Roy W. Wesley
Inspector General

Office of the Inspector General

California Substance Abuse Treatment Facility and State Prison at Corcoran Medical Inspection Results Cycle 5

November 2017

Fairness ◆ Integrity ◆ Respect ◆ Service ◆ Transparency

Office of the Inspector General

CALIFORNIA SUBSTANCE ABUSE TREATMENT FACILITY AND STATE PRISON AT CORCORAN

Medical Inspection Results

Cycle 5

Roy W. Wesley
Inspector General

Shaun R. Spillane
Public Information Officer

November 2017

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

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

In Cycle 5, for the first time, the OIG will be inspecting institutions delegated back to CDCR from the Receivership. There is no difference in the standards used for assessment of a delegated institution versus an institution not yet delegated. At the time of the Cycle 5 inspection of the California Substance Abuse Treatment Facility and State Prison at Corcoran (SATF), the Receiver had not delegated this institution back to CDCR.

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

EXECUTIVE SUMMARY

OVERALL RATING:

Adequate

The OIG performed its Cycle 5 medical inspection at the California Substance Abuse Treatment Facility and State Prison at Corcoran (SATF) from May to July 2017. The inspection included in-depth reviews of 64 patient files conducted by clinicians, as well as reviews of documents from 432 patient files, covering 91 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 13 health care quality indicators applicable to the institution, 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 registered nurses trained in monitoring medical policy compliance. Of the indicators, seven were rated by both case review clinicians and compliance inspectors, three were rated by case review clinicians only, and three were rated by compliance inspectors only. The *SATF Executive Summary Table* on the following page identifies the applicable individual indicators and scores for this institution.

SATF Executive Summary Table

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

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

Clinical Case Review and OIG Clinician Inspection Results

The clinicians' case reviews sampled patients with high medical needs and included a review of more than 1,531 patient care events.[1] Of the 13 indicators applicable to SATF, 10 were evaluated by clinician case review; all ten were rated *adequate.* 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

- Providers had high morale and felt supported by their leadership.
- SATF nursing care coordinators scheduled follow-up care for patients referred to them, and were usually able to consult with providers to resolve issues that required planning for higher levels of care.
- Nurses reviewed patient health care service requests timely and appropriately. Nursing staff typically scheduled and saw patients in the same day the patient turned in the request form.

Program Weaknesses — Clinical

- Provider care in the CTC was sometimes poor. Many significant deficiencies arose when providers failed to adequately review medical records or failed to attempt to retrieve missing community hospital discharge summaries. Despite being classified as a basic institution, SATF had many complex patients, especially in the CTC, who required additional time and skilled provider care.
- Nursing assessments were incomplete in multiple patient cases reviewed. In some cases, the nurse did not identify the urgency of the condition or appropriately refer the patient to a provider.
- As was the case in Cycle 4, health information management staff frequently scanned documents into the electronic medical record without a provider's review or signature.

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

Compliance Testing Results

Of the 13 health care indicators applicable to SATF, 10 were evaluated by compliance inspectors.[2] Four were *adequate*, and six were *inadequate*. There were 91 individual compliance questions within those 10 indicators, generating 1,227 data points, that tested SATF's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[3] Those 91 questions are detailed in *Appendix A — Compliance Test Results*.

Program Strengths — Compliance

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

- Nursing staff reviewed patient health care services requests and provided face-to-face encounters within required time frames.
- Registered nurses (RNs) completed the assessment and disposition sections of initial health care assessment forms for patients that transferred into SATF, and nursing staff properly completed medication transfer packages for patients that transferred out of SATF.
- The institution's main pharmacy followed proper security, organization, and cleanliness protocols, properly stored medications, and had strong controls in place for narcotic medications.
- SATF timely offered immunizations and colon cancer screenings to patients.
- The institution provided high-priority and routine specialty services within required time frames.
- The institution timely addressed patient's medical appeals and properly reviewed Emergency Medical Response Review Committee (EMRRC) minutes, in compliance with policy.

[2] The OIG's compliance inspectors are trained 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 Weaknesses — Compliance

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

- Providers did a poor job communicating diagnostic service results to patients.
- Clinicians at several SATF clinics did not follow good hand hygiene practices, and protocols to protect against blood borne pathogens were weak; inspectors found clinics that did not have sharps containers, or the sharps containers were not properly maintained.
- Several medication line locations had poor inventory count controls over narcotic medication, and several locations did not properly store non-narcotic medications.
- The institution did not always timely receive, and providers did not always timely review, routine and high-priority specialty service reports.

Population-Based Metrics

In general, SATF performed as well as or better than other entities reporting data, both statewide and nationally, in many areas measured by population-based metrics. In comprehensive diabetes care, for example, SATF outscores most State and nationwide health plans, while scoring less well in just a few measures; specifically, eye exams. With regard to immunizations and cancer screening, the institution scored lower than most of the other health care plans, but the high patient refusal rate negatively affected the institution's scores. SATF can improve their scores in these measures by educating patients on the benefits of these preventive services.

Recommendations

- The OIG recommends SATF provide training for health information management staff to ensure reports are reviewed and signed by providers prior to being scanned into medical records. When the EHRS is implemented, SATF should ensure that the health information management staff sends reports to providers for their review and signature electronically.

- The OIG recommends SATF leadership deliver training to providers regarding careful review of medical records for complex patients, such as those cared for in the CTC. This is especially important for providers who are unfamiliar with the patients because the providers are on call or covering on weekends. In addition, the OIG recommends that SATF train providers about the importance of careful record review for patients returning from outside hospitals to ensure that all diagnoses and management plans are appropriately addressed.

INTRODUCTION

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

The California Substance Abuse Treatment Facility and State Prison at Corcoran (SATF) was the 13th medical inspection of Cycle 5. During the inspection process, the OIG assessed the delivery of medical care to patients using the primary clinical health care indicators applicable to the institution. The *Administrative Operations* indicator is secondary because it does not reflect the actual clinical care provided.

ABOUT THE INSTITUTION

Located in Corcoran, Kings County, SATF operates as a medium-to-high-security, and maximum-security institution for general population inmates. SATF runs multiple medical clinics where staff members address routine requests for medical services. SATF also conducts patient screenings in its receiving and release clinic (R&R), treats patients requiring urgent or emergent care in its triage and treatment area (TTA), and houses patients requiring inpatient health care services in its correctional treatment center (CTC). SATF has been designated as a "basic care institution" by CDCR. 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 vacancy rate among medical managers, primary care providers, supervisors, and rank-and-file nurses was 9 percent in April 2017, with the highest vacancy percentage among primary care providers at 23 percent, which correlated to 3 vacancies out of 13 authorized positions.

SATF Health Care Staffing Resources as of April, 2017

	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff		Totals	
Description	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Authorized Positions	5	2%	13	6%	14.3	6%	130.2	80%	162.5	100%
Filled Positions	5	100%	10	77%	14	98%	119.6	92%	148.6	91%
Vacancies	0	0%	3	23%	0.3	2%	10.6	8%	13.9	9%
Recent Hires (within 12 months)	0	0%	1	10%	6	43%	16	9%	23	11%
Staff Utilized from Registry	0	0%	0	0%	0	0%	19	11%	19	9%
Redirected Staff (to Non-Patient Care Areas)	0	0%	0	0%	0	0%	3	2%	3	1%
Staff on Long-term Medical Leave	0	0%	0	0%	0	%	12	7%	12	6%

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

As of April 24, 2017, the Master Registry for SATF showed that the institution had a total population of 5,634. Within that total population, 2.2 percent were designated as high medical risk, Priority 1 (High 1), and 5.5 percent were designated as high medical risk, Priority 2 (High 2). Patients' assigned risk levels are based on the complexity of their required medical care related to their specific diagnoses, frequency of higher levels of care, age, and abnormal laboratory results and procedures. High 1 has at least two high-risk conditions; High 2 has only one. Patients at high medical risk are more susceptible to poor health outcomes than those at medium or low medical risk. Patients at high medical risk also typically require more health care services than do patients with lower assigned risk levels. The chart below illustrates the breakdown of the institution's medical risk levels at the start of the OIG medical inspection.

SATF Master Registry Data as of April 24, 2017

Medical Risk Level	# of Patients	Percentage
High 1	126	2.2%
High 2	308	5.5%
Medium	3,091	54.9%
Low	2,109	37.4%
Total	**5,634**	**100%**

OBJECTIVES, SCOPE, AND METHODOLOGY

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

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

The OIG rates each of the quality indicators applicable to the institution under inspection based on case reviews conducted by OIG clinicians and compliance tests conducted by OIG registered nurses. The 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 done by clinicians, while the ratings for the primary quality indicators *Health Care Environment* and *Preventive Services* are derived entirely from compliance testing done by registered nurse inspectors. As another example, primary quality indicators such as *Diagnostic Services* and *Specialty Services* receive ratings derived from both sources.

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 a patient needing immediate care, the OIG notifies the chief executive officer of health care services and requests a status report. Additionally, if the OIG learns of significant departures from community standards, it may report such departures to the institution's chief executive officer or to CCHCS. Because these matters involve confidential medical information protected by state and federal privacy laws, 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 added case reviews to the Cycle 4 medical inspections at the recommendation of its stakeholders, which continues in Cycle 5 medical inspections. 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 64 unique patients. *Appendix B, Table B–4: SATF Case Review Sample Summary* clarifies that both nurses and physicians reviewed charts for 15 of those patients, for 79 reviews in total. Physicians performed detailed reviews of 25 charts, and nurses performed detailed reviews of 15

charts, totaling 40 detailed reviews. For detailed case reviews, physicians or nurses looked at all encounters occurring in approximately six months of medical care. Nurses also performed a limited or focused review of medical records for an additional 39 patients. These generated 1,531 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 6 chronic care patient records, i.e., 3 diabetes patients and 3 anticoagulation patients (*Appendix B, Table B–1: SATF Sample Sets*), the 64 unique patients sampled included patients with 197 chronic care diagnoses, including 17 additional patients with diabetes (for a total of 20) and one additional anticoagulation patient (for a total of 4) (*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 found the Cycle 4 medical inspection sample size of 30 for detailed physician reviews far exceeded the saturation point necessary for an adequate qualitative review. At the end of Cycle 4 inspections, the case review results were reanalyzed using 50 percent of the cases; there were no significant differences in the ratings. To improve inspection efficiency while preserving the quality of the inspection, the samples for Cycle 5 medical inspections were reduced in number. In Cycle 5, for basic institutions with small high-risk populations, case review will use a sample size of detailed physician-reviewed cases 67 percent as large as that used in Cycle 4. For intermediate institutions and basic institutions housing many high-risk patients, case review physicians will use a sample 83 percent as large as that in Cycle 4. For SATF, the OIG used a sample size 83 percent as large as that used in Cycle 4 because SATF had many high-risk patients. Finally, for the most medically complex institution, California Health Care Facility (CHCF), the OIG will continue to use a sample size 100 percent as large as that used in Cycle 4.

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 May to July 2017, registered nurse inspectors attained answers to 91 objective medical inspection test (MIT) questions designed to assess the institution's compliance with critical policies and procedures applicable to the delivery of medical care. To conduct most tests, inspectors randomly selected samples of patients for whom the testing objectives were applicable and reviewed their electronic medical records. In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed medical records for 432 individual patients and analyzed specific transactions within their records for evidence that critical events occurred. Inspectors also reviewed management reports and meeting minutes to assess certain administrative operations. In addition, during the week of May 15, 2017, registered nurse 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 1,227 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 Cycle 5 medical inspection testing, the OIG reduced the number of compliance samples tested for 18 indicator tests from a sample of 30 patients to a sample of 25 patients. The OIG also removed some inspection tests upon stakeholder agreement that either were duplicated in the case reviews or had limited value. Lastly, for Cycle 4 medical inspections, the OIG tested two secondary (administrative) indicators; *Internal Monitoring, Quality Improvement, and Administrative Operations*; and *Job Performance, Training, Licensing, and Certifications,* and have combined these tests into one *Administrative Operations* indicator for Cycle 5 inspections.

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

Scoring of Compliance Testing Results

After compiling the answers to the 91 questions for the 10 applicable indicators, the OIG derived a score for each quality indicator by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Based on those results, the OIG assigned a rating to each quality indicator of *proficient* (greater than 85 percent), *adequate* (between 75 percent and 85 percent), or *inadequate* (less than 75 percent).

OVERALL QUALITY INDICATOR RATING FOR CASE REVIEWS AND COMPLIANCE TESTING

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

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

POPULATION-BASED METRICS

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

MEDICAL INSPECTION RESULTS

The quality indicators assess the clinical aspects of health care. As shown on the *SATF Executive Summary Table* on page *iii* of this report, 13 of the OIG's indicators were applicable to SATF. Of those 13 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 3 were rated by the compliance component alone. The *Administrative Operations* indicator is a secondary indicator, and, therefore, was not relied upon for the overall score for the institution. Based on the analysis and results in all the primary indicators, the OIG experts made a considered and measured opinion that the quality of health care at SATF was ***adequate***.

Summary of Case Review Results

The clinical case review component assessed 10 of the 13 indicators applicable to SATF. Of these 10 indicators, OIG clinicians rated all 10 *adequate*.

The OIG physicians rated the overall adequacy of care for each of the 25 detailed case reviews they conducted. Of these 25 cases, 21 were *adequate*, and 4 were *inadequate*. In the 1,531 events reviewed, there were 241 deficiencies, of which 39 were considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

Adverse Events Identified During Case Review

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

There were two adverse events identified in case 22. This was a complex patient with end-stage heart disease and multiple-organ failure. Most of his care was adequate, but during the final weeks of care, SATF clinicians did not adequately manage the patient's care. These errors likely led to the patient's untimely death. Different aspects of this patient's care are discussed in multiple areas within this report, including the *Emergency Services*, *Inter- and Intra-System Transfers*, *Pharmacy and Medication Management*, *Quality of Provider Performance*, and the *Specialized Medical Housing* indicators.

- In case 22, the patient developed severe shortness of breath and chest pressure. The provider waited 75 minutes before ordering an EKG, and did not decide to send the patient to the hospital for a possible heart attack until more than two hours after the patient presented with

chest discomfort and breathing difficulty. The patient did not transfer out of the facility until more than four hours after he had presented with his symptoms. The OIG considered this severe delay an adverse event.

- One month later (case 22), the patient was again hospitalized for worsening breathing problems. He was found to have blood clots in his lungs and required anticoagulation treatment. The hospital recommended two anticoagulation medications. SATF providers neglected to order either of the anticoagulation medications, and the patient did not receive these critical medications until five days later. Nurses later missed an administration of enoxaparin, one of the critical anticoagulation medications, which further increased the patient's risk of blood clot complications. The OIG also considered these errors an adverse event. The patient subsequently died in the hospital of worsening heart failure.

Summary of Compliance Results

The compliance component assessed 10 of the 13 indicators applicable to SATF. Of these 10 indicators, OIG inspectors rated none *proficient*, four *adequate*, and six *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.

1 — *ACCESS TO CARE*

This indicator evaluates the institution's ability to provide patients with timely clinical appointments. Areas specific to 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 a 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 patients have Health Care Services Request forms (CDCR Form 7362) available in their housing units.

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(71.7%)
Overall Rating:
Inadequate

In this indicator, the OIG case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance review resulting in an *inadequate* score. The OIG's internal review process considered those factors that led to both scores and ultimately rated this indicator *inadequate*, placing a heavier reliance on compliance testing. The case review assessments mainly focused on high-risk patients and targeted more recent patient appointments, but the compliance review randomly selected patients across various categories and evaluated the timeliness of appointments from two weeks to nine months prior to the inspection; this provided a more robust assessment of patients' access to medical care at SATF. In addition, compliance testing yielded extremely poor results in provider follow-up timeliness. Delays occurred in chronic care appointments, RN-to-provider referrals, provider follow-ups after specialty services, and provider appointments for patients new to the institution. As a result, an *inadequate* overall rating was deemed appropriate for this indicator.

Case Review Results

For the *Access to Care* indicator, the OIG clinicians reviewed 544 provider, nurse, specialty, and hospital events that required follow-up appointments, among which there were 22 deficiencies. Fifteen of the 22 deficiencies were significant.

RN Sick Call Access

SATF performed well with RN sick call access. At the onsite inspection, staff stated there were no backlogs in nursing appointments.

Provider-to-Provider Follow-up Appointments

Patients generally received timely appointments after providers ordered them. Among the 101 outpatient provider appointments reviewed, the OIG identified only five deficiencies, of which two were significant:

- In case 6, the patient was a high-risk patient with prior heart attacks and a stroke. The patient had uncontrolled blood pressure. The provider ordered a chronic care follow-up visit within

four weeks, but the appointment did not occur, resulting in a severe lapse in care. Although the patient was also non-compliant with some medical recommendations, it is possible that the lapse in care contributed to the patient's sudden death, which had no clear cause.

- In case 15, the on-call provider conducted an emergent encounter with the patient for chest pain and shortness of breath. The provider ordered a next-day follow-up, but the appointment did not occur. Fortunately, the patient's symptoms resolved and no harm occurred.

Nurse-to-Provider Referrals

There was a pattern of delayed provider appointments after nurse referrals. The OIG reviewed 26 events in which the nurse referred the patient to the provider. Five deficiencies were identified in these events, four of which were significant:

- In case 22, the patient saw the nurse for follow-up of a recent X-ray report showing that the patient had pneumonia. The nurse consulted the primary care provider, who ordered antibiotics and a follow-up appointment in seven days. The appointment did not occur.

- In case 39, the patient saw the nurse for complaints about side effects from one of his medications. The nurse referred the patient to the provider to be seen in three days, but the patient was not seen until one month later.

- In case 44, the patient saw the nurse for foot pain and swelling from shoes prescribed by the specialist. The nurse referred the patient to the provider, but the appointment did not occur, and the problem was not addressed.

- In case 49, the patient saw the nurse for weakness, vomiting, and chronic fatigue. The nurse referred the patient to a provider, but the appointment did not occur.

Nursing Follow-up Appointments

In general, nurses timely saw patients who were referred for nursing follow-up. Among the 20 RN referrals reviewed, there was only one minor deficiency whereby the RN appointment was delayed (case 14).

Provider Follow-up After Specialty Services

Providers appropriately saw their patients after specialty services. The OIG reviewed 96 specialty appointments and procedures that required a provider follow-up. There was no pattern of problems identified in this area. There was only one significant deficiency:

- In case 43, the provider follow-up appointment to review an urgent CT of the neck should have occurred within 3 days, but was 13 days late.

Intra-System Transfers

SATF performed adequately ensuring that patients who transferred in from other CDCR facilities were given timely provider appointments. The OIG clinicians reviewed 19 transfer-in events and found one minor deficiency.

Follow-up After Hospitalization

SATF ensured that providers saw their patients after outside hospitalizations or emergency room visits. The OIG clinicians reviewed 25 of these events, and all patients who returned from the hospital or emergency room received a provider follow-up appointment.

Follow-up After Urgent/Emergent Care

Providers appropriately saw their patients after TTA visits. The OIG reviewed 12 cases in which the patient went to the TTA, returned to housing, and required a provider follow-up appointment. The OIG found one significant deficiency:

- In case 17, the patient was seen in the TTA for severe back pain. The TTA provider treated the patient and ordered a provider follow-up within five days. The appointment did not occur until more than three weeks later. Fortunately, the patient's symptoms did not worsen.

Specialized Medical Housing

Providers admitted patients quickly to the CTC and saw them regularly. The OIG clinicians reviewed 4 CTC admissions and 313 CTC provider encounters. There was one significant deficiency:

- In case 17, the patient had a long, complex stay in the CTC for management of osteomyelitis (bone infection) of the spine. After he was discharged from the CTC, there was no provider follow-up, and the patient was lost to follow-up until the OIG's intervention during the onsite clinician visit.

Specialty Access and Follow-up

SATF performed adequately with specialty service access. Performance in this area is further discussed in the *Specialty Services* indicator. There was one significant deficiency:

- In case 2, the patient required a neurology consultation after being hospitalized for a seizure disorder. This appointment did not occur.

Diagnostic Results Follow-up

SATF performed adequately with provider follow-ups after abnormal laboratory results. There was only one significant deficiency:

- In case 34, the provider ordered a follow-up appointment after reviewing abnormal laboratory results. The appointment was not scheduled.

Clinician Onsite Inspection

The OIG clinicians interviewed SATF leadership and staff regarding access to care. Despite adequate case review performance, many of the yards had patient appointment backlogs caused because of three provider vacancies in the last six months. At the time of the onsite inspection, the vacancies had been filled. In addition, the backlogs decreased with the chief medical executive (CME) starting weekend clinics to catch up. SATF had also started using CCHCS telemedicine providers for primary care services to further reduce the backlogs. While improvements were made, the CME was concerned that the current staffing, even with all vacancies filled, was still insufficient. Classified by CCHCS as a basic institution, SATF nevertheless housed an approximately 10 percent high-risk medical population and a rising enhanced outpatient (EOP) population, both of which required additional provider resources.

Case Review Conclusion

The institution performed adequately with outpatient RN and provider access as well as follow-ups after specialty services, hospitalizations, and TTA services. CTC and specialty access was also adequate. There were problems with provider access after referral from the sick call nurse. The case review rating of the *Access to Care* indicator was *adequate*.

Compliance Testing Results

The institution performed in the *inadequate* range in the *Access to Care* indicator, with a compliance score of 71.7 percent. Several areas showed room for improvement:

- Among 24 sampled patients who suffered from one or more chronic care conditions, only 8 timely received their provider-ordered follow-up appointments (33 percent); 16 other patients received their appointments late or not at all. Three patients' follow-up appointments occurred between one and seven days late; six patients' appointments were from 10 to 51 days late; and two patients' appointments were 107 and 179 days late. For five patients, there was no evidence that they were seen at all (MIT 1.001).

- Among the 21 Health Care Services Request forms (CDCR Form 7362) sampled on which nursing staff referred the patient for a provider appointment, only 9 patients (43 percent) received a timely appointment. One patient received his appointment one day late; seven more patients received their appointments between 9 and 83 days late. For the final four patients, there was no evidence the appointments ever occurred (MIT 1.005).

- Only 16 of 28 sampled patients who received a routine or high-priority specialty service (57 percent) also received a timely follow-up appointment with a provider at SATF. Seven patients' high-priority specialty follow-up appointments were 10 to 60 days late. Three patients' routine specialty follow-up appointments were 5 to 14 days late; and for two patients, there was no evidence found that their routine specialty follow-up appointments occurred (MIT 1.008).

- Among 25 patients sampled who transferred into SATF from other institutions and were referred to a provider based on nursing staff's initial health care screening, only 16 (64 percent) were seen timely. Six patients received their provider appointments from 3 to 17 days late; two patients were seen 49 and 159 days late; for one final patient, there was no evidence to indicate he was ever seen (MIT 1.002).

The following tests earned *adequate* scores:

- Among 25 sampled patients who were discharged from a community hospital, 21 (84 percent) received a timely PCP follow-up appointment upon returning to SATF. One patient received his follow-up appointment three days late. For three other patients, there was no evidence found that the required follow-up appointments occurred (MIT 1.007).

- Inmates had access to health care services request forms at five of six housing units inspected (83 percent). One inspected housing unit did not have a supply of the forms available for patients' use (MIT 1.101).

- Of the ten sampled patients who were referred to and seen by a provider and for whom the provider subsequently ordered a follow-up appointment, nine (90 percent) received their follow-up appointments timely. One patient's appointment was 21 days late (MIT 1.006).

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

- For 52 of the 54 sampled patients who submitted health care services request forms, nursing staff completed a face-to-face encounter within one business day of reviewing the form (96 percent). For one patient, the nurse failed to complete the nursing assessment form, and for the final patient, there was no evidence the face-to-face encounter ever occurred (MIT 1.004).

- Inspectors sampled 55 health care services request forms submitted by patients across all facility clinics. Nursing staff reviewed 52 of the 55 service request forms on the same day they were received (95 percent). There was no evidence found that two of the forms were reviewed; on one final form, nursing staff did not annotate a date or time (MIT 1.003).

2 — *DIAGNOSTIC SERVICES*

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(54.9%)
Overall Rating:
Adequate

This indicator addresses several types of diagnostic services. Specifically, it addresses whether radiology and laboratory services were timely provided to patients, whether the primary care provider timely reviewed the results, and whether the results were communicated to the 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.

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 testing resulting in an *inadequate* score. The primary reason for the *inadequate* compliance score was that many reports were not timely reviewed by providers and were not timely communicated to patients. However, while case review also found this pattern, case review revealed that providers were aware of the diagnostic results, and patient care was not hindered. The OIG inspection team considered both case review and compliance testing results and concluded that the overall rating for the *Diagnostic Services* indicator was *adequate*.

Case Review Results

The OIG clinicians reviewed 189 diagnostic-related events and found nine deficiencies, with two significant. Of the nine deficiencies, seven were related to health information management and two were related to delayed tests or tests that were not performed.

Test Completion

Most diagnostic testing was scheduled and conducted in a timely manner as ordered. There were two significant deficiencies, but there was no pattern identified that would indicate a systemic problem in health care delivery.

- In case 8, the provider ordered laboratory tests for the next morning to monitor the patient's response to antibiotics. However, the laboratory tests were not done.

- In case 14, the provider ordered a hand X-ray for the next morning, but the test was not performed until five days later. This resulted in a delay in treating a bone fracture, and could have resulted in the bones healing in the wrong position (malunion).

Health Information Management

There were seven minor deficiencies in health information management of diagnostic results. Diagnostic laboratory test results were retrieved and forwarded to the medical providers for their review within the appropriate time frames. Laboratory test results then were scanned into the electronic medical records in a timely fashion. The providers were aware of the X-ray reports, as evidenced by their progress notes, as well as the signed Notification of Diagnostic Test Results (CDCR Form 7393), which communicates the results to the patient.

Clinician Onsite Inspection

SATF was able to properly process same-day, urgent, or "stat" (immediate) in-house diagnostic testing, including blood draws, electrocardiograms (EKGs), and X-rays. There was no pattern of delays or other problems identified in this indicator.

Case Review Conclusion

In general, SATF performed well with regard to diagnostic services, and this indicator was rated *adequate*.

Compliance Testing Results

The institution received an *inadequate* compliance score of 54.9 percent in the *Diagnostic Services* indicator, which encompasses radiology, laboratory, and pathology services. For clarity, each type of diagnostic service is discussed separately below:

Radiology Services

- Radiology services were timely performed for eight of ten patients sampled (80 percent); two patients received their services one and seven days late (MIT 2.001). SATF providers did not evidence timely review of any of the corresponding diagnostic service reports sampled by initialing and dating the report as CCHCS policy requires, scoring zero on this test (MIT 2.002). Providers then timely communicated the test results to only three of the ten patients (30 percent). Six patients' results were communicated from one to seven days late, and one final patient's radiology result was communicated 16 days late (MIT 2.003).

Laboratory Services

- The OIG tested ten ordered laboratory service samples. Inspectors were not able to find evidence of a particular order date for two of the original ten samples, so those two samples were not applicable for this specific test. Of the eight samples that were applicable, seven patients (88 percent) received their provider-ordered laboratory services timely; one of the services, which was ultimately refused by the patient, was offered three days late (MIT 2.004). Of the ten original laboratory service samples tested, there were nine laboratory services actually provided. The institution's providers reviewed all nine of the

resulting laboratory services reports within the required time frame (MIT 2.005). Finally, providers timely communicated the laboratory results to only five of the nine patients who received a laboratory service (56 percent); two patients' results were communicated one and three days late; one patient's result was communicated 56 days late; for one final patient, there was no evidence found that the report was communicated at all (MIT 2.006).

Pathology Services

- SATF received seven of the ten (70 percent) sampled final pathology reports timely. Three reports were received 18, 38, and 56 days late (MIT 2.007). With regard to providers' review and communication of the pathology results, SATF scored poorly. Providers evidenced their review by initialing and dating six of the ten reports (60 percent). One report was reviewed six days late, and three other reports had no evidence of review (MIT 2.008). Further, providers communicated pathology results timely to only one of nine applicable patients (11 percent). Six patients were notified of their pathology results from three to eight days late, and two patients never received their pathology results (MIT 2.009).

3 — *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 22 urgent or emergent events and found 19 deficiencies, with 3 of these deficiencies considered significant.

CPR Response

The CPR response was good. There were no significant deficiencies identified.

Provider Performance

Provider performance in the TTA was satisfactory. The OIG identified three provider deficiencies, of which two were significant:

- In case 20, the provider failed to give medications to reduce critically high blood pressure before transferring the patient to an outside emergency department.

- In case 22, the provider failed to timely manage a patient with unstable breathing and chest discomfort. The provider waited 75 minutes before ordering an EKG, and did not decide to send the patient to the hospital for a possible heart attack until more than two hours after he presented with chest discomfort. The OIG clinicians considered this an adverse event.

Nursing Documentation and Performance

Nursing documentation was generally appropriate and timely. The first responder data sheets identified the condition of the patients and the emergent care provided by the staff. The majority of the patients were transferred to the TTA without delays.

In general, the nursing care provided during emergency medical responses was sufficient. There was only one significant deficiency:

- In case 22, the nurse did not call 9-1-1 when the patient presented to the TTA with chest tightness and unstable breathing. Instead, the nurse called the provider and waited for the provider to respond. It took four hours before the patient was transferred to an outside emergency department for a possible heart attack. Furthermore, the nurse did not record the treatments ordered by the provider, the time that the provider was notified, or the time that the initial vital signs were taken. The OIG clinicians considered this an adverse event.

Emergency Medical Response Review Committee

The OIG clinicians evaluated seven Emergency Medical Response Review Committee (EMRRC) reviews of incidents in which patients were sent emergently to a community hospital. The EMRRC successfully identified deficiencies and documented quality improvement processes that included education and training.

Clinician Onsite Inspection

During the OIG onsite inspection, an emergency occurred; a patient was in respiratory distress. The SATF emergency response was observed to be timely and appropriate.

The TTA had three exam rooms, each with two beds. The OIG interviewed TTA staff and the supervisor. The TTA RN had worked in the TTA for four months, and felt that staff morale was positive and that support from nursing administrators was good. The TTA supervisor held daily meetings with all TTA staff and described their current quality improvement projects.

Case Review Conclusion

The OIG rated the *Emergency Services* indicator *adequate*.

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4 — *HEALTH INFORMATION MANAGEMENT*

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(60.7%)
Overall Rating:
Inadequate

Health information management is a crucial link in the delivery of medical care. Medical personnel require accurate information in order to make sound judgments and decisions. This indicator examines whether the institution adequately manages its health care information. This includes determining whether the information is correctly labeled and organized and available in the electronic medical records; whether various medical records (internal and external, e.g., hospital and specialty reports and progress notes) are obtained and scanned timely into patients' electronic medical records; 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 those factors that led to both results and rated this indicator *inadequate*. The compliance testing for this indicator provides a quantitative measure of the scanning of records and proper labeling and filing of electronic medical record documents by health information management staff. Compliance testing also revealed a notable issue with provider review of hospital discharge documents. As a result of these deficiencies, the overall score was determined to be *inadequate*.

During the OIG's testing period, SATF had not yet converted to the new Electronic Health Record System (EHRS); therefore, all testing occurred in the electronic Unit Health Record (eUHR) system.

Case Review Results

The OIG clinicians reviewed 1,531 events and found 61 deficiencies related to health information management, 3 of which were significant.

Inter-Departmental Transmission

There were no deficiencies identified in this area.

Hospital Records

The OIG reviewed 39 hospital events and identified seven minor deficiencies consisting of health information management staff scanning the reports without provider review and signature.

Specialty Services

The institution timely retrieved and scanned most specialty services reports. The OIG found six specialty services reports scanned without the required provider review and signature. While this did not hinder patient care in most events, it did delay important care in one case (case 9), which was a significant deficiency. This is also discussed in the *Specialty Services* indicator.

- In case 9, a cardiology consultation report was scanned into the electronic medical record without being reviewed or signed by the medical provider. As the provider was unaware of the recommendations, the provider did not promptly follow the recommendations. This contributed to a delay in performing the needed heart test (cardiac catheterization).

Diagnostic Reports

SATF performed well in this area with only four minor deficiencies. Performance in this area is also discussed in the *Diagnostic Services* indicator.

Urgent/Emergent Records

SATF performed well obtaining and scanning emergency care records. There were 49 events reviewed and nine minor deficiencies identified. Five involved missing or misfiled reports, and four involved reports scanned twice.

Scanning Performance

The OIG found that SATF scanned reports into the electronic medical record without a providers' review or signature. This is further discussed in the *Diagnostic Services* indicator.

Legibility

Illegible notes pose a significant medical risk to patients, especially when other providers need to review a patient's records or when a patient is transferred to a different health care team or to another institution. Many reports were dictated and transcribed and, therefore, legible. Occasional handwritten notes were illegible, or there was no signature stamp for identification.

Case Review Conclusion

SATF timely retrieved and scanned documents into patient electronic medical records. Many documents were scanned prior to review and signature by providers. This was also found in Cycle 4. The OIG case review clinicians rated the *Health Information Management* indicator *adequate*.

Compliance Testing Results

The institution earned an *inadequate* compliance score of 60.7 percent in the *Health Information Management* indicator. The following areas showed room for improvement:

- The institution scored zero in its labeling and filing of documents scanned into patients' electronic medical records. The errors included mislabeled and misfiled documents. Inspectors found 18 mislabeled documents and identified 6 documents that were missing. For this test, once the OIG identifies 24 mislabeled or misfiled documents, the maximum points are lost and the resulting score is zero (MIT 4.006).

- Among 25 sampled patients admitted to a community hospital and then returned to SATF, only 9 (36 percent) had a complete hospital discharge report that was timely reviewed by a primary care provider. For five patients, no hospital discharge record was found; for two patients, the hospital discharge record lacked key elements; for four patients, the provider review was two to three days late; and for five final patients, there was no evidence that a provider reviewed the hospital discharge record at all (MIT 4.007).

- Medication Administration Records (MARs) staff at SATF did not always timely scan medication administration records into patients' electronic medical records. Only 13 of 20 sampled documents (65 percent) were scanned within the required time frames. Seven MARs were scanned from one to 14 days late (MIT 4.005).

Two tests earned scores in the *adequate* range:

- SATF's medical records staff timely scanned 17 of the 20 sampled specialty service consultant reports into patients' electronic medical records (85 percent). One specialty report was scanned one day late, and two others were not found in the electronic medical records (MIT 4.003).

- The institution timely scanned 15 of the 18 sampled community hospital discharge reports or treatment records into patients' electronic medical records (83 percent); three reports were untimely by one, 3, and 11 days (MIT 4.004).

The institution earned one *proficient* score in this indicator:

- The institution timely scanned 19 of 20 sampled non-dictated progress notes, initial health screening forms, and requests for health care services into the electronic medical records (95 percent). One initial health screening form was scanned 33 days late (MIT 4.001).

5 — *HEALTH CARE ENVIRONMENT*

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

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(69.4%)

Overall Rating:
Inadequate

This indicator is evaluated entirely by compliance testing. There is no case review portion.

Compliance Testing Results

The institution received an *inadequate* compliance score of 69.4 percent in the *Health Care Environment* indicator, with areas needing improvement as follows:

- OIG inspectors observed clinicians' encounters with patients in 12 clinics. Clinicians followed good hand hygiene practices in only five clinics (42 percent). At seven clinic locations, clinicians failed to wash their hands before or after patient contact or before putting on gloves (MIT 5.104).

- Only 5 of 12 clinic locations (42 percent) met compliance requirements for essential core medical equipment and supplies. The remaining seven clinics were missing one or more functional pieces of properly calibrated core equipment or other medical supplies necessary to conduct a comprehensive exam. The missing items consisted of an appropriate Snellen eye exam chart distance marker, and tongue depressors. In addition, a nebulization unit and oto-ophthalmoscope did not have calibration stickers. The oto-ophthalmoscopes in two clinics were broken. Another clinic's oto-ophthalmoscope was missing a calibration sticker, and one other clinic's nebulization unit was missing a calibration sticker (MIT 5.108).

- Only 6 of 12 clinic exam rooms observed (50 percent) had appropriate space, configuration, supplies, and equipment to allow clinicians to perform a proper clinical examination. Three clinics had confidential records that were unsecured, visible, and easily accessible to inmate-porters. In another two clinics, patient examination was conducted without providing visual and reasonable auditory privacy. One clinic had a torn vinyl cover on the exam table (*Figure 1*), and another clinic

Figure 1: Exam Table with torn Vinyl

had cluttered exam room supplies (*Figure 2*) (MIT 5.110).

Figure 2: Cluttered exam room supplies

- Regarding proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste, only 7 of 12 clinics were compliant. SATF received a score of 58 percent on this test because two clinics had one or more exam rooms that lacked a sharps container. In another two clinics, sharps containers were not secured to fixed objects (*Figure 3*), and in another clinic, a sharps container was found overfilled at the time of inspection (MIT 5.105).

- Inspectors examined emergency response bags (EMRBs) to determine if they were inspected daily and inventoried monthly and whether they contained all essential items. They were compliant in 7 of the 11 clinical locations where they were stored (64 percent). One or more of the following deficiencies emerged at four locations: there was no documentation indicating that an inventory of the EMRB had been completed in the previous 30 days; and an EMRB log was missing one entry evidencing staff verified the bag's compartments were sealed and intact (MIT 5.111).

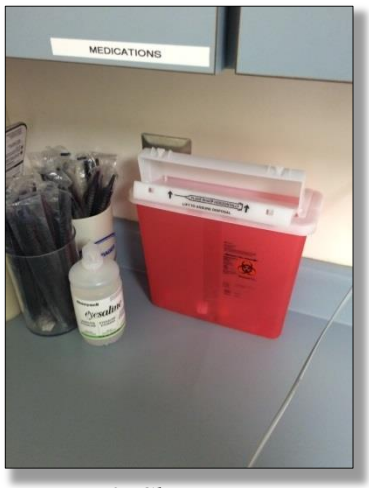

Figure 3: Sharps container not secured to a fixed object

The following tests scored in the *adequate* range:

- Out of 12 clinic locations inspected, 10 (83 percent) had operable sinks and sufficient quantities of hand hygiene supplies in the exam areas. Two separate clinics' inmate restrooms did not have sufficient quantities of hygiene supplies, such as antiseptic soap and disposable hand towels (MIT 5.103).

- Clinical health care staff at 9 of the 12 applicable clinics (75 percent) ensured that reusable invasive and non-invasive medical equipment was properly sterilized or disinfected. In two clinics, nursing staff failed to describe the process to disinfect the exam table prior to the start of the shift. In another clinic, previously sterilized invasive medical equipment packaging was found torn, compromising the sterility of the equipment (MIT 5.102).

- Inspectors found that 9 of the 12 clinics (75 percent) followed adequate medical supply storage and management protocols. Medical supplies at two clinics were not orderly or clearly identifiable, and in one clinic, staff's personal items were stored in the same area as medical supplies. In another clinic, there was no inventory replenishment system in place to ensure that medical supplies were stocked and restocked on a regular basis. Several medical supplies were found stored beyond the manufacturers guidelines (MIT 5.107).

- Clinic common areas at 9 of the 12 clinics (75 percent) had environments conducive to providing medical services. Three clinics lacked reasonable auditory privacy in the vital sign stations (MIT 5.109).

Two tests earned SATF *proficient* scores in this indicator:

- All 12 clinics were appropriately disinfected, cleaned, and sanitary. More specifically, in all clinics inspectors observed areas that were clean and not visibly dusty or dirty. In addition, cleaning logs were present and completed, indicating cleaning crews regularly cleaned the clinic (MIT 5.101).

- The non-clinic bulk medical supply storage areas met the supply management process and support needs of the medical health care program, earning SATF a score of 100 percent on this test (MIT 5.106).

Non-Scored Results

- The OIG gathered information to determine if the institution's physical infrastructure was maintained in a manner that supported health care management's ability to provide timely or adequate health care. The OIG did not score this question. When OIG inspectors interviewed health care managers, they did not identify any significant concerns. At the time of the OIG's medical inspection, SATF had several significant infrastructure projects underway, which consisted of increasing clinic space in primary care clinics, expanding medication distribution areas, and improving specialty care clinics and health records space. These projects started in the summer of 2015, and the institution estimated that these projects would be completed by the spring of 2018 (MIT 5.999).

6 — *INTER- AND INTRA-SYSTEM TRANSFERS*

Case Review Rating:
Adequate
Compliance Score:
Adequate
(80.7%)
Overall Rating:
Adequate

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

Case Review Results

The OIG clinicians reviewed 52 inter- and intra-system transfer events, including information from both the sending and receiving institutions. These included 21 transfers out for higher levels of care at community hospitals, 20 of which resulted in a return transfer back to the institution. One patient died at the hospital (case 22). There were 12 deficiencies, one of which was significant.

Transfers In and Out

The OIG clinicians reviewed 19 transfer-in events. There were three minor deficiencies. Among eight events regarding patients transferring out of the institution, there were two minor deficiencies with nursing documentation.

Hospitalizations

Patients returning from hospitalizations are some of the highest-risk encounters due to two factors. First, these patients are generally hospitalized for a severe illness or injury. Second, they are at risk due to potential lapses in care that can occur during any transfer. The OIG clinicians reviewed 20 hospitalizations and outside emergency room events and the patients' subsequent transfers back to SATF. Among these events, six minor deficiencies were identified, four of which consisted of health information management staff scanning discharge summaries into patients' electronic medical records prior to their being reviewed by the provider. There were two significant deficiencies:

- In case 22, the patient returned from the hospital with a discharge diagnosis of pulmonary emboli (blood clots in the lung). The nurse missed the diagnosis on the hospital discharge summary and, therefore, did not report the diagnosis to the on-call physician upon the patient's return to SATF. That physician and subsequent physicians failed to review the hospital discharge summary. This led to a delay in treatment of the patient's blood clots with blood-thinning medication. This case is further discussed in the *Quality of Provider Performance* and *Specialized Medical Housing* indicators.

Case Review Conclusion

SATF performed well with regard to *Inter- and Intra-System Transfers*, and the case review rating was *adequate*.

Compliance Testing Results

The institution obtained an *adequate* compliance score of 80.7 percent in the *Inter- and Intra-System Transfers* indicator, with two tests earning *proficient* scores of 100 percent:

- Nursing staff timely completed the assessment and disposition sections of the screening form for all 24 applicable patients sampled (MIT 6.002).

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

One test earned an *adequate* score:

- The OIG tested 24 applicable patients who transferred into SATF from other CDCR institutions to determine whether they received a complete initial health screening assessment from nursing staff on the day of their arrival; 20 of the assessments (83 percent) were complete and timely. For two patients, required elements of the assessment were not performed by nursing staff; for another patient, the assessment was not found in the electronic medical record; for one final assessment, compliance could not be ascertained because the encounter date was incorrect (MIT 6.001).

The following tests showed areas for needed improvement:

- Among 18 applicable sampled patients who transferred into SATF, 9 (50 percent) received their medication without interruption. Nine patients incurred medication interruptions of one or more dosing intervals upon arrival (MIT 6.003).

- Inspectors sampled 20 patients who transferred out of SATF to other CDCR institutions to determine whether nursing staff identified scheduled specialty service appointments on the patients' health care transfer forms. Nursing staff correctly listed the pending specialty

service appointments for 14 of 20 patients (70 percent). On six health care transfer forms sampled, staff failed to note the patients' pending specialty service appointments (MIT 6.004).

7 — *PHARMACY AND MEDICATION MANAGEMENT*

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(72.7%)
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 prescriber, staff, and patient.

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 review resulting in an *inadequate* score. The OIG's internal review process considered those factors that led to both scores and ultimately rated this indicator *inadequate*. While case review focused on medication administration, the compliance testing was a more robust assessment of medication administration and pharmacy protocols combined with onsite observations of medication and pharmacy operations. As a result, the compliance score of *inadequate* was deemed appropriate for the indicator rating.

Case Review Results

The OIG clinicians evaluated 81 events related to medications and found only 6 minor deficiencies and one significant deficiency. The case reviews revealed no pattern of deficiencies, and the case review rating of the *Pharmacy and Medication Management* indicator was *adequate.*

Medication Continuity

SATF performed well with medication continuity. Five cases had deficiencies in the form of delays in the delivery of medication to the patient in cases 1, 5, 15, 18, and the following:

- In case 22, some medication administration records for an injected blood-thinning medication was not in the electronic medical record. This deficiency is also discussed in the *Health Information Management* indicator.

Medication Administration

There was only one significant deficiency identified in medication administration by nursing staff:

- In case 22, SATF nurses did not administer a critical blood-thinning medication that was needed to treat the patient's blood clots that had travelled into his lungs.

Pharmacy Errors

The OIG clinicians did not identify any significant pharmacy deficiencies.

Clinician Onsite Inspection

OIG clinicians interviewed medication nurses at several clinics during the onsite inspection visit. The medication nurses were temporarily relocated from Yard A to the gym due to construction on site. Nurses stated that the gym area was well ventilated, and despite the high temperatures outside, there were no problems with medications exposed to heat. Medication management and storage areas in the gym were considered adequate. On Yard F, the construction of the medication room was completed. The room was spacious, clean, and capable of storing supplies and medical durable equipment. The office technician also shared a space in the room and did not interfere with the daily tasks of the medication administration team. The nurses on both yards reported a consistent practice of reporting medication errors, documenting, and reporting missed doses or "no-shows." There were no barriers between medication nurses and their supervisors. Nurses and psychiatric technicians from other yards also reported that supervisors were easily accessible by staff.

Case Review Conclusion

SATF performed well with regard to the *Pharmacy and Medication Management* indicator, and the case review rating was *adequate.*

Compliance Testing Results

The institution received an *inadequate* compliance score of 72.7 percent in the *Pharmacy and Medication Management* indicator. For discussion purposes below, this indicator is divided into three sub-indicators: medication administration, observed medication practices and storage controls, and pharmacy protocols.

Medication Administration

In this sub-indicator, the institution received an *inadequate* score of 74.6 percent. Room for improvement was evident in the following areas:

- SATF timely provided hospital discharge medications to 11 of 23 applicable patients sampled (48 percent). Nursing staff provided discharge medications from one to ten days late for six patients; two other patients each missed two medication doses. For three patients, there was no clear evidence found in the electronic medical record that their medication was either received or refused. For one final patient, there was a critical medication order that was not carried out (MIT 7.003).

- Nursing staff administered medications without interruption to three of five patients who were en route from one institution to another and had a temporary layover at SATF (60 percent). Two patients each missed one dosage of their ordered medication (MIT 7.006).

The following tests earned *adequate* scores:

- Among 21 patients sampled, 17 timely received chronic care medications (81 percent). There was no evidence one patient received one dose of a critical medication; three other patients did not receive their keep-on-person (KOP) medications at ordered intervals (MIT 7.001).

- Of the 25 sampled patients at SATF who had transferred from one housing unit to another, 21 (84 percent) received their prescribed medications without interruption. Four patients did not receive one or more doses of their medications at the next dosing interval after the transfer occurred (MIT 7.005).

One test in this sub-indicator earned a *proficient* score of 100 percent:

- All 25 patients sampled at SATF received their newly ordered medication in a timely manner (MIT 7.002).

Observed Medication Practices and Storage Controls

In this sub-indicator, the institution received an *inadequate* score of 50.3 percent. All but one test in this sub-indicator scored in the *inadequate* range, as follows:

- The institution employed adequate security controls over narcotic medications in 2 of the 11 applicable clinic and medication line locations where narcotics were stored (18 percent). At eight clinics, the narcotics logbook lacked evidence on multiple dates that a controlled substance inventory was performed by two licensed nursing staff; at another clinic, the narcotics logbook was missing a counter-signature for a disposal of controlled substance (MIT 7.101).

- SATF properly stored non-narcotic medications not requiring refrigeration in only two of the ten applicable clinic and medication line storage locations (20 percent). In eight locations, one or more of the following deficiencies were observed: the medication area lacked a designated area for return-to-pharmacy medications; external and internal medications were not properly separated when stored; medication rooms and cabinets were unlocked; multi-use medication was not labeled with the date it was opened; and there was no evidence that a monthly crash cart inventory was routinely practiced (MIT 7.102).

- Only three of the eight inspected medication preparation and administration areas (38 percent) demonstrated appropriate administrative controls and protocols. At five different locations, one or more deficiencies was observed: medication nurses did not consistently verify patients' identities with picture identification; medication nurses did not always ensure patients swallowed direct observation therapy medications; a medication nurse was observed signing a MAR prior to administering medications; medication nurses did not appropriately administer medication as ordered by the provider; and patients waiting to receive their medications did not have sufficient outdoor cover to protect them from heat or inclement weather (*Figure 4*) (MIT 7.106).

Figure 4: Insufficient cover to protect patients from inclement weather

- Nursing staff were compliant regarding proper hand hygiene and contamination control protocols at five of eight inspected locations (63 percent). At three locations, not all nursing staff washed or sanitized their hands when required, such as prior to putting on gloves, to re-gloving, and when preparing medications (MIT 7.104).

- Non-narcotic refrigerated medications were properly stored at 7 of 11 clinics and medication line storage locations (64 percent). At four locations, one or more deficiencies were identified: medication refrigerators were unlocked; medication refrigerators lacked a designated area for return-to-pharmacy medications; and insulin medication vials were found stored beyond the manufacturers' guidelines (MIT 7.103).

One test in this sub-indicator received a *proficient* score of 100 percent:

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

Pharmacy Protocols

In this sub-indicator, the institution received a *proficient* score of 97.6 percent, comprised of scores received at the institution's main pharmacy. Four of the five tests in this sub-indicator earned scores of 100 percent, as follows:

- In its main pharmacy, the institution followed general security, organization, and cleanliness management protocols; properly stored and monitored non-narcotic medications that

required refrigeration and those that did not; and maintained adequate controls over and properly accounted for narcotic medications (MIT 7.107, 7.108, 7.109, and 7.110).

- The institution's pharmacist in charge (PIC) followed required protocols for 22 of the 25 medication error reports and monthly statistical reports reviewed (88 percent). For three medication error reports, the PIC did not assign severity level of the medication error, and did not document the date when the medication error follow-up review was completed (MIT 7.111).

Non-Scored Tests

- In addition to testing of reported medication errors, inspectors follow up on any significant medication errors that were found during the compliance testing to determine whether the errors were properly identified and reported. At SATF, there were no applicable medication errors (MIT 7.998).

- The OIG interviewed patients in isolation units to determine if they had immediate access to their prescribed KOP rescue medications. All seven of the sampled patients had access to their rescue medications (MIT 7.999).

8 — *PRENATAL AND POST-DELIVERY SERVICES*

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

As SATF is a male-only institution, this indicator did not apply.

Case Review Rating:
Not Applicable
Compliance Score:
Not Applicable

Overall Rating:
Not Applicable

9 — *PREVENTIVE SERVICES*

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

Case Review Rating:
Not Applicable
Compliance Score:
Adequate
(77.9%)
Overall Rating:
Adequate

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

Compliance Testing Results

The institution performed in the *adequate* range in the *Preventive Services* indicator, with a compliance score of 77.9 percent. Four tests earned *proficient* scores, as follows:

- All 25 patients sampled timely received or were offered influenza vaccinations during the most recent influenza season (MIT 9.004).

- The OIG found that 29 of 30 patients sampled (97 percent) received timely annual tuberculosis (TB) screenings. CCHCS policy requires that screenings occur in the patient's birth month; one patient's screening occurred in the month following his birth month (MIT 9.003).

- SATF offered colorectal cancer screenings to 24 of 25 sampled patients subject to the annual screening requirement (96 percent). For one patient, there was no electronic medical record evidence either that health care staff offered a colorectal cancer screening within the previous 12 months or that the patient had a normal colonoscopy within the last ten years (MIT 9.005).

- The OIG tested whether patients who suffered from a chronic care condition were offered vaccinations for influenza, pneumococcal infection, and hepatitis. Among the 18 sampled patients with applicable chronic conditions, 16 patients (89 percent) were timely offered the vaccinations. There was no record that one patient received or refused the pneumococcal immunization or the hepatitis A and B vaccinations within the last five years; for one other patient, there was no evidence of receipt or refusal of the hepatitis A and B vaccinations (MIT 9.008).

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

- Among 12 sampled patients who received TB medications, the institution only properly monitored four of them (33 percent). Eight patients required weekly or monthly monitoring, but SATF clinicians did not monitor these patients in compliance with policy (MIT 9.002).

- The OIG sampled 11 patients at high risk for contracting the coccidioidomycosis infection (valley fever) who were 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 initially determined ineligible. The institution was compliant for 7 of the 11 patients sampled (64 percent). Four of the patients were not timely transferred (MIT 9.009):

    - Two patients were transferred out of the institution 12 and 44 days late.

    - One patient was transferred out of the institution 380 days late.

    - One patient, who was initially identified on November 18, 2016, as ineligible to be housed at SATF, was still there as of June 4, 2017. After a 60-day grace period for the institution to transfer the patient out of the facility, the patient remained at SATF more than 138 days.

- SATF scored poorly for the timely administration of TB medications. The OIG examined the health care records of all 12 patients who were on TB medications during the inspection period, and only eight patients received all of their required medications (67 percent). Four patients did not receive all of their ordered doses (MIT 9.001).

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

Case Review Results

The OIG nursing clinicians reviewed 303 nursing encounters, of which 174 were outpatient nursing encounters. Most were sick call requests, walk-in visits, and nursing follow-up visits. There were 52 deficiencies identified related to nursing care, two of which were significant. There were 31 deficiencies identified in the outpatient setting, none of which were significant. The OIG clinicians rated the *Quality of Nursing Performance* at SATF *adequate.*

Nursing Assessment, Intervention, and Documentation

The majority of nursing assessments, interventions, and documentation were timely and appropriate. In some cases, the SATF nurses did not adequately assess patients and did not communicate abnormal findings to providers. However, in these cases, the deficiencies were minor and unlikely to cause patient harm.

Sick Call

There were 90 outpatient sick calls reviewed. SATF nurses promptly triaged and scheduled patients for assessments on the next business day for the majority of patients. Deficiencies found in the sick call process included incomplete nursing assessments, insufficient recognition of potential urgency of patients' symptoms,, and failure to contact the provider for consultation. Additionally, in some cases, nurses did not assess vital signs or document a plan of care for patients.

Care Management

Care managers are defined by CCHCS as primary care RNs who develop, implement, and evaluate patient care services and care plans for assigned patient panels. At SATF, RN care managers often referred patients to providers for laboratory results follow-up, educated patients regarding non-compliance with medication, and coordinated continuity of care for patients returning from offsite specialty services or hospitalizations.

- In case 15, the interventions completed by the RN care manager was *proficient.* The patient in this case had returned from a cardiac procedure and had a lay-in accommodation to rest in his cell for recovery purposes. The RN went to the patient's cell to educate the patient on the discontinuance of his blood-thinning medication, and retrieved the remaining KOP medication from the patient. Since the patient was a lay in, he would not have gone to the medication line, and would have continued taking the discontinued medication that was kept in his housing area.

Urgent/Emergent

Nursing performance in the TTA and emergency medical response was good, although there was one case with a significant deficiency (case 22). This case and deficiency is discussed in the *Emergency Services* indicator.

Post Hospital Returns

Nurses' performance for patients returning from the hospital was good. They made timely assessments, documented notification to providers, and implemented hospital recommendations. Among the 14 hospital return nursing encounters reviewed, nine minor and two significant deficiencies were identified. These deficiencies are also summarized in the *Inter- and Intra-System Transfers* and *Access to Care* indicators.

- In case 2, a significant deficiency occurred when a follow-up specialty appointment was not scheduled.

- In case 22, a significant deficiency occurred in nursing performance regarding inadequate review of the patient's hospital discharge summary and not starting a medication to prevent further blood clots.

Specialized Medical Housing

Nursing care in the CTC was good. There were 46 nursing encounters reviewed with various minor deficiencies and two significant deficiencies. There were no specific patterns of deficiencies. Nursing assessments were complete and thorough. Medication and treatment refusals and changes in patient conditions were documented and reported to the provider promptly. Case review findings and deficiencies are summarized in the *Specialized Medical Housing* indicator.

Transfers

The OIG clinicians reviewed 12 nursing encounters involving transferring patients. The nursing performance in this area was sufficient. Patients who arrived at the institution were assessed appropriately and referred to the primary care team as required. Transfers out were also appropriately completed. Performance in this area is also discussed in the *Inter- and Intra-System Transfers* indicator.

Offsite Specialty Services Returns

There were 24 reviewed nursing encounters for patients returning from offsite specialty service appointments. The TTA nurses assessed patients appropriately, reviewed the consultation recommendations, and contacted the provider when necessary. Among the 17 deficiencies found in all of specialty services, only two minor ones concerned nursing care. Performance in this area is further discussed in the *Specialty Services* indicator.

Medication Administration

The SATF nurses performed well in this area. There were no significant deficiencies identified in this process. Performance in this area is discussed in the *Pharmacy and Medication Management* indicator.

Clinician Onsite Inspection

Upon the OIG clinicians' arrival at SATF, they were informed that many clinical staff were scheduled for education and training on the new electronic health record system (EHRS) during the week of the medical inspection, that current staffing in various clinics might be affected, and that certain staff may not be available for interviews. The shortage of staff was observed in the CTC and in Yard F, where there was a delay in the usual time for starting the morning huddle.

The OIG clinicians visited various clinical departments, units, and outpatient clinics. Construction was in progress on several housing yards. On Yard A, the clinic primary care provider, RN, and office technician had been relocated to the freestanding dialysis building, and medication nurses had been relocated to the gym. Although transportation of the patients to the relocation areas was required, the scheduled clinic services occurred as planned, and patients rarely refused their clinical appointments. The OIG clinicians attended morning huddles in the CTC and outpatient yards. In the CTC, all medical staff was present with the exception of the supervising RN. There were no patient appointment backlogs in the short term restricted housing unit (STRH). Implementation of a tracking log in the STRH ensured that all provider and nurse follow-up appointments and referrals were scheduled, and that patients were seen timely.

The OIG clinicians also interviewed the chief nursing executive (CNE), various supervisors, nurses in specialty services, TTA nurses, and the psychiatric technicians and nurses in the medication administration areas. Nursing supervisors were familiar with each staff member's role and responsibilities. Nursing staff generally felt the morale at SATF was positive, and that supervisory

response and support was available. The CNE was aware of the need to improve the nursing care plan documentation and had proactively obtained training materials for the staff.

Case Review Conclusion

The OIG clinicians rated the *Quality of Nursing Performance* indicator *adequate*.

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11 — *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 429 medical provider encounters and identified 97 deficiencies related to provider performance, 17 of which were significant. The OIG performed 25 detailed case reviews and rated 21 *adequate* and 4 *inadequate*. The OIG clinicians rated this indicator *adequate.*

Assessment and Decision-Making

In most cases, providers made satisfactory assessments and sound decisions. In some cases, the providers demonstrated *proficient* care:

- In case 15, the provider, with the patient's permission, contacted the patient's family before surgery to discuss a complex heart procedure.
- In cases 15 and 16, the providers performed focused medication reviews to evaluate the necessity of each of the many medications currently used by the patients (polypharmacy review).
- In case 16, the patient required many offsite eye consultation procedures and follow-up visits. The provider was able to coordinate all of the many visits, often daily, without any lapses in care.

However, the OIG also found some significant errors in assessment and decision-making. The following deficiencies were in outpatient management. Deficiencies that occurred in the CTC are discussed in *Specialized Medical Housing* indicator.

- In case 6, the provider failed to perform timely follow-up for a patient with uncontrolled hypertension. Prolonged hypertension increased the risk of permanent damage to various organs, including the heart, brain, and kidneys. In addition, the provider did not order appropriate laboratory monitoring after adjusting the patient's blood pressure medications. Not testing for abnormal electrolyte levels could have led to serious cardiac rhythm disturbances and even, possibly, sudden death.

- Also in case 6, during other encounters, the provider made infrequent blood pressure medication adjustments over seven months for a patient at high risk for heart disease and stroke. The patient died suddenly, and it is possible that some of the provider errors could have contributed to his death.

- In case 11, the provider failed to fully assess a patient with extremely poor vision. The provider should have performed a basic visual acuity test. In addition, the provider did not provide disability accommodations.

- In case 14, the provider failed to arrange for appropriate and timely follow-up for a patient with a fractured hand.

- In case 22, the provider failed to fully assess and manage a patient with a one-week respiratory illness who continued to cough up blood.

- In case 24, the provider inappropriately delayed a surgical referral for an eyelid cancer removal.

Specialized Medical Housing

This is more fully discussed in the *Specialized Medical Housing* indicator. While the provider performance here showed improvement from Cycle 4, this area continued to be the weakest area for providers at SATF. Nine of the significant deficiencies were in specialized medical housing.

Emergency Care

The OIG reviewed 26 emergency or urgent TTA encounters. There were three deficiencies, two of which were significant:

- In case 20, the provider appropriately sent the patient with a dangerously high blood pressure (220/123) to an outside emergency department. However, the provider failed to treat the patient's blood pressure with medications before sending the patient out.

- In case 22, the patient had chest pain and difficulty breathing. The provider never came to see the patient and waited 75 minutes before ordering an EKG. The patient had a possible heart attack, but the provider did not decide to send the patient to the hospital until more than two hours after the patient developed symptoms. The provider did not come in to assess the patient in the TTA.

Chronic Care

Providers generally provided adequate chronic care. However, some patients with high blood pressure were not appropriately managed, as described above. Most anticoagulation patients also received adequate care, with the exception of the following patient:

- In case 9, multiple providers failed to recognize a gross error in a warfarin (blood-thinning medication) dose. This led to a delay in properly adjusting the medication, and the patient was at risk for developing blood clots. Fortunately, no harm came to the patient due to this error.

Specialty Services

The OIG reviewed 150 specialty services events. In general, the SATF providers did well facilitating this medical care. There were two minor deficiencies, both of which were a result of the provider delaying or conducting an incomplete review of the specialist recommendations. These are also discussed in the *Specialty Services* indicator. One encounter showed excellent provider care:

- In case 17, the provider made a prompt telephone call to an infectious disease consultant to discuss an unexpected change in antibiotic therapy and to obtain guidance for a challenging patient who refused further therapy.

Clinician Onsite Inspection

The OIG inspectors learned from the leadership that SATF had three vacant provider positions over the last six months, which contributed to a backlog. The vacancies had been filled recently.

The OIG discussed the deficiencies in CTC care with the chief medical executive (CME). These deficiencies mainly occurred with the on-call providers, and many arose from incomplete record review causing missed diagnoses or lapsed medications. The TTA and CTC had designated providers. Since the providers worked on a four-day, ten-hour shift schedule, both the TTA and the CTC required frequent provider changes to accommodate the regularly assigned providers' days off. In addition, the CTC required an on-call physician to cover weekends and holidays. These schedules, while required for provider recruitment and retention, led to suboptimal continuity of patient care because the on-call provider was not familiar with the patients' needs.

Furthermore, per the CME, the on-call providers had been instructed to limit their interventions and to make few changes to primary providers' orders. The intention was to prevent inappropriate changes by on-call providers who did not have a complete knowledge of the patient. However, this may have also prevented the on-call providers from intervening for those patients with severe or complex illness who required major day-to-day treatment changes.

SATF had a robust provider morning report where staff reviewed important changes that occurred over the previous day. After the morning report, the providers went to their assigned clinics for the multidisciplinary team huddles.

The morale among the providers was generally high, and all reported that the CME was supportive. Other positive comments concerned the collegiality among group members, monthly group presentations, and adequate radiology and pharmacy support. The providers mentioned that working relationships with their nursing and custody colleagues was good.

Case Review Conclusion

The care provided by SATF medical providers was *adequate*. Of the 25 cases reviewed, 21 were *adequate*, and 4 were *inadequate*. Medical care in the CTC was adequate, but OIG clinicians identified areas that need improvement.

12 — *RECEPTION CENTER ARRIVALS*

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

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

Because SATF did not have a reception center, this indicator did not apply.

13 — *SPECIALIZED MEDICAL HOUSING*

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

Case Review Rating:
Adequate
Compliance Score:
Adequate
(85.0%)
Overall Rating:
Adequate

Case Review Results

The CTC was a 38-bed unit. There were 18 designated beds for patients with medical care needs, nine negative pressure rooms (rooms used to minimize the spread of airborne infections), and 20 beds for mental health patients. The OIG clinicians reviewed nine CTC admissions with 582 events. There were 313 provider encounters and 46 nursing encounters. There were 71 deficiencies, 10 of which were significant.

Provider Performance

SATF providers did well with most CTC encounters. There were many encounters reviewed, and providers generally made good quality assessments and decisions, reviewed documents with adequate depth, and performed admission history and physicals regularly. Provider care in the CTC was sufficient, but OIG clinicians noted several areas for improvement, and there were many significant deficiencies, particularly in case 22 (discussed below in detail). In addition, the discharge summaries often lacked sufficient detail to ensure continuity of medical care when the patients transferred to the outpatient clinics.

- In case 7, the patient was in hospice care for end-stage heart disease. Despite the patient having requested comfort measures only, the provider continued unnecessary medications such as iron, which could have worsened the already present constipation. In addition, there were inappropriate orders to withhold pain medication when the patient's blood pressure was low, which could have caused the patient unnecessary suffering.

- Also in case 7, an unnecessary and uncomfortable enema was ordered when other, more comfortable measures were possible.

- In case 8, the patient had congestive heart failure. On a single day, two providers examining the patient documented extremely discordant physical exam findings. This indicated a flawed examination or documentation by one of the providers.

- In case 9, the patient's warfarin (blood thinner) was mistakenly decreased to 10 percent of the original dose. The error was not recognized by multiple providers. Fortunately, no harm came to the patient, who required the blood thinner for the treatment of blood clots.

Five of the significant deficiencies were in case 22. This was a complex patient with end-stage heart disease and multiple-organ failure. Most of his care was adequate, but the final weeks of care were not adequately managed, and likely led to the patient's untimely death:

- The provider delayed sending the patient to a higher level of care when his condition was unstable.

- Multiple providers failed to recognize that the patient was not being treated for a blood clot in the lung for which he had recently been hospitalized.

- The providers failed to carefully review hospital discharge orders, and there was a delay in the patient receiving the correct blood-thinning medication.

- An initial history and physical exam (H&P) for the CTC admission was not done. Not only was this a deviation from standard practice, but the H&P was especially necessary for this complex patient.

- In one encounter, the provider failed to adequately address potential serious heart and gastrointestinal side effects of amitriptyline (chronic pain medication, also used for depression).

Nursing Performance

Nursing performance in the CTC was generally good. In the majority of cases, nursing assessments were timely and thorough, and the documentation addressed changes in patients' conditions with interventions. The patients who were admitted for end-of-life care received appropriate nursing care, and refusals of medications and treatments were reported to providers. Nursing care plans lacked specific interventions regarding changes in patients' conditions, but these deficiencies were mostly minor. There were eight nursing deficiencies related to monitoring and documentation. There were three deficiencies identified in the category of health information management, all consisting of missing documentation. Several nursing deficiencies, including one significant, occurred in one case:

- In case 22, the patient was diagnosed with heart failure, and the provider ordered daily fluid restrictions. The nursing staff failed to implement the fluid restriction on two different occasions, and the patient exceeded the daily fluid limit. This error placed the patient, whose heart was already compromised, at risk of increased cardiac stress. The nursing staff also did not adequately document specific interventions in the nursing care plan related to the providers' order of the fluid restriction.

Health Information Management

Specific deficiencies identified in this category are explained in *the Health Information Management* indicator.

Appointments and Scheduling

There were two deficiencies identified in this category, one of which was significant (case 17), which is discussed in the *Access to Care* indicator.

Clinician Onsite Inspection

The CTC was not adequately staffed at the time of the clinicians' onsite visit. The institution was currently in the education and training process for the EHRS implementation, and the CTC staffing assignment was affected on the day of the onsite inspection. In the case reviews, the OIG identified deficiencies related to the missing documentation of the utilization management nurse. It was discovered during the onsite visit that the utilization management nurse was unaware of the need to review each CTC patient's level of care on a monthly basis for the appropriateness of the continued inpatient admission. The CNE acknowledged the deficits and communicated a plan to improve the process with education and training for the staff.

The OIG discussed the deficiencies in CTC care with the chief medical executive (CME). While the OIG found the care provided by the assigned provider to be adequate, the temporary providers' care was often problematic. As discussed in the *Quality of Provider Performance* indicator, these deficiencies may have been caused by leadership's instructions to limit covering provider management, and to avoid making too many changes to primary providers' orders. This culture may have kept covering providers from fully reviewing or intervening for those patients with severe or complex illness who required major day-to-day treatment changes.

Case Review Conclusion

The weakest provider performance at SATF was in the CTC, as was also the case in Cycle 4. While Cycle 5 showed some improvement, more was still needed. The OIG recognized that two factors contributed to the poor performance. The first was lack of continuity. While there was an assigned provider, the provider was regularly scheduled three days off per week. This schedule frequently required other providers to see the patients when the assigned provider was out. The covering providers would often spend insufficient time reviewing the medical records of complex patients because they were only providing care for a day or two. This led to missed diagnoses or lapsed medications. The second factor contributing to the poor performance was the complexity of the medical patients. While categorized as a "basic" medical institution, SATF still had many high-risk, complex medical patients. Many CTC patients were temporarily housed from other institutions that lacked CTC beds. Providers sometimes failed to take a careful enough approach to these medically complex patients.

Because CTC provider care was minimally sufficient and CTC nursing care was adequate, the OIG rated the case review portion of *Specialized Medical Housing* indicator *adequate*.

Compliance Testing Results

The institution earned an *adequate* compliance score of 85.0 percent in the *Specialized Medical Housing* indicator. The following tests received *proficient* scores of 100 percent:

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

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

Two tests in this indicator received *inadequate* scores, as follows:

- Providers completed a history and physical (H&P) within 24 hours of admission to the CTC for seven out of the ten patients sampled (70 percent). Two patients were evaluated one day late; for one other patient's admission, the provider did not document a time on the H&P so its timeliness could not be ascertained (MIT 13.002).

- The OIG tested whether providers completed their Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes at required three-day intervals for patients housed in the CTC. Providers completed timely SOAPE notes for seven of ten sampled patients (70 percent). Provider notes were one day late for two patients, and for one final patient, the documentation on one SOAPE note was incomplete (MIT 13.003).

14 — *SPECIALTY SERVICES*

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 patient is updated on the plan of care.

Case Review Rating:
Adequate
Compliance Score:
Inadequate
(72.3%)
Overall Rating:
Adequate

In this indicator, the OIG case review and compliance review processes yielded different results, with the case review giving an *adequate* rating and the compliance testing an *inadequate* score. The OIG's internal review process considered the factors leading to both scores and ultimately determined the overall rating was *adequate*, mainly because the findings from case review showed very few deficiencies, which did not compromise the quality of care.

Case Review Results

The OIG clinicians reviewed 150 events related to *Specialty Services*, the majority of which were specialty consultations (84 offsite and 8 onsite) and procedures (12). There were 17 deficiencies, 9 of which were related to health information management. There were four significant deficiencies.

Access to Specialty Services

Specialty services were provided in a timely manner in most cases. There was no pattern of delay in providing specialty services. There were, however, three significant delays in follow-up with specialists:

- In case 2, the patient returned from a hospitalization for seizures. The provider ordered a neurology follow-up, but the appointment was not scheduled. The patient continued to have seizures and required a subsequent hospitalization.
- In case 17, the patient underwent spinal surgery to treat an abscess that had developed near the spinal cord. The surgeon requested a follow-up within two weeks, but the appointment did not occur until five weeks after the surgery. Fortunately, there were no immediate surgical complications.
- In case 26, the patient underwent surgery to remove his gallbladder. The provider ordered a two-week follow-up with the surgeon, but the appointment was not scheduled until four weeks after the surgery. Fortunately, there were no immediate surgical complications.

Nursing Performance

There were 24 specialty nursing events reviewed. TTA nurses reviewed the status and specialists' recommendations for patients returning to SATF from offsite consultations. The nurses reviewed the findings and recommendations from the specialty consultant, appropriately conveyed them to the on-call provider, and obtained orders needed for the recommended care. TTA nurses contacted specialists for clarification when the specialist reports were missing or illegible. Specialty telemedicine nurses coordinated telemedicine schedules, assisted telemedicine providers with patient evaluations, and retrieved necessary consultation reports to ensure availability during appointments.

Provider Performance

In general, SATF medical providers ordered specialty services to occur within appropriate time frames. Requests for specialty services were reviewed in a timely manner by the CME. After patients' specialty appointments, the consultation reports were often not signed off by providers prior to being scanned into the electronic medical records. Despite this, most specialist recommendations were timely implemented by the providers. There was no pattern of deficiencies.

Health Information Management

Consultation reports were generally retrieved promptly and scanned into the electronic medical records. However, there were nine health information management deficiencies, six of which involved reports being scanned prior to provider review and signature. One of these was significant:

- In case 9, the cardiology consultation report was scanned into the electronic medical record without being reviewed or signed by the medical provider. As the provider was unaware of the recommendations, the provider did not promptly follow the recommendations. This contributed to a delay in performing the needed heart test (cardiac catheterization).

Clinician Onsite Inspection

The OIG confirmed that specialty reports were scanned into the electronic medical records without a provider review or signature. While this did not often hinder patient care, some problems, such as that in case 9 (above), occasionally happened. This was also found in the OIG's Cycle 4 inspection. SATF leadership explained that there were personnel changes in health information management and the utilization management staff who dealt with specialty services. These changes may have contributed to some deficiencies. However, specialty services were, in general, functioning adequately for the needs of the patients at SATF.

Case Review Conclusion

Patients were provided adequate, appropriate, and timely specialty services. Both nursing and provider performances were satisfactory. Specialty report handling was problematic, as many of

those reports were scanned into the medical record without a provider review. The OIG clinicians rated this indicator *adequate.*

Compliance Testing Results

The institution received an *inadequate* compliance score of 72.3 percent in the *Specialty Services* indicator. The following tests showed areas for needed improvement:

- SATF timely received, and providers timely reviewed, 8 of the 14 applicable routine specialists' reports that inspectors sampled (57 percent). Providers reviewed the reports for three patients from four to six days late; one patient's report was reviewed 25 days late; for two final patients, there was no evidence found that their reports were either received by the institution or reviewed by a provider (MIT 14.004).

- When patients are approved or scheduled for specialty service appointments at one institution and then transfer to another, policy requires that the receiving institution reschedule and provide the patient's appointment within the required time frame. Only 12 of the 20 applicable patients sampled who transferred to SATF with an approved specialty service appointment (60 percent) received it within the required time frame. The remaining eight patients did not timely receive their previously approved appointments. One patient received his appointment one day late; three patients received their appointments 22, 37, and 59 days late; one patient received his appointment 152 days late; and three patients did not receive their appointments (MIT 14.005).

- The institution timely denied providers' specialty service requests for 10 of 16 patients sampled (63 percent). Five specialty services requests were denied between one and eight days late; one request was denied 53 days late (MIT 14.006).

- The institution timely received, and providers timely reviewed, high-priority specialists' reports for 10 of 15 patients sampled (67 percent). For one patient, the report was received by the institution one day late; for two patients, the reports were reviewed by a provider 12 and 14 days late; for another patient, there was no evidence found that a provider had reviewed the report; and for one final patient, there was no evidence found that a report was either received or reviewed (MIT 14.002).

- Among 15 applicable patients sampled for whom SATF's health care management denied a specialty service, only ten (67 percent) received a timely notification of the denied service, including the provider meeting with the patient within 30 days to discuss alternate treatment strategies. For one patient, the provider's follow-up visit occurred 11 days late; for the other four patients, there was no evidence found of a provider follow-up to discuss the denial (MIT 14.007).

Two tests in this indicator received scores in the *proficient* range:

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

- For 14 of 15 patients sampled (93 percent), high-priority specialty service appointments occurred within 14 calendar days of the provider's order; however, one patient received his specialty service one day late (MIT 14.001).

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15 — *ADMINISTRATIVE OPERATIONS (SECONDARY)*

Case Review Rating:
Not Applicable
Compliance Score:
Adequate
(78.4%)
Overall Rating:
Adequate

This indicator focuses on the institution's administrative health care oversight functions. The OIG evaluates whether the institution promptly processes patient medical appeals and addresses all appealed issues. Inspectors also verify that the institution follows reporting requirements for adverse/sentinel events and inmate deaths. The OIG verifies that the Emergency Medical Response Review Committee (EMRRC) performs required reviews and that staff perform required emergency response drills. Inspectors also assess whether the Quality Management Committee (QMC) meets regularly and adequately addresses program performance. For those institutions with licensed facilities, inspectors also verify that required committee meetings are held. In addition, 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. The *Administrative Operations* indicator is a secondary indicator, and, therefore, was not relied on for the overall score for the institution.

Compliance Testing Results

The institution performed in the *adequate* range in the *Administrative Operations* indicator, receiving a compliance score of 78.4 percent. Several tests earned scores of 100 percent, as follows:

- The institution promptly processed all inmate medical appeals in each of the most recent 12 months (MIT 15.001).

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

- Inspectors reviewed the last 12 months of SATF's local governing body (LGB) meeting minutes and determined that the LGB met at least quarterly and exercised responsibility for the quality management of patient heath care each quarter, as documented in the meeting minutes. As a result, SATF scored 100 percent on this test (MIT 15.006).

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

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

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

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

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

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

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

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

- All nursing staff hired within the last year timely received new employee orientation training (MIT 15.111).

The following tests scored in the *inadequate* range:

- The OIG reviewed the two reported adverse/sentinel events (ASE) that occurred at SATF during the prior 12-month period, each of which required a root-cause analysis and four monthly status reports per the plan of action. One ASE was reported to CCHCS's ASE Committee three days late; the ASE report was 19 days late; and no evidence was found that SATF submitted any of the required monthly status reports. For the second ASE, the institution did not submit the fourth monthly status report. As a result, SATF received a score of zero on this test (MIT 15.002).

- The QMC did not document discussions of the methodologies used to conduct periodic data validation of the institution's Dashboard data, or document discussions on the methodologies used to train the staff who collected the Dashboard data. Therefore, SATF received a score of zero on this test (MIT 15.004).

- The institution did not meet the emergency response drill requirements for the most recent quarter for each of its three watches, resulting in a score of zero. More specifically, the institution's first watch drill package did not contain a First Medical Responder–Data Collection Tool (CDCR Form 7463). The second watch drill package did not contain a

Triage and Treatment Services Flow Sheet (CDCR Form 7464); and the third watch drill package had multiple incomplete required forms (MIT 15.101).

- Inspectors reviewed six recent months' QMC meeting minutes and confirmed that for only two of the six tested months, the QMC evaluated program performance and took action when it identified improvement opportunities (33 percent) (MIT 15.003).

Non-Scored Results

- The OIG gathered non-scored data regarding the completion of death review reports by CCHCS's Death Review Committee (DRC). Seven deaths occurred during the OIG's review period: two unexpected (Level 1), and five expected (Level 2). The DRC was required to complete its death review summary report within 60 days from the date of death for the Level 1 deaths and within 30 days from the date of death for the Level 2 deaths; the reports should then have been submitted to the institution's chief executive officer (CEO) within seven calendar days thereafter. However, for the two Level 1 deaths, the DRC completed its reports 9 and 43 days late (69 and 103 days after death) and submitted them to SATF's CEO 61 and 49 days late; for three of the five Level 2 deaths, the DRC completed its reports 18, 47, and 66 days late (48, 77, and 96 days after death) and submitted them to the CEO 34, 54, and 79 days late; for the final two Level 2 deaths, the DRC completed its reports 25 and 29 days late (55 and 59 days after death), and the reports had not yet been submitted to the CEO at the time of the OIG's inspection (MIT 15.998).

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

RECOMMENDATIONS

- The OIG recommends SATF provide training for health information management staff to ensure reports are reviewed and signed by providers prior to being scanned into medical records. When the EHRS is implemented, SATF should ensure that the health information management staff sends reports to providers for their review and signature electronically.

- The OIG recommends SATF leadership deliver training to providers regarding careful review of medical records for complex patients, such as those cared for in the CTC. This is especially important for providers who are unfamiliar with the patients because the providers are on call or covering on weekends. In addition, the OIG recommends that SATF train providers about the importance of careful record review for patients returning from outside hospitals to ensure that all diagnoses and management plans are appropriately addressed.

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 Metric Comparison

Comprehensive Diabetes Care

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

When compared statewide, SATF outperformed Medi-Cal in four of the five measures, scoring slightly lower in regard to diabetic eye exams. SATF outperformed Kaiser north and south in three of the five measures, scoring slightly lower in diabetic blood pressure control and eye exams.

When compared nationally, SATF scored higher than Medicaid, commercial health plans, and Medicare, in four of the five diabetic measures, and scored higher than the United States Department of Veterans Affairs (VA) in three of four measures. SATF scored lower in diabetic eye exams compared to all of the national entities. However, the 22 percent refusal rate for eye exams negatively affected the institutions score.

Immunizations

Comparative data for immunizations was only fully available for the VA and partially available for Kaiser, commercial plans, Medicaid, and Medicare. With respect to administering influenza vaccinations to younger adults, SATF scored higher than all Medicaid and commercial health plans, but lower than Kaiser (both North and South) and the VA. The high patient refusal rate of 49 percent for influenza vaccinations to younger adults negatively affected the institutions score.

When administering influenza vaccinations to older adults, SATF scored higher than Medicare and matched the VA. With regard to administering pneumococcal vaccines to older adults, SATF scored lower than both Medicare and the VA.

Cancer Screening

With respect to colorectal cancer screening, SATF scored higher than commercial health plans and matched Medicare, but scored lower than Kaiser (both North and South) and the VA. However, the institution's score was negatively affected by a 31 percent refusal rate.

Summary

SATF's population-based metrics performance reflected an adequate chronic care program, and is comparable to the other health care plans reviewed. The institution may improve its scores for diabetic eye exams, influenza vaccinations for young adults, and colorectal cancer screenings by reducing patient refusals through educating patients on the benefits of these preventive services.

SATF Results Compared to State and National HEDIS Scores

Clinical Measures	California				National			
	SATF Cycle 5 Results[1]	HEDIS Medi-Cal 2015[2]	HEDIS Kaiser (No.CA) 2016[3]	HEDIS Kaiser (So.CA) 2016[3]	HEDIS Medicaid 2016[4]	HEDIS Com-mercial 2016[4]	HEDIS Medicare 2016[4]	VA Average 2015[5]
Comprehensive Diabetes Care								
HbA1c Testing (Monitoring)	**100%**	86%	94%	94%	86%	90%	93%	98%
Poor HbA1c Control (>9.0%)[6, 7]	**16%**	39%	20%	23%	45%	34%	27%	19%
HbA1c Control (<8.0%)[6]	**72%**	49%	70%	63%	46%	55%	63%	-
Blood Pressure Control (<140/90)	**82%**	63%	83%	83%	59%	60%	62%	74%
Eye Exams	**46%**	53%	68%	81%	53%	54%	69%	89%
Immunizations								
Influenza Shots - Adults (18–64)	**51%**	-	56%	57%	39%	48%	-	55%
Influenza Shots - Adults (65+)	**76%**	-	-	-	-	-	72%	76%
Immunizations: Pneumococcal	**61%**	-	-	-	-	-	71%	93%
Cancer Screening								
Colorectal Cancer Screening	**67%**	-	79%	82%	-	63%	67%	82%

1. Unless otherwise stated, data was collected in April 2017 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 Medi-Cal Managed Care*.

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

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

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

6. For this indicator, the entire applicable 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

SATF Range of Summary Scores: 54.91% - 85.00%	
Indicator	**Compliance Score (Yes %)**
1–***Access to Care***	71.72%
2–***Diagnostic Services***	54.91%
3–***Emergency Services***	Not Applicable
4–***Health Information Management (Medical Records)***	60.72%
5–***Health Care Environment***	69.42%
6–***Inter- and Intra-System Transfers***	80.67%
7–***Pharmacy and Medication Management***	72.66%
8–***Prenatal and Post-Delivery Services***	Not Applicable
9–***Preventive Services***	77.89%
10–***Quality of Nursing Performance***	Not Applicable
11–***Quality of Provider Performance***	Not Applicable
12–***Reception Center Arrivals***	Not Applicable
13–***Specialized Medical Housing (OHU, CTC, SNF, Hospice)***	85.00%
14–***Specialty Services***	72.33%
15–***Administrative Operations***	78.43%

Reference Number	1–*Access to Care*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
1.001	Chronic care follow-up appointments: Was the patient's most recent chronic care visit within the health care guideline's maximum allowable interval or within the ordered time frame, whichever is shorter?	8	16	24	33.33%	1
1.002	For endorsed patients received from another CDCR institution: If the nurse referred the patient to a provider during the initial health screening, was the patient seen within the required time frame?	16	9	25	64.00%	0
1.003	Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received?	52	3	55	94.55%	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?	52	2	54	96.30%	1
1.005	Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter?	9	12	21	42.86%	34
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?	9	1	10	90.00%	45
1.007	Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame?	21	4	25	84.00%	0
1.008	Specialty service follow-up appointments: Do specialty service primary care physician follow-up visits occur within required time frames?	16	12	28	57.14%	2
1.101	Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms?	5	1	6	83.33%	1
Overall percentage:					**71.72**	

Reference Number	2–*Diagnostic Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
2.001	Radiology: Was the radiology service provided within the time frame specified in the provider's order?	8	2	10	80.00%	0
2.002	Radiology: Did the primary care provider review and initial the diagnostic report within specified time frames?	0	10	0	0.00%	0
2.003	Radiology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	3	7	10	30.00%	0
2.004	Laboratory: Was the laboratory service provided within the time frame specified in the provider's order?	7	1	8	87.50%	2
2.005	Laboratory: Did the primary care provider review and initial the diagnostic report within specified time frames?	9	0	9	100.00%	1
2.006	Laboratory: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	5	4	9	55.56%	1
2.007	Pathology: Did the institution receive the final diagnostic report within the required time frames?	7	3	10	70.00%	0
2.008	Pathology: Did the primary care provider review and initial the diagnostic report within specified time frames?	6	4	10	60.00%	0
2.009	Pathology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	1	8	9	11.11%	1
Overall percentage:					**54.91%**	

3–*Emergency Services*

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

Reference Number	4–*Health Information Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated healthcare documents (provider progress notes) scanned within 3 calendar days of the patient encounter date?	19	1	20	95.00%	0
4.002	Are dictated/transcribed documents scanned into the patient's electronic health record within five calendar days of the encounter date?	Not Applicable				
4.003	Are High-Priority specialty notes (either a Form 7243 or other scanned consulting report) scanned within the required time frame?	17	3	20	85.00%	0
4.004	Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge?	15	3	18	83.33%	0
4.005	Are medication administration records (MARs) scanned into the patient's electronic health record within the required time frames?	13	7	20	65.00%	0
4.006	During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files?	0	24	24	0.00%	0
4.007	For patients discharged from a community hospital: Did the preliminary hospital discharge report include key elements and did a primary care provider review the report within three calendar days of discharge?	9	16	25	36.00%	0
Overall percentage:					**60.72%**	

Reference Number	5–*Health Care Environment*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
5.101	Are clinical health care areas appropriately disinfected, cleaned and sanitary?	12	0	12	100.00%	0
5.102	Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	9	3	12	75.00%	0
5.103	Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	10	2	12	83.33%	0
5.104	Does clinical health care staff adhere to universal hand hygiene precautions?	5	7	12	41.67%	0
5.105	Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	7	5	12	58.33%	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	Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	9	3	12	75.00%	0
5.108	Do clinic common areas and exam rooms have essential core medical equipment and supplies?	5	7	12	41.67%	0
5.109	Do clinic common areas have an adequate environment conducive to providing medical services?	9	3	12	75.00%	0
5.110	Do clinic exam rooms have an adequate environment conducive to providing medical services?	6	6	12	50.00%	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?	7	4	11	63.64%	1
Overall percentage:					**69.42%**	

Reference Number	6–*Inter- and Intra-System Transfers*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
6.001	For endorsed patients received from another CDCR institution or COCF: Did nursing staff complete the initial health screening and answer all screening questions on the same day the patient arrived at the institution?	20	4	24	83.33%	1
6.002	For endorsed patients received from another CDCR institution or COCF: When required, did the RN complete the assessment and disposition section of the health screening form; refer the patient to the TTA, if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening?	24	0	24	100.00%	1
6.003	For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption?	9	9	18	50.00%	7
6.004	For patients transferred out of the facility: Were scheduled specialty service appointments identified on the patient's health care transfer information form?	14	6	20	70.00%	0
6.101	For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents?	2	0	2	100.00%	0
Overall percentage:					**80.67%**	

Reference Number	*7–Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.001	Did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows?	17	4	21	80.95%	4
7.002	Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames?	25	0	25	100.00%	0
7.003	Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames?	11	12	23	47.83%	2
7.004	For patients received from a county jail: Were all medications ordered by the institution's reception center provider administered, made available, or delivered to the patient within the required time frames?	Not Applicable				
7.005	Upon the patient's transfer from one housing unit to another: Were medications continued without interruption?	21	4	25	84.00%	0
7.006	For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption?	3	2	5	60.00%	0
7.101	All clinical and medication line storage areas for narcotic medications: Does the Institution employ strong medication security over narcotic medications assigned to its clinical areas?	2	9	11	18.18%	0
7.102	All clinical and medication line storage areas for non-narcotic medications: Does the Institution properly store non-narcotic medications that do not require refrigeration in assigned clinical areas?	2	8	10	20.00%	1
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?	7	4	11	63.64%	0
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	3	8	62.50%	3
7.105	Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients?	8	0	8	100.00%	3
7.106	Medication preparation and administration areas: Does the Institution employ appropriate administrative controls and protocols when distributing medications to patients?	3	5	8	37.50%	3
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	7–*Pharmacy and Medication Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
7.108	Pharmacy: Does the institution's pharmacy properly store non-refrigerated medications?	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	Does the institution follow key medication error reporting protocols?	22	3	25	88.00%	0
Overall percentage:					**72.66%**	

8–*Prenatal and Post-Delivery Services*

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

Reference Number	9–*Preventive Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
9.001	Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed?	8	4	12	66.67%	0
9.002	Patients prescribed TB medication: Did the institution monitor the patient monthly for the most recent three months he or she was on the medication?	4	8	12	33.33%	0
9.003	Annual TB Screening: Was the patient screened for TB within the last year?	29	1	30	96.67%	0
9.004	Were all patients offered an influenza vaccination for the most recent influenza season?	25	0	25	100.00%	0
9.005	All patients from the age of 50 - 75: Was the patient offered colorectal cancer screening?	24	1	25	96.00%	0
9.006	Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy?	Not Applicable				
9.007	Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy?	Not Applicable				
9.008	Are required immunizations being offered for chronic care patients?	16	2	18	88.89%	7
9.009	Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner?	7	4	11	63.64%	0
Overall percentage:					**77.89%**	

10–*Quality of Nursing Performance*

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

11–*Quality of Provider Performance*

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

12–*Reception Center Arrivals*

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

Reference Number	13–*Specialized Medical Housing*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient on the day of admission, or within eight hours of admission to CMF's Hospice?	10	0	10	100.00%	0
13.002	For CTC and SNF only: Was a written history and physical examination completed within the required time frame?	7	3	10	70.00%	0
13.003	For OHU, CTC, SNF, and Hospice: Did the primary care provider complete the Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes on the patient at the minimum intervals required for the type of facility where the patient was treated?	7	3	10	70.00%	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 patient's cells?	1	0	1	100.00%	0
Overall percentage:					**85.00%**	

Reference Number	14–*Specialty Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
14.001	Did the patient receive the high priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service?	14	1	15	93.33%	0
14.002	Did the primary care provider review the high priority specialty service consultant report within the required time frame?	10	5	15	66.67%	0
14.003	Did the patient receive the routine specialty service within 90 calendar days of the primary care provider order or Physician Request for Service?	15	0	15	100.00%	0
14.004	Did the primary care provider review the routine specialty service consultant report within the required time frame?	8	6	14	57.14%	1
14.005	For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames?	12	8	20	60.00%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	10	6	16	62.50%	0
14.007	Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame?	10	5	15	66.67%	1
Overall percentage:					**72.33%**	

Reference Number	15–*Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.001	Did the institution promptly process inmate medical appeals during the most recent 12 months?	12	0	12	100.00%	0
15.002	Does the institution follow adverse / sentinel event reporting requirements?	0	2	2	0.00%	0
15.003	Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified?	2	4	6	33.33%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	0	1	1	0.00%	0
15.005	Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents?	12	0	12	100.00%	0
15.006	For institutions with licensed care facilities: Does the Local Governing Body (LGB), or its equivalent, meet quarterly and exercise its overall responsibilities for the quality management of patient health care?	4	0	4	100.00%	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?	0	3	3	0.00%	0
15.102	Did the institution's second level medical appeal response address all of the 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?	3	0	3	100.00%	0
15.104	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	5	0	5	100.00%	0
15.105	Are nursing staff who administer medications current on their clinical competency validation?	10	0	10	100.00%	0
15.106	Are structured clinical performance appraisals completed timely?	10	0	10	100.00%	0
15.107	Do all providers maintain a current medical license?	13	0	13	100.00%	0
15.108	Are staff current with required medical emergency response certifications?	2	0	2	100.00%	1
15.109	Are nursing staff and the Pharmacist-in-Charge current with their professional licenses and certifications, and is the pharmacy licensed as a correctional pharmacy by the California State Board of Pharmacy?	6	0	6	100.00%	1

Reference Number	15–*Administrative Operations*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
15.110	Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations?	1	0	1	100.00%	0
15.111	Are nursing staff current with required new employee orientation?	1	0	1	100.00%	0
Overall percentage:					**78.43%**	

APPENDIX B — CLINICAL DATA

Table B-1: SATF Sample Sets

Sample Set	Total
Anticoagulation	3
Death Review/Sentinel Events	3
Diabetes	3
Emergency Services – CPR	1
Emergency Services – Non-CPR	3
High Risk	5
Hospitalization	4
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	32
Specialty Services	4
	64

Table B-2: SATF Chronic Care Diagnoses

Diagnosis	Total
Anemia	5
Anticoagulation	4
Arthritis/Degenerative Joint Disease	6
Asthma	12
COPD	9
Cancer	6
Cardiovascular Disease	11
Chronic Kidney Disease	5
Chronic Pain	19
Cirrhosis/End-Stage Liver Disease	2
Deep Venous Thrombosis/Pulmonary Embolism	2
Diabetes	20
Gastroesophageal Reflux Disease	8
Hepatitis C	19
Hyperlipidemia	20
Hypertension	37
Mental Health	3
Seizure Disorder	6
Sleep Apnea	3
	197

Table B-3: SATF Event – Program

Program	Total
Diagnostic Services	192
Emergency Care	49
Hospitalization	39
Intra-system Transfers-In	19
Intra-system Transfers-Out	8
Not Specified	5
Outpatient Care	487
Specialized Medical Housing	579
Specialty Services	153
	1,531

Table B-4: SATF Review Sample Summary

	Total
MD Reviews Detailed	25
MD Reviews Focused	0
RN Reviews Detailed	15
RN Reviews Focused	39
Total Reviews	79
Total Unique Cases	64
Overlapping Reviews (MD & RN)	15

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

California Substance Abuse and Treatment Facility and State Prison at Corcoran (SATF)

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Access to Care			
MIT 1.001	Chronic Care Patients (25)	Master Registry	• Chronic care conditions (at least one condition per patient—any risk level) • **Randomize**
MIT 1.002	Nursing Referrals (25)	OIG Q: 6.001	• See ***Intra-system Transfers***
MITs 1.003–006	Nursing Sick Call (5 per clinic) (55)	MedSATS	• Clinic (each clinic tested) • Appointment date (2–9 months) • **Randomize**
MIT 1.007	Returns from Community Hospital (25)	OIG Q: 4.007	• See ***Health Information Management (Medical Records)*** (returns from community hospital)
MIT 1.008	Specialty Services Follow-up (30)	OIG Q: 14.001 & 14.003	• See ***Specialty Services***
MIT 1.101	Availability of Health Care Services Request Forms (6)	OIG onsite review	• Randomly select one housing unit from each yard
Diagnostic Services			
MITs 2.001–003	Radiology (10)	Radiology Logs	• Appointment date (90 days–9 months) • **Randomize** • Abnormal
MITs 2.004–006	Laboratory (10)	Quest	• Appt. date (90 days–9 months) • Order name (CBC or CMPs only) • **Randomize** • Abnormal
MITs 2.007–009	Pathology (10)	InterQual	• Appt. date (90 days–9 months) • Service (pathology related) • **Randomize**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Health Information Management (Medical Records)			
MIT 4.001	Timely Scanning (20)	OIG Qs: 1.001, 1.002, & 1.004	• Non-dictated documents • 1st 10 IPs MIT 1.001, 1st 5 IPs MITs 1.002, 1.004
MIT 4.002	(0)	OIG Q: 1.001	• Dictated documents • First 20 IPs selected
MIT 4.003	(20)	OIG Qs: 14.002 & 14.004	• Specialty documents • First 10 IPs for each question
MIT 4.004	(18)	OIG Q: 4.007	• Community hospital discharge documents • First 20 IPs selected
MIT 4.005	(20)	OIG Q: 7.001	• MARs • First 20 IPs selected
MIT 4.006	(24)	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.007	Returns From Community Hospital (25)	Inpatient claims data	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • **Randomize** (each month individually) • First 5 patients from each of the 6 months (if not 5 in a month, supplement from another, as needed)
Health Care Environment			
MIT 5.101–105 MIT 5.107–111	Clinical Areas (12)	OIG inspector onsite review	• Identify and inspect all onsite clinical areas.
Inter- and Intra-System Transfers			
MIT 6.001–003	Intra-System Transfers (25)	SOMS	• Arrival date (3–9 months) • Arrived from (another CDCR facility) • Rx count • **Randomize**
MIT 6.004	Specialty Services Send-Outs (20)	MedSATS	• Date of transfer (3–9 months) • **Randomize**
MIT 6.101	Transfers Out (2)	OIG inspector onsite review	• R&R IP transfers with medication

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Pharmacy and Medication Management			
MIT 7.001	Chronic Care Medication (25)	OIG Q: 1.001	*See* ***Access to Care*** • At least one condition per patient—any risk level • **Randomize**
MIT 7.002	New Medication Orders (25)	Master Registry	• Rx count • **Randomize** • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns from Community Hospital (25)	OIG Q: 4.007	• See ***Health Information Management (Medical Records)*** *(returns from community hospital)*
MIT 7.004	RC Arrivals – Medication Orders *(N/A at this institution)*	OIG Q: 12.001	• See ***Reception Center Arrivals***
MIT 7.005	Intra-Facility Moves (25)	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • **Randomize**
MIT 7.006	En Route (5)	SOMS	• Date of transfer (2–8 months) • Sending institution (another CDCR facility) • **Randomize** • NA/DOT meds
MITs 7.101–103	Medication Storage Areas (varies by test)	OIG inspector onsite review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–106	Medication Preparation and Administration Areas (varies by test)	OIG inspector onsite review	• Identify and inspect onsite clinical areas that prepare and administer medications
MITs 7.107–110	Pharmacy (1)	OIG inspector onsite review	• Identify & inspect all onsite pharmacies
MIT 7.111	Medication Error Reporting (25)	Monthly medication error reports	• All monthly statistic reports with Level 4 or higher • Select a total of 5 months
MIT 7.999	Isolation Unit KOP Medications (7)	Onsite active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in isolation units
Prenatal and Post-Delivery Services			
MIT 8.001–007	Recent Deliveries *(N/A at this institution)*	OB Roster	• Delivery date (2–12 months) • **Most recent** deliveries (within date range)
	Pregnant Arrivals *(N/A at this institution)*	OB Roster	• Arrival date (2–12 months) • **Earliest** arrivals (within date range)

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Preventive Services			
MITs 9.001–002	TB Medications (12)	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • **Randomize**
MIT 9.003	TB Evaluation, Annual Screening (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • Birth Month • **Randomize**
MIT 9.004	Influenza Vaccinations (25)	SOMS	• Arrival date (at least 1 year prior to inspection) • **Randomize** • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening (25)	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • **Randomize**
MIT 9.006	Mammogram *(N/A at this institution)*	SOMS	• Arrival date (at least 2 yrs prior to inspection) • Date of birth (age 52–74) • **Randomize**
MIT 9.007	Pap Smear *(N/A at this institution)*	SOMS	• Arrival date (at least three yrs prior to inspection) • Date of birth (age 24–53) • **Randomize**
MIT 9.008	Chronic Care Vaccinations (25)	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • **Randomize** • Condition must require vaccination(s)
MIT 9.009	Valley Fever (11)	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • **All**

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Reception Center Arrivals			
MITs 12.001–008	RC *(N/A at this institution)*	SOMS	• Arrival date (2–8 months) • Arrived from (county jail, return from parole, etc.) • **Randomize**
Specialized Medical Housing			
MITs 13.001–004	CTC (10)	CADDIS	• Admit date (1–6 months) • Type of stay (no MH beds) • Length of stay (minimum of 5 days) • **Randomize**
MIT 13.101	Call Buttons CTC (all)	OIG inspector onsite review	• Review by location
Specialty Services			
MITs 14.001–002	High-Priority (15)	MedSATS	• Approval date (3–9 months) • **Randomize**
MITs 14.003–004	Routine (15)	MedSATS	• Approval date (3–9 months) • Remove optometry, physical therapy or podiatry • **Randomize**
MIT 14.005	Specialty Services Arrivals (20)	MedSATS	• Arrived from (other CDCR institution) • Date of transfer (3–9 months) • **Randomize**
MIT 14.006–007	Denials (16)	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 samples)	Data Source	Filters
Administrative Operations			
MIT 15.001	Medical Appeals (all)	Monthly medical appeals reports	• Medical appeals (12 months)
MIT 15.002	Adverse/Sentinel Events (2)	Adverse/sentinel events report	• Adverse/sentinel events (2–8 months)
MITs 15.003–004	QMC Meetings (6)	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.005	EMRRC (12)	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.006	LGB (4)	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills (3)	Onsite summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	2nd Level Medical Appeals (10)	Onsite list of appeals/closed appeals files	• Medical appeals denied (6 months)
MIT 15.103	Death Reports (3)	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.104	RN Review Evaluations (5)	Onsite supervisor periodic RN reviews	• RNs who worked in clinic or emergency setting six or more days in sampled month • **Randomize**
MIT 15.105	Nursing Staff Validations (10)	Onsite nursing education files	• On duty one or more years • Nurse administers medications • **Randomize**
MIT 15.106	Provider Annual Evaluation Packets (10)	Onsite provider evaluation files	• All required performance evaluation documents
MIT 15.107	Provider licenses (13)	Current provider listing (at start of inspection)	• Review all

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

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

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Administrative Operations			
MIT 15.110	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations (all)	Onsite listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 15.111	Nursing Staff New Employee Orientations (all)	Nursing staff training logs	• New employees (hired within last 12 months) •
MIT 15.998	Death Review Committee (7)	OIG summary log - deaths	• Between 35 business days & 12 months prior • CCHCS death reviews

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

November 21, 2017

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

Dear Mr. Wesley:

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 the Substance Abuse Treatment Facility (SATF) conducted from May 2017 to July 2017. California Correctional Health Care Services (CCHCS) acknowledges the OIG findings.

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

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
Ryan Baer, Senior Deputy Inspector General, OIG
Stephen Tseng, M.D., Chief Physician and Surgeon, OIG
Penny Horper, R.N., MSN, CPHQ, Nurse Consultant Program Review, OIG
Yulanda Mynhier, Director, Health Care Policy and Administration, CCHCS
R. Steven Tharratt, M.D., MPVM, FACP, Director, Health Care Operations, CCHCS
Roscoe Barrow, Chief Counsel, CCHCS Office of Legal Affairs, CCHCS
Renee Kanan, M.D., Deputy Director, Medical Services, CCHCS
Jane Robinson, R.N., Deputy Director, Nursing Services, CCHCS
Annette Lambert, Deputy Director, Quality Management, Clinical Information and Improvement Services, CCHCS
Christopher Podratz, Regional Health Care Executive, Region III, CCHCS
Felix Igbinosa, M.D., Regional Deputy Medical Executive, Region III, CCHCS
Steven A. Jones, Regional Nursing Executive, Region III, CCHCS
Clarence Cryer, Chief Executive Officer, SATF
Lara Saich, Chief, Health Care Regulations and Policy Section and Program Compliance Section, CCHCS
Dawn DeVore, Staff Services Manager II, Program Compliance Section, CCHCS
Amanda Oltean, Staff Services Manager I, Program Compliance Section, CCHCS