project, which began in November 2015, was in progress and reported to be on task; the project was scheduled for completion in August 2017.

- The Statewide Medication Distribution project involves the renovation and remodeling of clinical medication administration and distribution areas. The project began in April 2015, and the work at several facilities had already been completed. Although unscheduled at the time of this inspection, the work on the last two facilities was anticipated to begin in January 2017.

- SATF reported that roof repair projects were recently completed on two yards, scheduled to start in May 2017 on another yard, and planned but unscheduled on other yards.

Recommendation for CCHCS

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

Recommendations for SATF

The OIG recommends that SATF develop local operating procedures that ensure the following:

- All clinical areas maintain a full complement of core medical equipment that includes a Snellen vision chart with a permanent distance marker, peak flow device with disposable mouth pieces, nebulizers with kits and tubing; and each exam room has an oto-ophthalmoscope and tips, and a biohazard waste receptacle.

- Staff members regularly monitor medical equipment items to ensure they are in working order and currently calibrated, and torn areas on vinyl-covered exam tables are repaired or the tables are replaced.

INTER- AND INTRA-SYSTEM TRANSFERS

Case Review Rating:
Adequate
Compliance Score:
Adequate
(80.3%)

Overall Rating:
Adequate

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

Case Review Results

The OIG clinicians reviewed 135 inter- and intra-system transfers. These included 21 intra-system transfer-in events; 16 intra-system transfer-out events; and 98 hospitalization events, each of which resulted in a transfer back to the institution. In general, the inter- and intra-system transfer processes at SATF were *adequate*. The OIG found 54 deficiencies, of which 11 were considered significant (six deficiencies in case 10, two in case 9, and one each in cases 6, 15, and 21). The significant deficiencies were primarily in the area of pharmacy and medication management and specifically involved breaks in continuity of prescribed medications.

Transfers In

- In case 9, when the diabetic patient arrived at SATF, the provider and nurse inappropriately used an older medication list. This led to discontinuation of a diabetes medication and a blood pressure medication. The deficiency is also discussed in the *Pharmacy and Medication Management* indicator.

Transfers Out

- In case 9, the patient was transferred out of SATF without all of his prescribed medications, including regular insulin, blood pressure medication, and iron tablets. The parole medication receipt was incomplete; it did not include a notation about whether the patient accepted the medications or if he wanted a pharmacy consultation.

Hospitalizations

Patients returning from hospitalization or from outside emergency departments (EDs) are some of the highest-risk encounters due to two factors. First, these patients have usually been admitted for management of a severe illness or injury. Second, they are at risk due to potential lapses in care that can occur during transfer. SATF hospital return patients were processed through the TTA. When patients returned outside of provider regular work hours, they were evaluated by the TTA nurse, who reviewed the discharge documents, communicated this information to the on-call provider, and obtained verbal orders to implement a plan of care. The majority of patients returning from community hospitals received appropriate and timely services. However, a significant deficiency was found in the following case:

- In case 21, the patient returned from the hospital after an evaluation for chest pain. He did not receive the newly ordered medications aspirin and Harvoni (hepatitis C treatment), and did not receive a cardiology clinic appointment that was advised by the hospital. Also, hospital discharge summaries were not found in the patient's medical record for two of his hospital admissions.

The OIG clinicians also noted deficiencies in the ordering, dispensing, and administering of medications. The following cases illustrate some of these deficiencies, which are also discussed in the *Pharmacy and Medication Management* indicator:

Physician Ordering Process

- In case 9, the provider did not order topical nasal mupirocin ointment, which was recommended in the hospital discharge summary. This patient had recurrent episodes of cellulitis (bacterial infection of the skin and underlying tissues), which can be prevented with the treatment.

- In case 10, the provider, without explanation, discontinued ciprofloxacin (antibiotic to prevent infection in patients with chronic liver disease) when ordering medications following the patient's return from the hospital. The antibiotic was not resumed until two weeks later.

- In case 15, the provider did not order immediate-release morphine for relief of breakthrough pain, as recommended in the hospital discharge summary, for a patient with metastatic malignancy (cancer that has spread).

Medication Dispensing Process

- In case 6, Carvedilol (antihypertensive) was not dispensed by the pharmacy as ordered.

- In case 10, on two occasions, the patient's nurse administered (NA) and keep-on-person (KOP) medications were not timely resumed following his return from the hospital.

Medication Administration Process

- In case 10, the nurse gave only half the ordered dose of spironolactone (diuretic). On two subsequent occasions, because the pharmacy did not generate a new MAR following the patient's return from the hospital, the nurse used the previous MAR. This resulted in the omission of four medications.

Onsite Visit

SATF acknowledged that the pharmacy and medication management transfer process was an area needing improvement. One of the quality improvement projects was the medication administration process improvement program (MAPIP), whereby an interdisciplinary team, during a monthly audit, focused on areas of medication management needing improvement.

Compliance Testing Results

The institution obtained an *adequate* score of 80.3 percent in the *Inter- and Intra-System Transfers* indicator, scoring 100 percent on the following test:

- For all 30 sampled patients who transferred into SATF from other CDCR institutions, nursing staff timely completed the assessment and disposition sections of the initial health screening form (MIT 6.002).

The institution scored in the *adequate* range on the following three tests:

- SATF scored 83 percent when the OIG tested six patients who transferred out of the institution to determine whether the patient's transfer package included the required medications and related documentation. One patient's transfer packet did not include ordered KOP medication (MIT 6.101).

- Nursing staff completed an initial screening assessment form on the same day the patient arrived for 23 of the 30 patients tested (77 percent). For seven patients, nursing staff neglected to answer one or more questions, or did not complete an answer on a patient's initial health screening form (MIT 6.001).

- Inspectors sampled 20 patients who transferred out of SATF to another CDCR institution to determine whether SATF identified the patients' previously approved and still pending specialty service appointments on their Health Care Transfer Information forms (CDCR Form 7371). Staff had identified the appointments on the transfer forms for 15 of the sampled patients (75 percent) (MIT 6.004).

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

- Of 21 sampled patients who transferred into the institution with an existing medication order, 14 (67 percent) received their medications without interruption upon arriving at SATF. Three patients received their directly observed therapy (DOT) medications one to two days late; two patients missed evening doses of one or more DOT medications. For one patient, the nurse indicated that the patient did not come to the medication line to receive evening doses of two DOT medications, but documented that the patient did receive evening doses of two other DOT medications. Another patient was administered his once-per-week dosage of three TB medications twice. After his provider changed the patient's weekly regimen from Thursday to Friday, one nurse administered the medications on Thursday, per the old order; another nurse administered the same medications on Friday, per the new order (MIT 6.003).

Recommendations

No specific recommendations.

PHARMACY AND MEDICATION MANAGEMENT

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

Overall Rating:
Inadequate

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

Case Review Results

The OIG clinicians evaluate pharmacy and medication management as secondary processes as they relate to the quality of clinical care provided to patients. Compliance testing, which is a more targeted approach, is given more weight for the overall rating of this indicator. During the onsite visit, the OIG clinicians met with medical, nursing, and pharmacy representatives to discuss their case review findings.

OIG clinicians identified 70 pharmacy and medication management errors, of which 20 were significant deficiencies. These included errors in medication administration, delays in nursing staff's informing providers of medication non-compliance, interruptions in continuation of medications, provider medication errors, and pharmacy errors. The OIG clinicians rated the *Pharmacy and Medication Management* indicator *inadequate*.

Nursing Medication Administration Errors

Nursing medication administration errors included continued administration of medications after they were discontinued by a provider and failure to administer medications as ordered. Of the 25 deficiencies identified, the following 3 were significant:

- In case 9, the provider and nurse inappropriately used an older medication list form from the transferring institution, instead of the current form. This led to inappropriate discontinuation of a diabetes and a blood pressure medication.

- In case 17, the patient with recurrent cellulitis (skin infection) and leg ulcers did not receive trimethoprim/sulfamethoxazole (antibiotics) and prednisone (steroid) as ordered.

- In case 29, at three different times during the review period, the patient continued to receive carbamazepine, nortriptyline, and oxcarbazepine (pain medications) despite provider orders to discontinue these medications.

Cases in which patients experienced delays in receiving their prescribed KOP medications included cases 10, 23, and 52. Providers were not timely notified of the patient's refusal of medications in cases 6, 7, 8, 19, 22, and 23. Medications that were refused included blood pressure medication (cases 6, 7, and 19), seizure medication (case 7 and 22), and metformin (diabetes medication) (case 6).

Provider Medication Errors

Provider medication errors are discussed in the *Quality of Provider Performance* indicator.

Pharmacy Errors

Several pharmacy errors were noted during the case review. During the onsite inspection, the OIG clinicians learned that the most significant of these pharmacy errors (case 16) was attributed to a pharmacist who had been reprimanded for the error and was no longer working at the institution.

- In case 16, the patient with systemic fungal infection received an incorrect dose of fluconazole (anti-fungal medication) dispensed by the pharmacy.

Other significant deficiencies primarily related to delays in dispensing prescribed medications (cases 9, 10, 11, 21, 54, and 74). Some of the other pharmacy and medication management deficiencies are discussed in the *Inter- and Intra-System Transfers*, *Specialized Medical Housing, and Emergency Services* indicators.

Medication Continuity Errors

While patients at SATF received refills of medications prescribed for chronic medical problems in a timely manner, deficiencies in medication continuity were noted for patients returning from the hospital. These are discussed in the *Inter- and Intra-Systems Transfers* indicator.

Compliance Testing Results

The institution received an *inadequate* compliance score of 73.3 percent in the *Pharmacy and Medication Management* indicator. For discussion purposes, this indicator is divided into three sub-indicators: medication administration, observed medication practices and storage controls, and pharmacy protocols.

Medication Administration

In this sub-indicator, the institution received an average score of 69 percent, showing need for improvement in the following areas:

- The OIG sampled records of ten patients who were temporarily housed at SATF while in transit to another institution and found that none of them received all of their prescribed medications without interruption. Five patients did not receive their medication at all during their layover at SATF; five other patients did not receive one dose of their medication. These missed medications included blood pressure, thyroid, and psychiatric medications (MIT 7.006).

- Inspectors reviewed records for 30 patients who had transferred from one housing unit to another. Only 21 of them (70 percent) received their prescribed medications without interruption. For five patients, although nursing staff indicated "no show" as the reason for missed doses, they failed to document their follow-up efforts to deliver the medication to the patient or bring the patient to the medication line location. In four instances, nursing staff did not indicate the reason for the missed dose (MIT 7.005).

SATF performed well in the following three areas of this sub-indicator:

- Nursing staff timely provided long-term chronic care medications to all of the 26 patients sampled (MIT 7.001).

- Among 30 patients sampled, 26 (87 percent) timely received their newly ordered medications. Three patients received their medications from two to eight days late. There was no evidence that one patient received his KOP medication at all (MIT 7.002)

- SATF timely provided hospital discharge medications to 26 of 30 patients sampled (87 percent). For three patients, nursing staff provided discharge medications one to two days late; for one patient, there was no evidence that the patient received his KOP discharge medication at all (MIT 7.003).

Observed Medication Practices and Storage Controls

In this sub-indicator, the institution received an average score of 59 percent, with opportunities for improvement in the following areas:

- The institution employed strong medication security controls over narcotic medications at only two of nine inspected clinic and medication line locations that stored narcotics (22 percent). At seven locations, two nursing staff did not perform a physical inventory count of the controlled substances at every shift change; at one of those clinics, nursing staff pre-packed anticipated needed narcotics and removed them from the narcotics locker, but did not update the control log (MIT 7.101).

- The institution properly stored non-narcotic medications that required refrigeration at only 5 of the 13 applicable clinics, receiving a score of 39 percent. In eight clinics' refrigerators, there was no designated location for medication that needed to be returned to the pharmacy.

For one of those refrigerators, some of temperature logs were missing. Inspectors also observed an open vial of insulin that had passed its expiration date (MIT 7.103).

- Inspectors observed the medication distribution process at seven pill line locations and determined that only three of them (43 percent) demonstrated appropriate administrative controls and protocols. Inspectors identified the following deficiencies at the four remaining clinics (MIT 7.106):
    - At two clinics, nursing staff failed to wipe the rubber stopper of a multi-dose vial of insulin before and between uses.
    - At one clinic, the nurse allowed a patient to self-administer insulin with a contaminated needle that had dropped on the floor.
    - At another clinic, the nurse failed to compare the ordered dose to the corresponding MAR and allowed a patient to self-administer insulin. The patient administered two doses of intermediate-acting (NPH) insulin instead of one dose each of regular insulin and NPH insulin. NPH insulin starts to work more slowly, but lasts longer than regular insulin. After the OIG notified the SRN, the on-call clinician ordered additional monitoring of the patient's blood sugar level.
    - A nurse interviewed by inspectors at one clinic was unable to articulate the process for reporting medication errors.
    - Four pill line locations did not have an overhang or shade protection for patients waiting outdoors during extreme heat or inclement weather.
- Inspectors observed the medication preparation and administration processes at seven medication line locations. Nursing staff were compliant regarding proper hand hygiene and contamination control protocols at five locations (71 percent). At two of the medication lines, nurses failed to wash or sanitize their hands between glove changes (MIT 7.104).

SATF received an *adequate* score in the following indicator:

- SATF properly stored non-narcotic medications that did not require refrigeration in 14 of 18 clinic and medication line storage areas inspected (78 percent). In three clinics, internal and external medications were stored together; in two of those clinics, there were also opened and undated bottles of saline solution, as well as expired medication. In another clinic, there were expired bottles of sterile water (MIT 7.102).

The institution received a score of 100 percent in the following area:

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

Pharmacy Protocols

For this sub-indicator, the institution received a *proficient* score of 95 percent, including individual test scores of 100 percent in the following test areas:

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

SATF received an *adequate* score in the following area:

- The institution followed required medication error reporting protocols for 23 of 30 sampled medication error reports and related monthly statistical reports reviewed (77 percent). For two medication error reports, the pharmacist in charge did not complete the medication error follow-up report within five days; one was completed 14 days late and another, 62 days late. For all five of the related monthly statistical reports, there was no evidence the reports were timely submitted to CCHCS's chief of pharmacy services (MIT 7.111).

Non-Scored Tests

- In addition to testing reported medication errors, OIG inspectors follow up on any significant medication errors found during the case reviews or compliance testing to determine whether the errors were properly identified and reported. The OIG provides those results for information purposes only; however, at SATF, the OIG did not find any applicable medication errors subject to this test (MIT 7.998).

- Inspectors interviewed patients housed in isolation units to determine if they had immediate access to their prescribed KOP rescue inhalers and nitroglycerin medications. All 19 of the applicable patients interviewed indicated their prescribed medications were in their possession (MIT 7.999).

Recommendations

No specific recommendations.

PREVENTIVE SERVICES

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

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(64.7%)

Overall Rating:
Inadequate

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

Compliance Testing Results

The institution performed in the *inadequate* range in the *Preventive Services* indicator, with a compliance score of 64.7 percent. The institution received *inadequate* scores in four of seven test areas, as discussed below:

- Only two of nine patients sampled who were prescribed tuberculosis (TB) medications received their required monthly or weekly monitoring (22 percent). Five patients did not receive required monthly monitoring for one or more months during the three-month test period; two patients did not receive required weekly monitoring for three or more weeks during the 12-week test period (MIT 9.002).

- Although SATF timely conducted annual TB screenings within the prior year for all 30 sampled patients, nursing staff conducted those screenings properly for only 13 of them (43 percent). Nurses properly screened only one of the 15 patients identified as Code 22 (requiring a TB skin test in addition to screening of signs and symptoms) and 12 of the 15 patients identified as Code 34 (requiring screening of signs and symptoms only). Inspectors identified the following deficiencies (MIT 9.003):

    - For 12 of the Code 22 patients, an LVN or psychiatric technician read the test results, rather than an RN, public health nurse, or primary care provider; for one other Code 22 patient, the name and title of the person reading the test was not legible.

    - For eight Code 22 patients, nurses did not document the test administration (start) time or test read (end) time, which prohibited inspectors from determining if the nurse timely read the test results within the 48-to-72-hour window; for one other Code 22 patient, the test was read more than 72 hours after the administration time.

- For three Code 34 patients, nursing staff did not complete the required signs and symptoms check or history sections of the Tuberculin Testing/Evaluation Report (CDCR Form 7331).

- Of the nine patients sampled who were prescribed TB medications, only four received all required doses of their medication during the three-month test period (44 percent). Three patients who missed medication doses did not receive required provider counseling; one patient, after transferring into SATF, received his first dose of medication seven days late; another patient received an extra dose of medication twice (MIT 9.001).

- The OIG tested whether patients who suffered from a chronic care condition were offered vaccinations for influenza, pneumonia, and hepatitis. At SATF, 11 of the 17 sampled patients (65 percent) received all recommended vaccinations at the required intervals. Five patients had no record that they received or were offered the recommended pneumococcal vaccinations; one patient had no record that he received or was offered hepatitis A and B vaccinations (MIT 9.008).

The institution scored at the *adequate* level in the following area:

- The OIG sampled 13 patients at high risk for contracting the coccidioidomycosis infection (valley fever) who were identified as medically restricted and ineligible to reside at SATF, to determine if the patients were transferred out of the institution within 60 days from the time they were determined ineligible. SATF was compliant for 11 of the 13 patients sampled, scoring 85 percent. The two remaining patients were transferred out of SATF two and three days late (MIT 9.009).

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

- SATF was compliant in offering annual influenza vaccinations to all 30 sampled patients (MIT 9.004).

- SATF offered colorectal cancer screenings to 28 of 30 sampled patients subject to the annual screening requirements (93 percent). For one patient, there was no eUHR evidence either that health care staff offered a colon cancer screening within the previous 12 months or that the patient had a normal colonoscopy within the last ten years. For another patient, a physician progress note from 2011 indicated that the patient had received a colonoscopy within the last ten years. However, the note did not indicate if the results were within normal limits, and the colonoscopy results were not found in the eUHR (MIT 9.005).

Recommendations

No specific recommendations.

QUALITY OF NURSING PERFORMANCE

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

Overall Rating:
Adequate

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

Case Review Results

Overall, the outpatient nursing care provided at SATF was *adequate*. There were 552 nursing encounters reviewed, of which 384 encounters were for outpatient nursing. There were 53 deficiencies found in outpatient nursing, of which five were significant. Nursing staff generally collected and reviewed health care services request forms timely, and most patients with non-urgent medical conditions were appropriately scheduled for nurse clinic visits on the next business day. However, there were patient encounters in which the nurse failed to identify potentially urgent conditions and intervene appropriately. The following five cases demonstrated significant nursing deficiencies:

- In case 10, the patient was discharged from a community hospital where he was diagnosed and treated for massive fluid retention. Upon the patient's return to SATF, the provider ordered weekly weight checks for two months. The patient gained 32 pounds in two weeks. The licensed vocational nurses weighed the patient weekly but failed to notify the RN or the provider about the weight gain.

- In case 11, the patient submitted several requests to refill his blood pressure medication. The sick call nurse did not contact the patient about why he needed medication refills so soon after the previous refills. Eventually, one clinic nurse discovered that the patient was incorrectly taking double doses of his blood pressure medication and had significantly low blood pressure. The nurse failed to contact the provider.

- In case 16, the patient submitted a sick call request for worsening vision after recent cataract laser surgery. The nurse reviewed the request form but did not see the patient for this potentially urgent condition on the same day. Two days later, when the patient was examined, the sick call nurse did not check his vision or refer him to a provider.

- In case 59, the patient with leg paralysis and a catheter had a possible bladder infection. The sick call nurse did not complete an assessment for urinary tract infection.

- In case 70, the patient with a suprapubic catheter had cloudy urine, pain on urination, and thick discharge at the catheter site. The nurse timely reviewed the patient's sick call request form but did not assess the patient for a possible urinary tract infection that same day.

The following cases demonstrate minor deficiencies in implementation and documentation of wound care and appropriate initiation of provider contacts and referrals:

- In cases 17, 18, and 19, the nurses failed to provide or document appropriate wound care.

- In case 24, the sick call nurse assessed the patient more than three times for unresolved severe lower back pain, but failed to contact the provider for higher-level evaluation. Other cases in which nurses did not contact the provider involved new skin ulcers, elevated blood pressures, and abnormal finger stick glucose results (cases 19, 21, and 30).

- In case 34, the nurse washed the patient's ear canals to remove wax. Afterward, the nurse failed to inspect the ear or refer that patient for subsequent follow-up assessment.

Clinician Onsite Visit

During the onsite interview, nursing supervisors indicated that a checklist was used to monitor the quality of nursing practice. The chief nurse executive indicated the institution did not have an audit tool to monitor nursing practice and performance, and instead used the ACA Area Inspection Worksheet. Nursing administrators and staff identified issues that affected staff morale. These included frequent mandatory overtime work requirements for LVNs and licensed psychiatric technicians (LPTs) and untimely annual performance evaluations. Individual staff competency assessments for assigned clinical areas were not found for many nursing staff members during the OIG's review of nursing training records. Nurse administrators had recently created a tracking system to ensure that annual proficiency assessments were completed timely for all nursing staff.

Although SATF was in the process of hiring new LVNs and using registry personnel, positions were hard to fill because they were limited-term positions.

Recommendations

The OIG recommends that management at SATF implement the following:

- Create a quality control process to monitor basic nursing services, such as assessment and intervention for urgent conditions, wound care, and documentation.

QUALITY OF PROVIDER PERFORMANCE

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

Case Review Rating:
Adequate
Compliance Score:
Not Applicable

Overall Rating:
Adequate

Case Review Results

The OIG clinicians reviewed 698 medical provider encounters and orders and identified 177 deficiencies related to provider performance at SATF. Of these, 52 deficiencies were significant and placed the patients at increased risk for harm. Deficiencies were observed in several aspects of provider performance—most notably, the assessment and decision-making process, review of patient records, timely review of results and reports, management of chronic medical conditions, and the quality of documentation. Despite the large number of deficiencies that were noted, taking into account the complexity of the patients in a basic institution, the OIG clinicians rated this indicator as borderline *adequate*.

Assessment and Decision-Making

Errors in assessment and decision making by providers were noted on review of the records of 26 patients. The following significant deficiencies resulted in the OIG clinicians assessing the level of care inadequate in 6 of the 30 case reviews:

- In case 13, the patient had coronary artery disease and reflux esophagitis (painful inflammation of the esophagus). The patient's primary care provider incorrectly concluded that ongoing encounters for throat and chest pain were due to esophagitis. However, the patient was subsequently found to have coronary artery disease. He later had a heart attack and died.

- In case 15, the pain caused by the patient's metastatic malignancy (cancer that has spread) was inadequately managed. In addition to inappropriate choices in the morphine formulation and dosage, on several occasions, the adequacy of pain control was not appropriately documented and, in some instances, pain control was not even addressed in the provider evaluation.

- In case 23, a provider failed to follow up on a sleep study report that was not available during a clinic visit, which led to failure to discuss the results with the patient and to implement the recommendations. During the onsite visit, the medical team at SATF

acknowledged that this report, which had been scanned before provider review, had been overlooked.

- In case 22, the patient's primary provider erroneously concluded that the patient had not had any recent seizures and inappropriately discontinued phenytoin (seizure medication). Just a month earlier, while at a different institution, the patient had presented with status epilepticus (continuous seizures) with a low phenytoin level. After stopping the phenytoin, the patient had three additional seizures, two of which led to hospital admissions.

- In case 10, the provider did not change the Physician Order for Life Sustaining Treatment, from "do not resuscitate" to "attempt resuscitation," until a month after the patient changed his mind and wanted resuscitation if needed. Another deficiency was the provider's failure to recognize that ciprofloxacin (antibiotic) had erroneously been discontinued. This placed the patient, who had advanced liver disease, at risk for developing spontaneous bacterial peritonitis (severe abdominal infection).

- In case 30, this patient with diabetes mellitus, who was followed by one provider for most of the duration of the review period, received inadequate management of his diabetes. Changes to the long-acting insulin dose were infrequent and inadequate. These changes failed to control his fasting blood glucose levels. Even after acknowledging that the patient had poorly controlled diabetes, the provider did not schedule the patient for timely follow-up visits to assess the impact of the increased insulin dose and reinforce the necessity for lifestyle changes.

Review of Records

Adequate review of records is essential, especially when the provider is not familiar with the patient's history, when investigations have been performed, when the patient has been evaluated by a specialist, or when the patient has returned from a higher level of care. Inadequate record review led to lapses in patient care in cases 9, 10, 11, 16, 22, 32, and 59.

The most significant of these deficiencies was in case 16, when the provider failed to recognize that the patient was only receiving half the prescribed dose of fluconazole (anti-fungal medication).

Chronic Care

Identification and appropriate management of chronic health problems, such as diabetes mellitus, hypertension, and hyperlipidemia, are important in reducing the risk for both acute and long-term complications. Several deficiencies in glycemic control (management of blood sugar levels) and management of hypertension were noted in cases 11, 21, and the following:

- In case 26, on three occasions, even after sub-therapeutic INRs (blood not adequately thinned) were noted, the warfarin dosage was not appropriately increased.

Specialty Services

Providers at SATF appropriately referred patients for specialty consultation, the exception being case 14. This patient, who had been recently transferred to SATF, was not referred to a hematologist for follow-up as originally intended by the sending institution.

Quality of Documentation

Adequate documentation is important for adequate health care delivery and becomes even more important when there is lack of continuity of care. Deficiencies arising from inadequate documentation in the CTC are discussed in the *Specialized Medical Housing* indicator. The use of cloned notes by providers was also noted in the outpatient setting (cases 16 and 33). In case 16, this practice led to providers failing to recognize that the patient was only receiving half the prescribed dose of fluconazole (discussed previously). Incomplete listing of the patient's health problems or documentation of the management plan was noted in many instances (cases 6, 7, 9, 12, 13, 15, 16, 17, 19, 22, 33, and 35).

Providers did not always document the on-call provider telephone encounters (cases 6, 9, 10, 15, 17, and 59). The OIG clinicians learned that the on-call provider shared this information verbally with the other providers during the morning report, but this should have been considered a supplement to, rather than a replacement for, the documentation process.

Health Information Management

Delays in reviewing laboratory results and diagnostic reports are discussed in the *Diagnostic Services* and *Health Information Management* indicators.

Provider Continuity

Adequate continuity of care was provided in the outpatient setting. However, this was not always the case in specialized medical housing. In case 22, seven providers evaluated the patient during his first month in the CTC, which led to delays in the care of a skin infection. This is discussed in detail in the *Specialized Medical Housing* indicator.

Emergency Care

While patients presenting to the TTA were appropriately managed on most occasions, the following errors were noted. These cases are also discussed in the *Emergency Services* indicator.

- In case 10, the provider did not examine the abdomen in a patient who reported abdominal pain and had a recent history of nausea and vomiting.

- In case 15, the provider should have arranged for emergent transportation to a higher level of care for a patient with severe abdominal pain, rectal bleeding, and hypotension. The patient did not leave the TTA until nearly two and a half hours after his arrival.

Clinician Onsite Inspection

The OIG inspectors learned that, despite its designation as a basic institution, 11 percent of patients at SATF were classified as medically "high-risk." As of April 2016, there were 12 providers at SATF, including one registry provider. Management anticipated recruiting two more providers, one of whom would replace the registry provider. Following the morning report, providers went to their assigned clinics for multidisciplinary team huddles. The TTA and CTC had designated providers. Since the providers worked four days a week, ten hours per shift, both the TTA and the CTC required frequent changes in providers on the assigned provider's regular day off. An on-call provider covered the CTC on weekends and holidays.

Overall, the morale among the providers was high, and all reported that the chief physician and surgeon and the chief medical executive (CME) were supportive. Other positive comments regarded the collegiality among group members, monthly group presentations, and adequate radiology and pharmacy support. The CME had expressly communicated that providers see all patients as scheduled, resulting in no provider backlogs in the outpatient clinics. The providers mentioned that working relationships with their nursing and custodial colleagues were good.

The CME was proud to report that the providers functioned well as a unit while taking care of a challenging patient population. Since recruitment was a challenge, efforts were directed to support and nurture the providers. The providers described the four-day workweek schedule as a valuable incentive to recruitment and retention. SATF leadership assessed providers with annual reviews and by analyzing patients' medical appeals. When the OIG discussed the finding of cloned notes with the CME, he replied that this had already been addressed individually and with the group.

Recommendations

No specific recommendations.

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

This indicator addresses whether the institution follows appropriate policies and procedures when admitting inmate-patients to onsite inpatient facilities, including completion of timely nursing and provider assessments. The chart review assesses all aspects of medical care related to these housing units, including quality of provider and nursing care. SATF's only specialized medical housing is a 38-bed correctional treatment center (CTC).

Case Review Rating:
Inadequate
Compliance Score:
Adequate
(84.0%)

Overall Rating:
Inadequate

In this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *inadequate* rating, and the compliance testing resulting in an *adequate* score. While each area's results are discussed in detail below, the variance is readily explained by the different testing approaches. For example, if the CTC documents were present in the medical records, that finding would be positively reflected in the compliance score. However, if the clinical quality of those same documents were poor, that would be negatively reflected in the case review rating. During case review, the OIG clinicians found many deficiencies regarding providers' continuity of care, especially with pain management; at times, this led to delays in care. Similarly, compliance testing revealed that providers often failed to complete patient assessments at required intervals. As a result, the case review rating of *inadequate* was deemed a more accurate reflection of the appropriate overall indicator rating.

Case Review Results

At the time of the OIG clinicians' onsite inspection in April 2016, the CTC at SATF had 18 beds designated for medical patients and 20 for mental health patients. Records of ten patients with 475 encounters were reviewed. There were 163 deficiencies, 30 of which were significant. While nursing care in the CTC was adequate, there were significant problems with the provider performance. Five of the ten patient case reviews that involved specialized medical housing care were inadequate. A combination of superficial assessments, inadequate review of records, documentation deficiencies, questionable patient care management decisions, and failure to reevaluate patients within mandated intervals led to the *inadequate* case review rating for this indicator.

Access to Care

Despite a process ensuring CTC patients would be seen by a provider at least once every 72 hours, as required by CCHCS policy, this did not always occur. This is also discussed in the *Access to Care* indicator.

Nursing Performance

In general, the CTC nursing staff provided adequate care. Nurses completed required admission and shift assessments and interventions, provided patient monitoring and follow-up care, and adequately documented patient care. Of the 163 deficiencies found in specialized medical housing, 42 were for nursing encounters, and only 3 of these were significant:

- In case 9, the patient was receiving an intravenous antibiotic for cellulitis (skin infection) on his leg. The provider ordered a vancomycin (antibiotic) trough level reading (blood test for lowest antibiotic concentration level). A blood sample for this test should have been drawn 30 minutes before the next scheduled dose of the drug, which was being administered once every 12 hours. However, the nurse drew the blood sample about two hours after completion of the antibiotic dose, thereby resulting in an inaccurate trough level.

- In case 10, the patient with worsening ascites (fluid accumulating in the abdominal cavity) returned from an offsite diagnostic ultrasound when he reported shortness of breath and generalized weakness. The nurse did not check the patient's vital signs or assess his lungs during the episode of shortness of breath. Eventually, the provider evaluated the patient and sent him to an outside hospital for a higher level of assessment and care. Additionally, the provider ordered weight checks twice a week, but nursing staff documented only three weights during a four-week time period.

- In case 15, the patient had rectal cancer and received chemotherapy. The CTC nurses did not notify the provider when he developed fever over a three-day period. The patient was eventually sent to the community hospital emergency department for care.

Other deficiencies in the nursing care provided in the CTC included lack of provider notification when changes occurred in the patient's condition, lack of regular wound assessment and care, and incomplete or illegible nursing documentation. These deficiencies were found in the cases cited above, as well as in various other cases, such as the following:

- In case 8, the patient was admitted to the CTC for care after surgery for a gunshot wound to the abdomen. The patient had a colostomy (opening in the large bowel allowing stool to drain). On one occasion, the patient's blood pressure was very low (81/43), but the nurse did not ask the patient if he had important symptoms, such as lightheadedness, chest pain, or shortness of breath. The nurse also failed to reassess his blood pressure and notify the provider.

- In case 22, the patient needed dressing changes to an ear wound. Some daily wound assessment and dressing changes were not completed. Nurses also provided inconsistent descriptions of the wound (described as intact skin, healed wound, and non-healing wound). Cases 8, 15, and 19 also showed inconsistent wound assessment and dressing changes.

Provider Performance

Several of the patients in the CTC at SATF had complex medical problems. Superficial assessments, inadequate review of records, and the lack of continuity of patient care led to several questionable patient care management decisions. These errors were compounded by the use of cloned notes by a few providers.

The most significant deficiencies were noted in cases 15 and 10. Both are discussed in the *Quality of Provider Performance* indicator. Inadequate evaluations, failure to counsel patients refusing to take medications, and questionable management decisions were noted.

- In case 7, the provider failed to recognize that the patient had been refusing to take his medications and undergo laboratory testing.

- In case 19, providers did not recognize that the patient with iron deficient anemia, was refusing to take several of his medications, including an iron supplement. The cause for this patient's iron deficient anemia had not yet been established by the end of the OIG clinicians' review period. This was a significant deficiency.

- In case 22, the patient was evaluated by seven different providers during his first month in the CTC. Lacking appropriate communication between providers and adequate review of records, this patient was diagnosed and treated for vitamin B12 deficiency, despite the laboratory testing showing a normal B12 level. Later during his CTC stay, the providers did not evaluate his pacemaker incision site as recommended by the telemedicine cardiologist, who was concerned that the patient might have a skin infection at the site.

- In case 31, a provider ordered treatment for hyperkalemia (high potassium level), unaware that this problem had already been addressed by another provider. This resulted in an unnecessary duplicate treatment order to lower the patient's potassium level. This was a significant deficiency.

Documentation deficiencies were noted in the following cases:

- In case 7, failure to document discontinuation of warfarin led to other providers ordering an INR (test to assess the effect of warfarin in thinning blood) and attributing the normal result to the patient's non-compliance.

- In case 15, the provider's sequential notes were detailed, but they were cloned from prior notes. These failed to document the patient's response to the change in pain management.

- In case 19, the provider failed to document the location, size, or appearance of leg ulcers, which were the reason for the patient's admission to the CTC. This was a significant deficiency.

Clinician Onsite Inspection

As discussed in the *Quality of Provider Performance* indicator, the CTC had a designated medical provider to ensure continuity of care. In this individual's absence, another medical provider was assigned to the CTC. During regular working hours, the treatment and triage area (TTA) provider was available to assist the CTC provider, if necessary. The CTC provider met with the nursing staff before starting daily rounds, and this was followed by a discussion of patients who were in community hospitals, which included discharge planning. The provider reviewed the patient's medication list during rounds, and was accompanied by the lead RN or the patient's own nurse, and a custodial officer. The patient's medication list was reviewed during rounds. The chief physician and surgeon joined the team for rounds once a week and was available at other times for assistance with challenging clinical problems. One provider who frequently used cloned notes and was responsible for some of the questionable management decisions was no longer working at SATF or with CCHCS. SATF had a Fall Risk Quality Improvement Team, which focused on inpatient safety from an interdisciplinary perspective.

Clinician Summary

While nursing care in the CTC was adequate, there were significant problems with the provider performance. A combination of superficial assessments, inadequate review of records, documentation deficiencies, questionable patient care management decisions, and failure to reevaluate patients within mandated intervals led to an *inadequate* case review rating for this indicator.

Compliance Testing Results

The institution received an *adequate* compliance score of 84.0 percent in the *Specialized Medical Housing* indicator, which focused on the institution's correctional treatment center (CTC).

SATF scored in the *proficient* range on the following three tests:

- The OIG observed the working order of a sample of call buttons in CTC patient rooms and found that all of them were working properly. According to staff interviewed, custody officers and clinicians were able to efficiently respond and access patients' rooms within one minute when an emergent event occurred. As a result, the institution received a score of 100 percent on this test (MIT 13.101).

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

- Providers evaluated nine of the ten patients within 24 hours of the patients' admission to the CTC (90 percent); the provider evaluated the remaining patient one day late (MIT 13.002).

SATF scored in the *adequate* range on the following test:

- Providers completed a history and physical (H&P) within 72 hours of admission for eight of the ten sampled patients (80 percent). Two patients received their H&P from 14 hours to four days late (MIT 13.003).

SATF scored in the *inadequate* range on the following test:

- Providers completed their subjective, objective, assessment, plan, and education (SOAPE) notes at the required three-day intervals for only five of the ten patients sampled (50 percent). For five patients, the provider completed one or more SOAPE notes from one to four days late (MIT 13.004).

Recommendations

The OIG recommends that management at SATF take the following steps:

- Implement an educational training program on wound assessment, care, and documentation, including methods for nursing managers to monitor nursing performance.

- Evaluate and improve processes currently in place for nursing staff to communicate with providers, both during office hours and after.

SPECIALTY SERVICES

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(71.2%)

Overall Rating:
Adequate

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

For this indicator, the OIG's case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance review resulting in an *inadequate* score. The OIG's internal review process considered those factors that led to both results and ultimately rated this indicator *adequate*. The key deficiency revealed by compliance testing was that patients transferring into SATF did not always timely receive previously approved or scheduled specialty appointments. Also, denials for specialty services often were not timely communicated to the providers who had requested the services or to the patients for whom the services were requested. Case review, however, found few deficiencies in this indicator. In fact, the OIG clinicians found that specialty services were provided timely in all cases reviewed and that providers' requests for specialty services were timely processed.

Case Review Results

The OIG clinicians reviewed 129 events related to specialty services, the majority of which were specialty consultations, imaging studies, and surgical procedures. Fourteen deficiencies were found in this category, of which only two were significant. The OIG clinicians, therefore, rated the *Specialty Services* indicator *adequate*.

Access to Specialty Services

Specialty services were provided in a timely manner in all the cases reviewed.

Health Information Management

The two significant deficiencies in this indicator occurred when specialty services reports were unavailable. These are also discussed in *Health Information Management* indicator.

- In case 10, the RN failed to provide the consulting gastroenterologist the report of the CT scan of the liver (imaging scan for liver cancer) that had already been performed.

- In case 26, the 24-hour Holter monitor (heart rhythm test) report was not scanned into the eUHR.

Nursing Performance

SATF nurses performed adequate assessments for patients returning from specialty appointments and, if recommendations were available, communicated this information to providers to obtain management orders.

Provider Performance

In general, the providers at SATF made appropriate requests for specialty services, and the CME or designee reviewed these in a timely manner.

Clinician Onsite Inspection

The OIG clinicians learned that health information management staff scanned records as soon as they were received, without confirming if a provider had reviewed them.

Clinician Summary

Patients at SATF were appropriately referred with timely access to specialty services. Nursing performance was satisfactory. This indicator was rated *adequate*.

Compliance Testing Results

The institution received an *inadequate* compliance score of 71.2 percent in the *Specialty Services* indicator, showing opportunity for improvement in the following areas:

- SATF timely denied providers' specialty service requests for only 8 of 19 sampled patients (42 percent). The 11 untimely denials were from 2 to 12 days late (MIT 14.006).

- When patients are approved or scheduled for specialty services appointments at one institution and then transfer to another institution, policy requires that the receiving institution timely schedule and hold the patient's appointment. Only 9 of the 20 patients sampled who transferred to SATF with an approved specialty service appointment (45 percent) received it within the required time frame. Seven patients received their specialty service appointment between 15 and 66 days late, and four did not receive an appointment at all (MIT 14.005).

- Among 19 patients sampled who had a specialty service denied by SATF's health care management, 11 (58 percent) received timely notification of the denial of service. For three patients, this requirement was not met at all; five patients received notification from 9 to 83 days late (MIT 14.007).

The institution scored in the *adequate* range in the following test area:

- Providers reviewed the routine specialty services reports within the required timeline for 12 of 15 patients sampled (80 percent). Two patients' reports were reviewed from two to eight days late; for one patient, there was no evidence that a provider reviewed the report (MIT 14.004).

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

- For 14 of 15 patients sampled (93 percent), high-priority specialty services appointments occurred within 14 calendar days of the provider's order. One patient received the specialty service four days late. Providers reviewed the high-priority specialty services reports within the required time frame for 13 of the 15 patients (87 percent). Two reports were reviewed 13 and 65 days late (MIT 14.001, 14.002).

- For 14 of 15 patients sampled (93 percent), routine specialty services appointments occurred within 90 calendar days of the provider's order. One patient's specialty service appointment was seven days late (MIT 14.003).

Recommendation

The OIG recommends that specialty consultation notes and diagnostic study reports be sent to providers for their review and signature before they are scanned into the eUHR.

SECONDARY (ADMINISTRATIVE) QUALITY INDICATORS OF HEALTH CARE

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

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

INTERNAL MONITORING, QUALITY IMPROVEMENT, AND ADMINISTRATIVE OPERATIONS

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(51.7%)

Overall Rating:
Inadequate

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

Compliance Testing Results

The institution scored in the *inadequate* range in the *Internal Monitoring, Quality Improvement, and Administrative Operations* indicator, receiving a compliance score of 51.7 percent and showed room for improvement in the following five test areas:

- Based on information obtained from SATF's chief executive officer (CEO), the Quality Management Committee (QMC) meeting minutes, and other subcommittee meeting minutes, the institution did not take adequate steps to ensure the accuracy of its Dashboard data. Specifically, the OIG found no documentation in any forum that addressed methodologies used to train staff who collected Dashboard data. As a result, SATF received a score of zero on this test (MIT 15.004).

- The OIG inspected incident review packages for 12 emergency medical response incidents reviewed by SATF's Emergency Medical Response Review Committee (EMRRC) during the prior six-month period. None of the sampled incident packages included the required Emergency Medical Response Review Event Checklist, six of the packages were not reviewed by the warden, and two of the packages were not reviewed by either the warden or the CEO, so SATF received a score of zero on this test (MIT 15.007).

- SATF provided sufficient evidence that it had improved or reached all targeted performance objectives for only one of the 14 applicable quality improvement initiatives identified in its 2015 Performance Improvement Work Plan (7 percent) (MIT 15.005).

- Inspectors reviewed SATF's local governing body (LGB) meeting minutes to determine if the LGB met quarterly to exercise its responsibility for the quality management of patient health care. The LGB met in all four quarters reviewed; however, for three of those

meetings, the minutes were approved from 5 to 11 months late, resulting in a score of 25 percent (MIT 15.006).

- Inspectors reviewed drill packages for three medical emergency response drills conducted in the prior quarter. Only one of the three drill packages was complete. One drill package lacked the Medical Report of Injury or Unusual Occurrence (CDCR Form 7219) and the Triage and Treatment Services Flow Sheet (CDCR Form 7464). Another drill package lacked the Crime Incident Report (CDCR Form 837), which was required for the drill scenario. As a result, SATF scored 33 percent on this test (MIT 15.101).

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

- The institution promptly processed patient medical appeals in each of the most recent 12 months (MIT 15.001). Based on a sample of ten second-level medical appeals, the institution's responses addressed all of the patients' appealed issues (MIT 15.102).

- SATF's QMC met monthly, evaluated program performance, and took action when improvement opportunities were identified (MIT 15.003).

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

Other Information Obtained from Non-Scored Areas

- The OIG gathered data regarding the completion of death review summary reports by CCHCS's Death Review Committee (DRC). The DRC timely completed its death reviews and reported the results to the institution's CEO for only two of the ten deaths that occurred during the review period. As discussed below, CCHCS changed its death review reporting time frames for deaths that occurred after November 2015 (MIT 15.996):

    - Prior to November 1, 2015, the DRC was required to complete a death review summary within 30 business days of a patient's death and submit the results to the institution's CEO. The OIG allowed five additional business days for that communication. Of the nine deaths that occurred prior to November 1, 2015, the DRC had timely completed its review for two of them, but timely reported the results to the CEO for only one. Seven reviews were completed between 2 and 86 days late (45 to 128 calendar days after the death); eight reviews were reported to the CEO between 11 and 92 days late (61 to 141 calendar days after the inmate's death).

    - As of November 1, 2015, the DRC was required to complete a death review summary within 60 calendar days of a patient's death for a Level I (unexpected death) review, or 30 calendar days for a Level II (expected death) review and

submit the results to the institution's CEO.[5] The OIG allowed seven additional calendar days for that communication. For the one death that occurred on or after November 1, 2015, the DRC timely completed its death review summary and timely submitted the results to the CEO.

- Inspectors met with the SATF's acting CEO to inquire about the institution's protocols for tracking appeals. The health care appeals coordinator provided management staff with routine medical appeal tracking reports on a weekly basis that included information on delinquent and overdue appeals, and monthly appeals reports ranked by the number of appeals filed in the following areas: medication, treatment, copayments, and specialist referral requests. The CME spoke directly to providers concerning problems and issues indicated by the appeal tracking reports. When problem areas were substantiated, they were brought to the attention of the department head. If the problems were identified as systemic, they were addressed by the Quality Management Committee. During the six months preceding the OIG's inspection, there were no specific problem areas that management considered critical (MIT 15.997).

- Data regarding SATF's practices for implementing local operating procedures (LOPs) was obtained from the institution's correctional health services administrator. The health program specialist (HPS) was responsible for reviewing new or revised statewide policies and procedures and determining what, if any, impact they had on SATF's existing LOPs. The HPS met with subject matter experts to develop new LOPs, when needed. The institution's Operating Procedure Committee approved new LOPs and annually evaluated and updated existing LOPs. The committee was made up of management staff from pharmacy, nurses, physicians, and custody officers. Once approved, the institution used training meetings and emails to timely communicate new or modified LOPs to all health care staff. At the time of OIG's inspection, SATF had implemented 43 of the 49 applicable stakeholder recommended LOPs (88 percent) (MIT 15.998).

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

Recommendations

No specific recommendations.

[5] CCHCS defines an unexpected death as any "unanticipated death" that is not related to the natural course of a patient's illness or underlying condition, and an "expected death" as a medically anticipated death that is related to the natural course of a patient's illness or underlying condition.

JOB PERFORMANCE, TRAINING, LICENSING, AND CERTIFICATIONS

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

Case Review Rating:
Not Applicable
Compliance Score:
Proficient
(95%)

Overall Rating:
Proficient

Compliance Testing Results

The institution received a *proficient* compliance score of 95 percent in the *Job Performance, Training, Licensing, and Certifications* indicator, with scores of 100 percent in the following areas:

- All clinical providers at SATF were current with their professional licenses, and structured clinical performance appraisals were completely timely (MIT 16.001, 16.103).
- All of the ten nursing staff members sampled who administered medications were current with their clinical competency validations (MIT 16.102).
- All required provider, nursing, and custody staff members at SATF were current with their emergency response certifications (MIT 16.104).
- All nursing staff and the pharmacist in charge were current with their professional licenses and certification requirements (MIT 16.105).
- The institution's pharmacy and all authorized clinical providers who prescribed controlled substances at SATF were current with their Drug Enforcement Agency registrations (MIT 16.106).
- All nursing staff hired at SATF within the last year received timely new employee orientation (MIT 16.107).

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

- Inspectors examined nursing supervisors' performance evaluation reviews conducted for five nurses during December 2015. Three of the five nurses received sufficiently completed reviews (60 percent). For two nurses, the supervisor documented neither aspects of nursing care that were well done nor those that needed improvement, and the documentation did not confirm that the supervising nurse discussed the findings with the nurse; for one of those nurses, the supervisor also failed to complete the required number of reviews (MIT 16.101).

Recommendations

No specific recommendations.

POPULATION-BASED METRICS

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

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

Methodology

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

Comparison of Population-Based Metrics

For the California Substance Abuse Treatment Facility and State Prison at Corcoran, nine HEDIS measures were selected and are listed in the following *SATF 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 Metrics 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. SATF performed very well with its management of diabetes.

When compared statewide, SATF significantly outperformed Medi-Cal in all five diabetic measures selected. The institution also outperformed Kaiser Permanente in three of the five measures, scoring slightly lower than Kaiser, Southern California, in dilated eye exams and lower than Kaiser statewide in blood pressure control for diabetics. When compared nationally, SATF outperformed Medicaid, Medicare, and commercial health plans (based on data obtained from health maintenance organizations) in each of the five diabetic measures. SATF outperformed the U.S. Department of Veterans Affairs (VA) in all applicable measures except diabetic eye examinations, for which it scored 10 percentage points lower than the VA.

Immunizations

Comparative data for immunizations was only fully available for the VA and partially available for Kaiser, commercial entities, and Medicare. For the administration of influenza shots to younger adults, SATF outperformed Kaiser, commercial entities, and the VA results; for flu shots to older adults, the institution outperformed both Medicare and the VA. The institution had timely offered influenza immunizations to all patients sampled, but they refused the offers. With regard to administering pneumococcal vaccinations to older adults, SATF outperformed Medicare, but scored significantly lower than the VA.

Cancer Screening

For colorectal cancer screenings to older adults, SATF's score was significantly lower than Kaiser's and the VA, but was higher than commercial entities and matched Medicare. However, the institution timely offered the screening to all but one of the patients sampled, but they refused the offer.

Summary

Overall, SATF's HEDIS performance reflects an adequate chronic care program. While the institution scored comparatively well in most areas of comprehensive diabetic care and influenza immunizations, it did not perform as well in pneumococcal immunizations and colorectal cancer screenings. For influenza immunization and cancer screening measures, SATF has an opportunity to improve its scores by placing an emphasis on educating patients regarding their refusals of these preventive services.

SATF Results Compared to State and National HEDIS Scores

Clinical Measures	California				National			
	SATF Cycle 4 Results[1]	HEDIS Medi-Cal 2015[2]	HEDIS Kaiser (No. CA) 2015[3]	HEDIS Kaiser (So.CA) 2015[3]	HEDIS Medicaid 2015[4]	HEDIS Com-mercial 2015[4]	HEDIS Medicare 2015[4]	VA Average 2014[5]
Comprehensive Diabetes Care								
HbA1c Testing (Monitoring)	**100%**	86%	95%	94%	86%	91%	93%	99%
Poor HbA1c Control (>9.0%)[6, 7]	**12%**	39%	18%	24%	44%	31%	25%	19%
HbA1c Control (<8.0%)[6]	**77%**	49%	70%	62%	47%	58%	65%	-
Blood Pressure Control (<140/90)	**80%**	63%	84%	85%	62%	65%	65%	78%
Eye Exams	**80%**	53%	69%	81%	54%	56%	69%	90%
Immunizations								
Influenza Shots - Adults (18–64)	**65%**	-	54%	55%	-	50%	-	58%
Influenza Shots - Adults (65+)	**82%**	-	-	-	-	-	72%	76%
Immunizations: Pneumococcal	**79%**	-	-	-	-	-	70%	93%
Cancer Screening								
Colorectal Cancer Screening	**67%**	-	80%	82%	-	64%	67%	82%

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

2. HEDIS Medi-Cal data was obtained from the California Department of Health Care Services 2015 *HEDIS Aggregate Report for the Medi-Cal Managed Care Program*.

3. Data was obtained from Kaiser Permanente November 2015 reports for the Northern and Southern California regions.

4. National HEDIS data for Medicaid, commercial plans, and Medicare was obtained from the 2015 *State of Health Care Quality Report*, available on the NCQA website: www.ncqa.org. The results for commercial plans were based on data received from various health maintenance organizations.

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

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

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

APPENDIX A — COMPLIANCE TEST RESULTS

California Substance Abuse Treatment Facility Range of Summary Scores: 51.72% - 95.00%	
Indicator	**Overall Score (Yes %)**
Access to Care	80.27%
Diagnostic Services	76.67%
Emergency Services	Not Applicable
Health Information Management (Medical Records)	68.93%
Health Care Environment	80.35%
Inter- and Intra-System Transfers	80.33%
Pharmacy and Medication Management	73.30%
Prenatal and Post-Delivery Services	Not Applicable
Preventive Services	64.67%
Quality of Nursing Performance	Not Applicable
Quality of Provider Performance	Not Applicable
Reception Center Arrivals	Not Applicable
Specialized Medical Housing (OHU, CTC, SNF, Hospice)	84.00%
Specialty Services	71.19%
Internal Monitoring, Quality Improvement, and Administrative Operations	51.72%
Job Performance, Training, Licensing, and Certifications	95.00%

Reference Number	*Access to Care*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
1.001	**Chronic care follow-up appointments:** Was the inmate-patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter?	24	6	30	80.00%	0
1.002	**For endorsed inmate-patients received from another CDCR institution:** If the nurse referred the inmate-patient to a provider during the initial health screening, was the inmate-patient seen within the required time frame?	11	19	30	36.67%	0
1.003	**Clinical appointments:** Did a registered nurse review the inmate-patient's request for service the same day it was received?	50	0	50	100.00%	0
1.004	**Clinical appointments:** Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed?	48	2	50	96.00%	0
1.005	**Clinical appointments:** If the registered nurse determined a referral to a primary care provider was necessary, was the inmate-patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter?	11	3	14	78.57%	36
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?	5	1	6	83.33%	44
1.007	**Upon the inmate-patient's discharge from the community hospital:** Did the inmate-patient receive a follow-up appointment within the required time frame?	24	6	30	80.00%	0
1.008	**Specialty service follow-up appointments:** Do specialty service primary care physician follow-up visits occur within required time frames?	19	9	28	67.86%	2
1.101	**Clinical appointments:** Do inmate-patients have a standardized process to obtain and submit health care services request forms?	6	0	6	100.00%	0
Overall percentage:					**80.27%**	

Reference Number	*Diagnostic Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
2.001	**Radiology:** Was the radiology service provided within the time frame specified in the provider's order?	9	1	10	90.00%	0
2.002	**Radiology:** Did the primary care provider review and initial the diagnostic report within specified time frames?	9	1	10	90.00%	0
2.003	**Radiology:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	10	0	10	100.00%	0
2.004	**Laboratory:** Was the laboratory service provided within the time frame specified in the provider's order?	8	2	10	80.00%	0
2.005	**Laboratory:** Did the primary care provider review and initial the diagnostic report within specified time frames?	10	0	10	100.00%	0
2.006	**Laboratory:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	10	0	10	100.00%	0
2.007	**Pathology:** Did the institution receive the final diagnostic report within the required time frames?	9	1	10	90.00%	0
2.008	**Pathology:** Did the primary care provider review and initial the diagnostic report within specified time frames?	1	9	10	10.00%	0
2.009	**Pathology:** Did the primary care provider communicate the results of the diagnostic study to the inmate-patient within specified time frames?	3	7	10	30.00%	0
Overall percentage:					**76.67%**	

Emergency Services	Scored Answers
Assesses reaction times and responses to emergency situations. The OIG RN clinicians will use detailed information obtained from the institution's incident packages to perform focused case reviews.	**Not Applicable**

Reference Number	*Health Information Management (Medical Records)*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated progress notes, initial health screening forms, and health care services request forms scanned into the eUHR within three calendar days of the inmate-patient encounter date?	19	1	20	95.00%	0
4.002	Are dictated / transcribed documents scanned into the eUHR within five calendar days of the inmate-patient encounter date?	Not Applicable				
4.003	Are specialty documents scanned into the eUHR within the required time frame?	20	0	20	100.00%	0
4.004	Are community hospital discharge documents scanned into the eUHR within three calendar days of the inmate-patient date of hospital discharge?	19	1	20	95.00%	0
4.005	Are medication administration records (MARs) scanned into the eUHR within the required time frames?	14	6	20	70.00%	0
4.006	During the eUHR review, did the OIG find that documents were correctly labeled and included in the correct inmate-patient's file?	0	12	12	0.00%	0
4.007	Did clinical staff legibly sign health care records, when required?	20	12	32	62.50%	0
4.008	**For inmate-patients discharged from a community hospital:** Did the preliminary hospital discharge report include key elements and did a PCP review the report within three calendar days of discharge?	18	12	30	60.00%	0
Overall percentage:					**68.93%**	

Reference Number	*Health Care Environment*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
5.101	**Infection Control:** Are clinical health care areas appropriately disinfected, cleaned and sanitary?	11	3	14	78.57%	0
5.102	**Infection control:** Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	12	1	13	92.31%	1
5.103	**Infection Control:** Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	13	1	14	92.86%	0
5.104	**Infection control:** Does clinical health care staff adhere to universal hand hygiene precautions?	13	1	14	92.86%	0
5.105	**Infection control:** Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	13	1	14	92.86%	0
5.106	**Warehouse, Conex and other non-clinic storage areas:** Does the medical supply management process adequately support the needs of the medical health care program?	1	0	1	100.00%	0
5.107	**Clinical areas:** Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	14	0	14	100.00%	0
5.108	**Clinical areas:** Do clinic common areas and exam rooms have essential core medical equipment and supplies?	8	6	14	57.14%	0
5.109	**Clinical areas:** Do clinic common areas have an adequate environment conducive to providing medical services?	12	2	14	85.71%	0
5.110	**Clinical areas:** Do clinic exam rooms have an adequate environment conducive to providing medical services?	9	5	14	64.29%	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?	3	8	11	27.27%	3
5.999	**For Information Purposes Only:** Does the institution's health care management believe that all clinical areas have physical plant infrastructures sufficient to provide adequate health care services?	Information Only				
Overall percentage:					**80.35%**	

Reference Number	*Inter- and Intra-System Transfers*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
6.001	**For endorsed inmate-patients received from another CDCR institution or COCF:** Did nursing staff complete the initial health screening and answer all screening questions on the same day the inmate-patient arrived at the institution?	23	7	30	76.67%	0
6.002	**For endorsed inmate-patients received from another CDCR institution or COCF:** When required, did the RN complete the assessment and disposition section of the health screening form; refer the inmate-patient to the TTA, if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening?	30	0	30	100.00%	0
6.003	**For endorsed inmate-patients received from another CDCR institution or COCF:** If the inmate-patient had an existing medication order upon arrival, were medications administered or delivered without interruption?	14	7	21	66.67%	9
6.004	**For inmate-patients transferred out of the facility:** Were scheduled specialty service appointments identified on the Health Care Transfer Information Form 7371?	15	5	20	75.00%	0
6.101	**For inmate-patients transferred out of the facility:** Do medication transfer packages include required medications along with the corresponding Medication Administration Record (MAR) and Medication Reconciliation?	5	1	6	83.33%	4
Overall percentage:					**80.33%**	

Reference Number	*Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.001	Did the inmate-patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows?	26	0	26	100.00%	4
7.002	Did health care staff administer or deliver new order prescription medications to the inmate-patient within the required time frames?	26	4	30	86.67%	0
7.003	**Upon the inmate-patient's discharge from a community hospital:** Were all medications ordered by the institution's primary care provider administered or delivered to the inmate-patient within one calendar day of return?	26	4	30	86.67%	0
7.004	**For inmate-patients received from a county jail:** Were all medications ordered by the institution's reception center provider administered or delivered to the inmate-patient within the required time frames?	Not Applicable				
7.005	**Upon the inmate-patient's transfer from one housing unit to another:** Were medications continued without interruption?	21	9	30	70.00%	0
7.006	**For inmate-patients en route who lay over at the institution:** If the temporarily housed inmate-patient had an existing medication order, were medications administered or delivered without interruption?	0	10	10	0.00%	0
7.101	**All clinical and medication line storage areas for narcotic medications:** Does the institution employ strong medication security controls over narcotic medications assigned to its clinical areas?	2	7	9	22.22%	13
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?	14	4	18	77.78%	4
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?	5	8	13	38.46%	9
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	2	7	71.43%	15
7.105	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when preparing medications for inmate-patients?	7	0	7	100.00%	15
7.106	**Medication preparation and administration areas:** Does the institution employ appropriate administrative controls and protocols when distributing medications to inmate-patients?	3	4	7	42.86%	15
7.107	**Pharmacy:** Does the institution employ and follow general security, organization, and cleanliness management protocols in its main and satellite pharmacies?	1	0	1	100.00%	0

Reference Number	*Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.108	**Pharmacy:** Does the institution's pharmacy properly store non-refrigerated medications?	1	0	1	100.00%	0
7.109	**Pharmacy:** Does the institution's pharmacy properly store refrigerated or frozen medications?	1	0	1	100.00%	0
7.110	**Pharmacy:** Does the institution's pharmacy properly account for narcotic medications?	1	0	1	100.00%	0
7.111	**Pharmacy:** Does the institution follow key medication error reporting protocols?	23	7	30	76.67%	0
7.998	**For Information Purposes Only:** During eUHR compliance testing and case reviews, did the OIG find that medication errors were properly identified and reported by the institution?	Information Only				
7.999	**For Information Purposes Only:** Do inmate-patients in isolation housing units have immediate access to their KOP prescribed rescue inhalers and nitroglycerin medications?	Information Only				
Overall percentage:					**73.30%**	

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

Reference Number	*Preventive Services*	Scored Answers				
		Yes	No	Yes + No	Yes %	N/A
9.001	**Inmate-patients prescribed TB medications:** Did the institution administer the medication to the inmate-patient as prescribed?	4	5	9	44.44%	0
9.002	**Inmate-patients prescribed TB medications:** Did the institution monitor the inmate-patient monthly for the most recent three months he or she was on the medication?	2	7	9	22.22%	0
9.003	**Annual TB Screening:** Was the inmate-patient screened for TB within the last year?	13	17	30	43.33%	0
9.004	Were all inmate-patients offered an influenza vaccination for the most recent influenza season?	30	0	30	100.00%	0
9.005	**All inmate-patients from the age of 50 through the age of 75:** Was the inmate-patient offered colorectal cancer screening?	28	2	30	93.33%	0
9.006	**Female inmate-patients from the age of 50 through the age of 74:** Was the inmate-patient offered a mammogram in compliance with policy?	Not Applicable				
9.007	**Female inmate-patients from the age of 21 through the age of 65:** Was the inmate-patient offered a pap smear in compliance with policy?	Not Applicable				
9.008	Are required immunizations being offered for chronic care inmate-patients?	11	6	17	64.71%	13
9.009	Are inmate-patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	11	2	13	84.62%	0
Overall percentage:					**64.67%**	

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

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

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

Reference Number	*Specialized Medical Housing (OHU, CTC, SNF, Hospice)*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	**For all higher-level care facilities:** Did the registered nurse complete an initial assessment of the inmate-patient on the day of admission, or within eight hours of admission to CMF's Hospice?	10	0	10	100.00%	0
13.002	**For OHU, CTC, & SNF only:** Did the primary care provider for OHU or attending physician for a CTC & SNF evaluate the inmate-patient within 24 hours of admission?	9	1	10	90.00%	0
13.003	**For OHU, CTC, & SNF only:** Was a written history and physical examination completed within 72 hours of admission?	8	2	10	80.00%	0
13.004	**For all higher-level care facilities:** Did the primary care provider complete the Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes on the inmate-patient at the minimum intervals required for the type of facility where the inmate-patient was treated?	5	5	10	50.00%	0
13.101	**For OHU and CTC Only:** Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter inmate-patient's cells?	1	0	1	100.00%	0
Overall percentage:					**84.00%**	

Reference Number	*Specialty Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	Did the inmate-patient receive the high-priority specialty service within 14 calendar days of the PCP order?	14	1	15	93.33%	0
14.002	Did the PCP review the high priority specialty service consultant report within the required time frame?	13	2	15	86.67%	0
14.003	Did the inmate-patient receive the routine specialty service within 90 calendar days of the PCP order?	14	1	15	93.33%	0
14.004	Did the PCP review the routine specialty service consultant report within the required time frame?	12	3	15	80.00%	0
14.005	**For endorsed inmate-patients received from another CDCR institution:** If the inmate-patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames?	9	11	20	45.00%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	8	11	19	42.11%	0
14.007	Following the denial of a request for specialty services, was the inmate-patient informed of the denial within the required time frame?	11	8	19	57.89%	0
Overall percentage:					**71.19%**	

Reference Number	*Internal Monitoring, Quality Improvement, and Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.001	Did the institution promptly process inmate medical appeals during the most recent 12 months?	12	0	12	100.00%	0
15.002	Does the institution follow adverse/sentinel event reporting requirements?	Not Applicable				
15.003	Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified?	6	0	6	100.00%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	0	1	1	0.00%	0
15.005	For each initiative in the Performance Improvement Work Plan (PIWP), has the institution performance improved or reached the targeted performance objective(s)?	1	13	14	7.14%	2
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?	1	3	4	25.00%	0
15.007	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	0	12	12	0.00%	0
15.101	Did the institution complete a medical emergency response drill for each watch and include participation of health care and custody staff during the most recent full quarter?	1	2	3	33.33%	0
15.102	Did the institution's second level medical appeal response address all of the inmate-patient's appealed issues?	10	0	10	100.00%	0
15.103	Did the institution's medical staff review and submit the initial inmate death report to the Death Review Unit in a timely manner?	10	0	10	100.00%	0
15.996	**For Information Purposes Only:** Did the CCHCS Death Review Committee submit its inmate death review summary to the institution timely?	Information Only				
15.997	**For Information Purposes Only:** Identify the institution's protocols for tracking medical appeals.	Information Only				
15.998	**For Information Purposes Only:** Identify the institution's protocols for implementing health care local operating procedures.	Information Only				
15.999	**For Information Purposes Only:** Identify the institution's health care staffing resources.	Information Only				
Overall percentage:					**51.72%**	

Reference Number	*Job Performance, Training, Licensing, and Certifications*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
16.001	Do all providers maintain a current medical license?	13	0	13	100.00%	0
16.101	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	3	2	5	60.00%	0
16.102	Are nursing staff who administer medications current on their clinical competency validation?	10	0	10	100.00%	0
16.103	Are structured clinical performance appraisals completed timely?	11	0	11	100.00%	0
16.104	Are staff current with required medical emergency response certifications?	3	0	3	100.00%	0
16.105	Are nursing staff and the Pharmacist in Charge current with their professional licenses and certifications?	5	0	5	100.00%	1
16.106	Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	1	0	1	100.00%	0
16.107	Are nursing staff current with required new employee orientation?	1	0	1	100.00%	0
Overall percentage:					**95.00%**	

APPENDIX B — CLINICAL DATA

Table B-1: SATF Sample Sets	
Sample Set	**Total**
Anticoagulation	2
Death Review/Sentinel Events	5
Diabetes	3
Emergency Services — CPR	5
Emergency Services — Non-CPR	5
High Risk	5
Hospitalization	5
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	40
Specialty Services	5
	81

Table B-2: SATF Chronic Care Diagnoses	
Diagnosis	**Total**
Anemia	1
Anticoagulation	3
Arthritis/Degenerative Joint Disease	11
Asthma	10
COPD	11
Cancer	6
Cardiovascular Disease	11
Chronic Kidney Disease	8
Chronic Pain	24
Cirrhosis/End-Stage Liver Disease	5
Coccidioidomycosis	4
DVT/PE	1
Deep Venous Thrombosis/Pulmonary Embolism	1
Diabetes	20
Gastroesophageal Reflux Disease	13
Gastrointestinal Bleed	3
Hepatitis C	24
Hyperlipidemia	23
Hypertension	40
Mental Health	14
Migraine Headaches	1
Seizure Disorder	9
Sleep Apnea	2
Thyroid Disease	3
	248

Table B-3: SATF Event — Program	
Program	**Total**
Diagnostic Services	185
Emergency Care	86
Hospitalization	98
Intra-System Transfers In	17
Intra-System Transfers Out	4
Not Specified	8
Outpatient Care	799
Specialized Medical Housing	444
Specialty Services	131
	1,772

Table B-4: SATF Case Review Sample Summary	
	Total
MD Reviews, Detailed	30
MD Reviews, Focused	0
RN Reviews, Detailed	20
RN Reviews, Focused	51
Total Reviews	101
Total Unique Cases	81
Overlapping Reviews (MD & RN)	20

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

California Substance Abuse Treatment Facility and State Prison			
Quality Indicator	**Sample Category (number of samples)**	**Data Source**	**Filters**
Access to Care			
MIT 1.001	Chronic care patients (30)	Master Registry	• Chronic care conditions (at least one condition per inmate-patient—any risk level) • **Randomize**
MIT 1.002	Nursing Referrals (30)	OIG Q: 6.001	• See ***Intra-system Transfers***
MITs 1.003-006	Nursing sick call (5 per clinic) 50	MedSATS	• Clinic (each clinic tested) • Appointment date (2–9 months) • **Randomize**
MIT 1.007	Returns from community hospital (30)	OIG Q: 4.008	• See ***Health Information Management (Medical Records)*** (returns from community hospital)
MIT 1.008	Specialty services follow-up (30)	OIG Q: 14.001 & 14.003	• See ***Specialty Services***
MIT 1.101	Availability of health care services request forms (6)	OIG onsite review	• Randomly select one housing unit from each yard
Diagnostic Services			
MITs 2.001–003	Radiology (10)	Radiology Logs	• Appointment date (90 days–9 months) • **Randomize** • Abnormal
MITs 2.004–006	Laboratory (10)	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • **Randomize** • Abnormal
MITs 2.007–009	Pathology (10)	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • **Randomize**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Health Information Management (Medical Records)			
MIT 4.001	Timely scanning (20)	OIG Qs: 1.001, 1.002, & 1.004	• Non-dictated documents • 1st 10 IPs MIT 1.001, 1st 5 IPs MITs 1.002, 1.004
MIT 4.002	*N/A at this institution*	OIG Q: 1.001	• Dictated documents • First 20 IPs selected
MIT 4.003	(20)	OIG Qs: 14.002 & 14.004	• Specialty documents • First 10 IPs for each question
MIT 4.004	(20)	OIG Q: 4.008	• Community hospital discharge documents • First 20 IPs selected
MIT 4.005	(20)	OIG Q: 7.001	• MARs • First 20 IPs selected
MIT 4.006	(12)	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (12 or more = No)
MIT 4.007	Legible signatures & review (32)	OIG Qs: 4.008, 6.001, 6.002, 7.001, 12.001, 12.002 & 14.002	• First 8 IPs sampled • One source document per IP
MIT 4.008	Returns from community hospital (30)	Inpatient claims data	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • **Randomize** (each month individually) • First 5 inmate-patients from each of the 6 months (if not 5 in a month, supplement from another, as needed)
Health Care Environment			
MIT 5.101-105 MIT 5.107–111	Clinical areas (14)	OIG inspector onsite review	• Identify and inspect all onsite clinical areas.
Inter- and Intra-System Transfers			
MIT 6.001-003	Intra-system transfers (30)	SOMS	• Arrival date (3–9 months) • Arrived from (another CDCR facility) • Rx count • **Randomize**
MIT 6.004	Specialty services send-outs (20)	MedSATS	• Date of transfer (3–9 months) • **Randomize**
MIT 6.101	Transfers out (10)	OIG inspector onsite review	• R&R IP transfers with medication

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
Pharmacy and Medication Management			
MIT 7.001	Chronic care medication (30)	OIG Q: 1.001	*See* ***Access to Care*** • At least one condition per inmate-patient—any risk level • **Randomize**
MIT 7.002	New Medication Orders (30)	Master Registry	• Rx count • **Randomize** • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns from Community Hospital (30)	OIG Q: 4.008	• See ***Health Information Management (Medical Records)*** *(returns from community hospital)*
MIT 7.004	RC arrivals – medication orders *N/A at this institution*	OIG Q: 12.001	• See ***Reception Center Arrivals***
MIT 7.005	Intra-facility moves (30)	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • **Randomize**
MIT 7.006	En Route (10)	SOMS	• Date of transfer (2–8 months) • Sending institution (another CDCR facility) • **Randomize** • NA/DOT meds
MITs 7.101-103	Medication storage areas (varies by test)	OIG inspector onsite review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–106	Medication Preparation and Administration Areas (varies by test)	OIG inspector onsite review	• Identify and inspect onsite clinical areas that prepare and administer medications
MITs 7.107-110	Pharmacy (1)	OIG inspector onsite review	• Identify & inspect all onsite pharmacies
MIT 7.111	Medication error reporting (30)	Monthly medication error reports	• All monthly statistic reports with Level 4 or higher • Select a total of 5 months
MIT 7.999	Isolation unit KOP medications (19)	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 patients)	Data Source	Filters
Preventive Services			
MITs 9.001–002	TB medications (9)	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • **Randomize**
MIT 9.003	TB Code 22, annual TST (15)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (22) • **Randomize**
	TB Code 34, annual screening (15)	SOMS	• Arrival date (at least 1 year prior to inspection) • TB Code (34) • **Randomize**
MIT 9.004	Influenza vaccinations (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • **Randomize** • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal cancer screening (30)	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 (30)	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 (13)	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 patients)	Data Source	Filters
Reception Center Arrivals			
MITs 12.001–008	RC *N/A at this institution*	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • **Randomize**
Specialized Medical Housing			
MITs 13.001–004	CTC (10)	CADDIS	• Admit date (1–6 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • **Randomize**
MIT 13.101	Call buttons CTC (all)	OIG inspector onsite review	• Review by location
Specialty Services Access			
MITs 14.001–002	High-priority (15)	MedSATS	• Approval date (3–9 months) • **Randomize**
MITs 14.003–004	Routine (15)	MedSATS	• Approval date (3–9 months) • Remove optometry, physical therapy or podiatry • **Randomize**
MIT 14.005	Specialty services arrivals (20)	MedSATS	• Arrived from (other CDCR institution) • Date of transfer (3–9 months) • **Randomize**
MIT 14.006-007	Denials (19)	InterQual	• Review date (3–9 months) • **Randomize**
	(*0*)	IUMC/MAR Meeting Minutes	• Meeting date (9 months) • Denial upheld • **Randomize**

Quality Indicator	Sample Category (number of patients)	Data Source	Filters
Internal Monitoring, Quality Improvement, & Administrative Operations			
MIT 15.001	Medical appeals (all)	Monthly medical appeals reports	• Medical appeals (12 months)
MIT 15.002	Adverse/sentinel events (*N/A at this institution*)	Adverse/sentinel events report	• Adverse/sentinel events (2–8 months)
MITs 15.003–004	QMC Meetings (6)	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.005	Performance improvement work plans (PIWP) (16)	Institution PIWP	• PIWP with updates (12 months) • Medical initiatives
MIT 15.006	LGB (4)	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.007	EMRRC (12)	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.101	Medical emergency response drills (3)	Onsite summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	2nd level medical appeals (10)	Onsite list of appeals/closed appeals files	• Medical appeals denied (6 months)
MIT 15.103	Death Reports (10)	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.996	Death Review Committee (10)	OIG summary log - deaths	• Between 35 business days & 12 months prior • CCHCS death reviews
MIT 15.998	Local operating procedures (LOPs) (all)	Institution LOPs	• All LOPs

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Job Performance, Training, Licensing, and Certifications			
MIT 16.001	Provider licenses (13)	Current provider listing (at start of inspection)	• Review all
MIT 16.101	RN Review Evaluations (5)	Onsite supervisor periodic RN reviews	• RNs who worked in clinic or emergency setting six or more days in sampled month • **Randomize**
MIT 16.102	Nursing Staff Validations (10)	Onsite nursing education files	• On duty one or more years • Nurse administers medications • **Randomize**
MIT 16.103	Provider Annual Evaluation Packets (all)	OIG Q:16.001	• All required performance evaluation documents

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

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

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

January 17, 2017

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

Dear Mr. Barton:

The purpose of this letter is to inform you that the Office of the Receiver has reviewed the draft report of the Office of the Inspector General (OIG) Medical Inspection Results for California Substance Abuse Treatment Facility (SATF) conducted from February to April 2016. California Correctional Health Care Services (CCHCS) acknowledges all OIG findings.

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

Sincerely,

Janet Lewis

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

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