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Inspector General

Office of the Inspector General

# Sierra Conservation Center
# Medical Inspection Results
# Cycle 5

August 2018

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

# Office of the Inspector General
# SIERRA CONSERVATION CENTER
# Medical Inspection Report
# Cycle 5

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August 2018

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# FOREWORD

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

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

In Cycle 5, for the first time, the OIG will be inspecting institutions delegated back to CDCR from the Receivership. There is no difference in the standards used for assessment of a delegated institution versus an institution not yet delegated. By the time of the Cycle 5 inspection of Sierra Conservation Center, the Receiver had delegated this institution back to CDCR (August 2016).

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

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# EXECUTIVE SUMMARY

The OIG completed the Cycle 5 medical inspection of Sierra Conservation Center (SCC) in August 2018. The vast majority of our inspection findings were based on SCC's health care delivery between February 2017 and October 2017. Our policy compliance inspectors performed an onsite inspection in October 2017. After reviewing the institution's health care delivery, our case review clinicians performed an onsite inspection in December 2017 to follow up on their findings.

**OVERALL RATING:**

***Adequate***

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

Our clinician team reviewed 47 cases that contained 897 patient-related events. Our compliance team tested 84 policy questions by observing SCC's processes and examining 348 patient records and 997 data points. We distilled the results from both the case review and compliance testing into 13 health care indicators and have listed the individual indicators and ratings applicable for this institution in the *SCC Executive Summary Table* on the following page. Our experts made a considered and measured opinion that the overall quality of health care at SCC was ***adequate***.

## SCC Executive Summary Table

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

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

## *Expert Clinician Case Review Results*

Our expert clinicians reviewed cases of patients with many medical needs and included a review of 897 patient care events.[1] The vast majority of our case review covered the period between April 2017 and October 2017. As depicted on the executive summary table on page *iv*, we rated 10 of the 13 indicators applicable to SCC. Of those ten applicable indicators, we rated two *proficient*, seven *adequate*, and one *inadequate.* When determining the overall adequacy of care, we paid particular attention to the clinical nursing and provider quality indicators, as adequate health care staff can sometimes overcome suboptimal compliance or performance with processes and programs. However, the opposite is not true; inadequate health care staff cannot provide adequate care, even though the established processes and programs may be adequate. We identified inadequate medical care based on the risk of significant harm to the patient, not the actual outcome.

**Program Strengths — Clinical**

- SCC completed diagnostic laboratory and x-ray tests reliably. Providers reviewed and communicated them to patients promptly.

- The institution transitioned to the Electronic Health Record System (EHRS), which improved its report handling processes. The institution placed nearly all records, including internally generated documents and offsite reports, into the EHRS timely and appropriately. SCC's proficient performance in this area was a significant improvement from that in Cycle 4.

- SCC performed well with sick call access, which we also found in Cycle 4.

**Program Weaknesses — Clinical**

- SCC experienced provider shortages during this review period. SCC continued to rely on a "rover" provider (a floating, unassigned provider who covered several areas including the TTA and the OHU and saw patients who the institution could not schedule due to the lack of available appointments). The use of the rover led to poor provider continuity in the medical clinics and the OHU, which we also found in Cycle 4.

- Nurses performed poorly for patients who transferred into the institution. The nurses did not refer complex patients to nurse care managers, did not ensure continuity of medications, and did not order provider follow-up appointments.

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

## *Compliance Testing Results*

Of the 13 health care indicators applicable to SCC, our compliance inspectors[2] evaluated 10. Of these, three were proficient, two were *adequate*, and five were *inadequate*. The vast majority of our compliance testing was of medical care that occurred between February 2017 and October 2017. There were 84 individual compliance questions within those 10 indicators, generating 997 data points that tested SCC's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[3] *Appendix A — Compliance Test Results* provides details for the 84 questions.

**Program Strengths — Compliance**

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

- SCC nursing staff completed all initial assessments on the same day when they admitted patients to the OHU.
- Staff at SCC managed patients' health care information extremely well.
- SCC timely provided or offered influenza vaccinations and colorectal cancer screenings. SCC also timely administered tuberculosis (TB) medications and conducted TB screenings during each patient's birth month.
- Nursing staff timely reviewed patients' health care services requests. Patients also received timely provider follow-up appointments.
- Patients at SCC received approved high-priority and routine specialty services within required time frames.

**Program Weaknesses — Compliance**

The following are some of SCC's weaknesses identified during our compliance testing:

- The institution did not always provide patients with pathology services within the required time frame, and providers did a poor job communicating pathology results to the patients timely.

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

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

- Several clinic locations at SCC lacked necessary equipment for clinicians to perform comprehensive examination services. Examination rooms at SCC did not have environments conducive for clinical services.

- Nursing staff at medication line locations did not follow proper security controls over narcotic medications, and staff at several locations did not safely store non-narcotic medications that require refrigeration.

- Supervising physicians and nurses did not properly document their reviews of their subordinate staff.

## *Recommendations*

- The CEO and chief medical executive (CME) should improve provider staffing and decrease the institution's reliance on a "rover" provider because the use of the rover provider resulted in poor provider continuity in all areas of the institution.

- The CEO should apply quality improvement methods to develop the institution's ability to properly care for patients transferring into SCC. In this inspection, we found numerous problems with the transfer-in process, including nurses failing to ensure that their transfer patients received provider and nurse follow-ups, the inability to maintain medication continuity, and the inability to provide specialty appointments for those patients who had pending specialty referrals.

- The chief nurse executive and the pharmacist in charge should improve the institution's ability to administer medications promptly for patients returning from an outside hospital and for those patients with prescriptions for new medications.

- The CEO should expand the institution's diagnostic report tracking system to improve its ability to retrieve, review, and communicate pathology reports because we found the institution had difficulty properly processing these important reports.

- The CEO should ensure that the institution's information technology department installs and verifies that all providers in all areas, including Yard C, are able to view images in the radiology system.

### *Population-Based Metrics*

In comprehensive diabetes care, SCC outperformed most state and national health care plans in the five diabetic measures. However, SCC scored lower than Kaiser and the VA for diabetic blood pressure control and lower than the VA for diabetic eye exams.

With regard to immunization measures, comparative data was only fully available for the VA and partially available for Kaiser, commercial plans, Medicaid, and Medicare. SCC scored lower than all other health care plans for influenza immunizations for both younger and older adults, and for pneumococcal immunizations. Colorectal cancer screening scores were mixed, with the institution scoring higher than Northern California Kaiser, commercial health plans, and Medicare, and scoring lower than Southern California Kaiser and the VA.

SCC performed well in clinical measures for diabetes care and cancer screening compared to the other health care plans reviewed. The institution may improve its scores for immunizations and colorectal cancer screenings by reducing patient refusals through educating patients on the benefits of these preventive services.

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# INTRODUCTION

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

Sierra Conservation Center (SCC) was the 29th 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

Sierra Conservation Center (SCC), located in the City of Jamestown in Tuolumne County, opened in 1965. SCC provides housing, programs, and services for minimum- and medium-custody inmates. It is one of the only two prisons in the State responsible for the training and placement of male inmates in the Conservation Camp Program. SCC administers 20 male camps located from Central California to the California-Mexico border. SCC houses inmates designated low to medium medical risk with infrequent care needs, mostly managed at local community hospitals or with transfer back to the main SCC facility for a higher level of managed care.

The institution runs six medical clinics where medical personnel handle non-urgent requests for medical services. SCC conducts screening in its receiving and release clinical area, treats patients who need urgent or emergent care in its triage and treatment area (TTA), and treats patients requiring outpatient health services and assistance with activities of daily living in the outpatient housing unit (OHU). CCHCS has designated SCC a "basic" care institution. Basic institutions are in rural areas away from tertiary care centers and specialty care providers whose services would likely be used by higher-risk patients. Basic institutions can provide limited specialty medical services and consultation for a generally healthy patient population.

In addition, on August 17, 2014, 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 as identified in the following *SCC Health Care Staffing Resources as of October 2017* table, SCC's vacancy rate among medical managers, primary care providers, supervisors, and rank-and-file nurses was 13 percent, with the highest vacancy percentages among primary care providers at 29 percent.

## SCC Health Care Staffing Resources as of October 23, 2017

| | Management | | Primary Care Providers | | Nursing Supervisors | | Nursing Staff | | Totals | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Description** | **Number** | **%** | **Number** | **%** | **Number** | **%** | **Number** | **%** | **Number** | **%** |
| *Authorized Positions* | 6 | 7% | 7 | 9% | 9.5 | 12% | 57.7 | 72% | 80.2 | 100% |
| *Filled Positions* | 6 | 100% | 5 | 71% | 8 | 84% | 52.4 | 91% | 71.4 | 89% |
| *Vacancies* | 0 | 0% | 2 | 29% | 1.5 | 16% | 7.3 | 13% | 10.8 | 13% |
| *Recent Hires (within 12 months)* | 2 | 33% | 1 | 20% | 3 | 38% | 20 | 38% | 26 | 36% |
| *Staff Utilized from Registry* | 0 | 0% | 0 | 0% | 0 | 0% | 3 | 6 | 3 | 4% |
| *Redirected Staff (to Non-Patient Care Areas)* | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% |
| *Staff on Extended Leave* | 0 | 0% | 0 | 0% | 0 | 0% | 2 | 4% | 2 | 3% |

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

As of October 23, 2017, the Master Registry for SCC showed that the institution had a total population of 4,498. Within that total population, 0.3 percent of patients were high medical risk, Priority 1 (High 1), and 1.3 percent were 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 tests and procedures. High 1 has at least two high-risk conditions; High 2 has only one. Patients at high medical risk are more susceptible to poor health outcomes than those at medium or low medical risk. Patients at high medical risk also typically require more health care services than do patients with lower assigned risk levels. The table on the following page illustrates the breakdown of the institution's medical risk levels at the start of the OIG medical inspection.

## SCC Master Registry Data as of October 23, 2017

| Medical Risk Level | Number of Patients | Percentage |
|---|---|---|
| High 1 | 15 | 0.3% |
| High 2 | 57 | 1.3% |
| Medium | 753 | 16.7% |
| Low | 3,673 | 81.7% |
| **Total** | **4,498** | **100.0%** |
| | | |

# OBJECTIVES, SCOPE, AND METHODOLOGY

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

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

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

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

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

## CASE REVIEWS

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

### Exhibit 1. Case Review Definitions

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

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

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

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

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

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

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

## *Patient Selection for Retrospective Case Reviews*

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

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

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

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

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

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

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

## *Benefits and Limitations of Targeted Subpopulation Review*

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

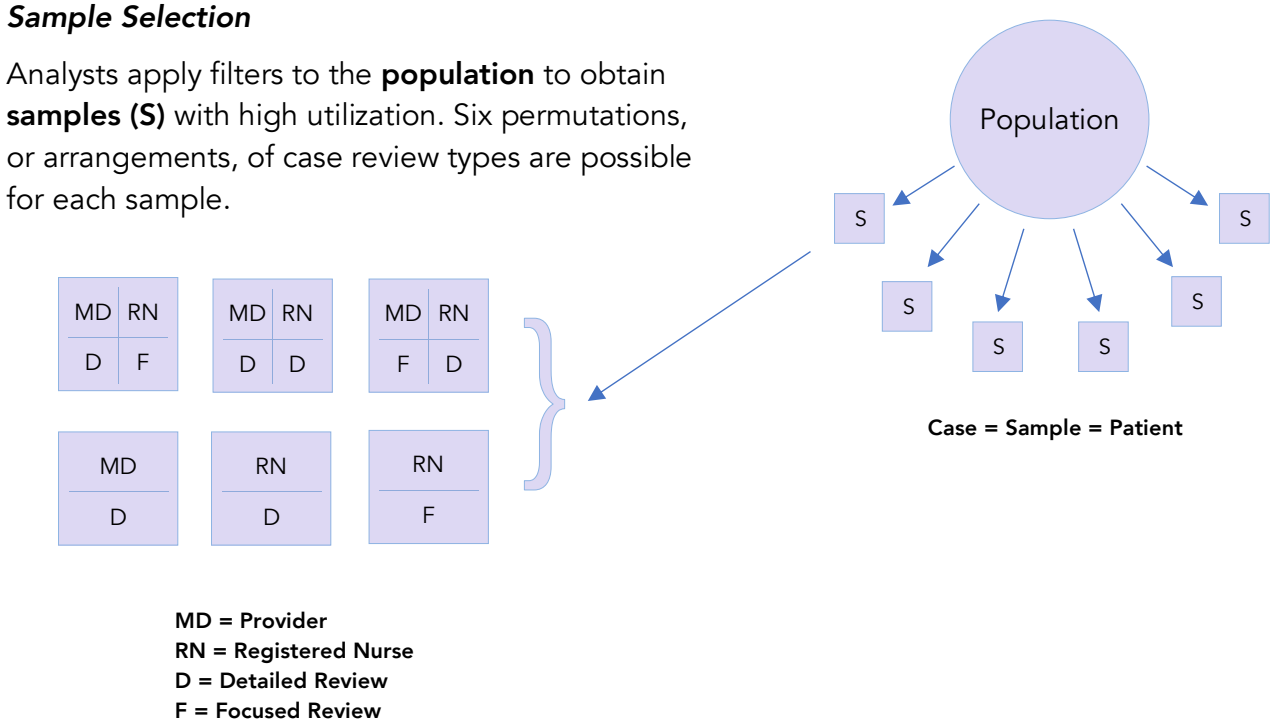
Since the targeted subpopulation does not represent the institution's general prison population, the OIG cautions against inappropriate extrapolation of medical *conditions* or *outcomes* from the retrospective case reviews to the general population. For example, if the high-risk diabetic patients reviewed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

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

## *Case Review Sampling Methodology*

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

## Chart 1. Case Review Sample Selection




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

## *Case Reviews Sampled*

As indicated in *Appendix B, Table B–1: SCC Sample Sets*, the OIG clinicians evaluated medical charts for 47 unique patients. *Appendix B, Table B–4: SCC Case Review Sample Summary,* clarifies that both nurses and physicians reviewed charts for 14 of those cases, for 61 reviews in total. Physicians performed detailed reviews of 20 cases, and nurses performed detailed reviews of 12 cases, totaling 32 detailed reviews. For detailed case reviews, physicians or nurses looked at all encounters occurring in approximately six months of medical care. Nurses and physicians

also performed a limited or focused review of medical records for an additional 29 cases. These generated 897 clinical events for review (*Appendix B, Table B–3: SCC Event—Program*). The inspection tool provides details on whether the encounter was adequate or had significant deficiencies and identifies deficiencies by programs and processes to help the institution focus on improvement areas.

While the sample method specifically pulled only 5 chronic patient records, i.e., 3 diabetes cases and 2 anticoagulation cases (*Appendix B, Table B–1: SCC Sample Sets*), the 47 unique cases sampled included patients with 108 chronic diagnoses, including 13 additional patients with diabetes (for a total of 16) (*Appendix B, Table B–2: SCC 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, we assessed the overall operation of the institution's system and staff for adequacy.

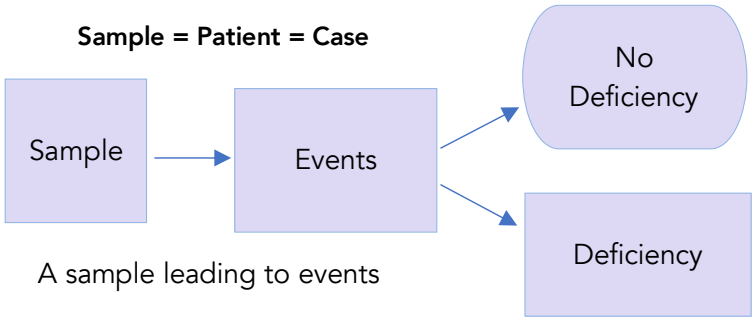
## *Case Review Testing Methodology*

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

## Chart 2. Case Review Testing and Deficiencies

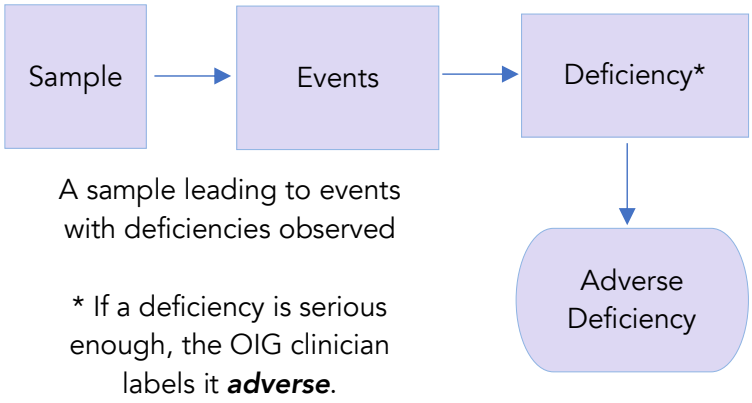
### *Case Review Testing*

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




### *Deficiencies*

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




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

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

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

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## COMPLIANCE TESTING

### *Sampling Methods for Conducting Compliance Testing*

Our registered nurse inspectors obtained answers to 84 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 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 348 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 October 23, 2017, registered nurse field inspectors conducted a detailed onsite inspection of SCC's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 997 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 SCC's plant infrastructure, protocols for tracking medical appeals and local operating procedures, and staffing resources.

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

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 84 questions for the 10 indicators for which compliance testing was applicable, the OIG compliance team derived a score for each quality indicator by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Based on those results, the OIG assigned a rating to each quality indicator of *proficient* (greater than 85.0 percent), *adequate* (between 75.0 percent and 85.0 percent), or *inadequate* (less than 75.0 percent).

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## OVERALL QUALITY INDICATOR RATING FOR CASE REVIEWS AND COMPLIANCE TESTING

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

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

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## 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 SCC, the OIG reviewed some of the compliance testing results, randomly sampled additional patients' records, and obtained SCC data from the CCHCS Master Registry. The OIG compared those results to HEDIS metrics reported by other statewide and national health care organizations.

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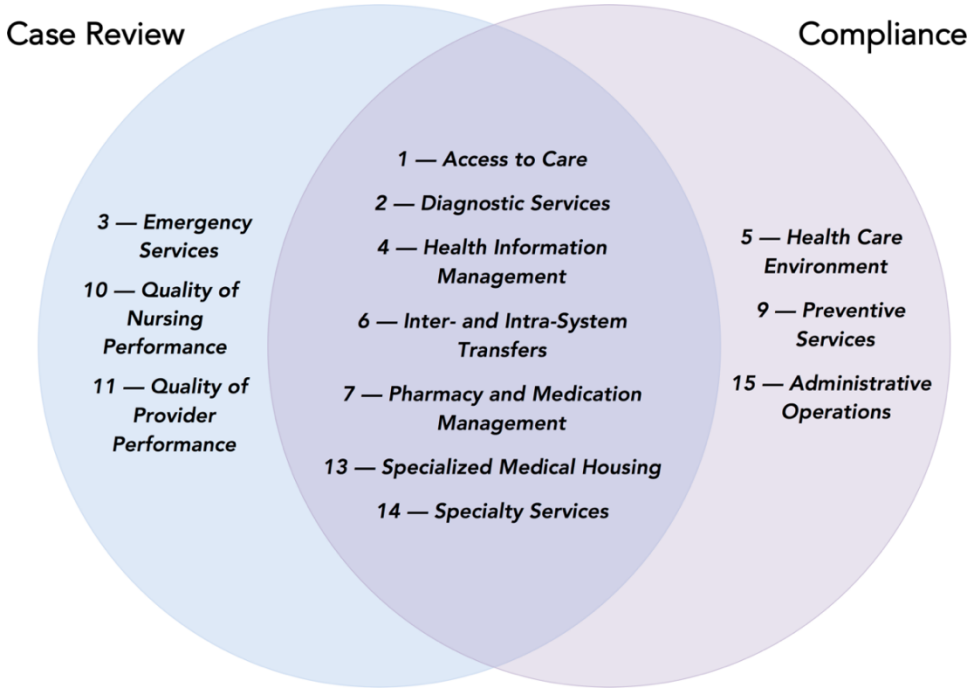
# MEDICAL INSPECTION RESULTS

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

**Chart 3. Inspection Indicator Review Distribution**




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

**Summary of Case Review Results:** The clinical case review component assessed 10 of the 13 indicators applicable to SCC. Of these ten indicators, OIG clinicians rated two *proficient*, seven *adequate*, and one *inadequate*.

The OIG physicians rated the overall adequacy of care for each of the 20 detailed case reviews they conducted. Of these 20 cases, one was *proficient*, 16 were *adequate,* and 3 were *inadequate*. In the 897 events reviewed, there were 81 deficiencies, of which 29 deficiencies were considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

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

- In case 12, the patient had symptoms consistent with a transient ischemic attack (blockage of blood flow to the brain that can be a precursor to a permanent stroke.) The provider did not send the patient to the hospital for an emergent workup, did not order a brain imaging scan, and did not expedite the ordered diagnostic studies. The patient had a remarkably high risk of stroke, and these errors placed the patient at very high risk of significant harm. We also discuss the case in the *Quality of Provider Performance* indicator.

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

## 1 — *ACCESS TO CARE*

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

***Case Review Rating:***
*Adequate*
***Compliance Score:***
*Adequate*
*(83.7%)*

***Overall Rating:***
*Adequate*

### *Case Review Results*

We reviewed 363 provider, nurse, specialty, and hospital events that required a follow-up appointment and identified nine deficiencies relating to *Access to Care*, of which six were significant (more likely than not to cause patient harm if not rectified). The institution generally performed well with health care access, and deficiencies were uncommon. The case review rating for this indicator was *adequate*.

**Provider-to-Provider Follow-up Appointments**

SCC generally did well with provider-ordered follow-up appointments. Requested follow-ups occurred within the time frames requested. The following was an exception:

- In case 17, the primary care provider did not examine the newly-arrived patient and ordered a 30-day chronic care appointment. At the next appointment, a different provider failed to evaluate the patient's chronic conditions and rescheduled the patient to see his regular primary care provider. The patient did not receive a chronic care evaluation and examination at the institution until two months after he arrived.

**RN Sick Call Access**

RN sick call access was very good. SCC reported there was no backlog of nursing appointments. We reviewed 49 sick call events and identified only two cases in which the nurse appointment did not occur timely:

- In case 36, the nurse appointment did not occur within one business day after the sick call nurse reviewed the request.

- In case 40, the nurse did not assess a patient with a recurrent skin infection on the same day the nurse reviewed the request.

**RN-to-Provider Referrals**

SCC also scheduled nurse-to-provider referral appointments appropriately. There were only two delays:

- In case 31, the nurse requested a provider appointment. This appointment occurred more than two weeks late.

- In case 36, the nurse requested a provider appointment. This appointment occurred one week late.

**RN Follow-up Appointments**

SCC had no difficulty with scheduling and completing nursing follow-up appointments. There were no patterns of errors, but there were two deficiencies that resulted from nurse oversights:

- In cases 12 and 31, the nurse planned a follow-up to rinse the patients' ear canals but neglected to schedule the appointments.

**Provider Follow-up After Specialty Services**

SCC performed well with follow-up after specialty visits. We did not identify any deficiencies in this area.

**Intra-System Transfers**

When the receiving nurse ordered proper appointments for patients transferring into the institution, SCC performed well with providing timely access to nurses and providers. Unfortunately, the receiving nurse often failed to order the needed appointments for these patients. The *Inter- and Intra-System Transfers* indicator discusses this performance as well.

**Follow-up After Hospitalization**

SCC did well with access to providers after hospitalization. We did not identify any deficiencies in this area.

**Follow-up After Urgent/Emergent Care**

SCC also provided timely access to providers after an emergent or urgent appointment. There were no problems in this area.

**Specialized Medical Housing**

SCC provided timely provider access in the specialized medical housing unit. We did not identify any deficiencies in this area.

**Specialty Access and Follow-up**

SCC provided good access to specialists. When providers ordered specialty follow-ups, they occurred timely. The *Specialty Services* indicator also discusses performance in this area.

**Diagnostic Results Follow-up**

SCC did well with diagnostic result follow-ups with one exception.

- In case 13, the provider requested a 14-day follow-up to review abnormal laboratory results. This follow-up occurred 22 days late.

**Clinician Onsite Inspection**

During population management and utilization management meetings, the scheduling supervisor reviewed the master registry and notified providers if any patients needed to be seen. When a provider called out sick, SCC staff reviewed and rescheduled the appointments whenever possible. Patients that could not wait to be rescheduled were seen by the "rover" provider (provider assigned to address unscheduled or unanticipated medical situations) or by the chief physician or chief medical executive.

**Case Review Conclusion**

SCC did not have any provider or nurse backlogs. The scheduling supervisor kept the clinic staff abreast of the due dates of upcoming appointments. We did not identify any problems with follow-ups after specialty services, hospitalizations, or rounding in the outpatient housing unit. However, we did see occasional delays with provider and nurse follow-ups, especially for patients that had transferred into the institution. SCC performed well with regard to the *Access to Care* indicator, and the case review rating was *adequate*.

## *Compliance Testing Results*

The institution performed in the *adequate* range with a compliance score of 83.7 percent in the *Access to Care* indicator. The following tests earned *proficient* scores of 100 percent:

- Inspectors sampled 30 Health Care Services Request forms (CDCR Form 7362s) submitted by patients across all facility clinics. Nursing staff reviewed all request forms on the same day they received them (MIT 1.003).

- SCC offered all ten sampled patients a follow-up appointment with a provider within five days of discharge from a community hospital (MIT 1.007).

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

Four tests received scores in the *adequate* range:

- Inspectors sampled 25 patients with chronic care conditions; 20 patients (80.0 percent) received timely provider follow-up appointments. Four patients received their provider-ordered follow-up appointments from 25 to 78 days late. For one remaining patient, there was no evidence a follow-up appointment occurred (MIT 1.001).

- Among 25 patients who transferred into SCC from other institutions, 19 (76.0 percent) were timely seen by a provider based on their medical risk level. Two patients received their provider appointments one and four days late. Two patients received their provider appointments 60 and 120 days late. Finally, two patients did not receive their provider appointments at all (MIT 1.002).

- Among 17 health care services request forms sampled on which nursing staff referred the patient for a provider appointment, 14 patients (82.4 percent) received a timely appointment. Three patients received appointments 7, 13, and 20 days late (MIT 1.005).

- Of the four sampled patients whom a nurse referred to see a provider, and for whom that provider subsequently ordered a follow-up appointment, three patients (75.0 percent) received their follow-up appointments timely. For one patient, the follow-up visit was five days late (MIT 1.006).

We found room for improvement in the following two areas:

- For 21 of the 30 patients sampled who submitted health care services request forms (70.0 percent), nursing staff completed a face-to-face encounter within one business day of reviewing the form. In the nine exceptions, the nurse conducted the visit between one and four days late (MIT 1.004).

- Only 21 of the 30 sampled patients (70.0 percent) who received a high-priority or routine specialty service also received a timely follow-up appointment with a provider. Of the nine patients who did not receive a timely follow-up appointment, six patients' high-priority specialty follow-up appointments were from one to 11 days late; two patients' routine specialty follow-up appointments were 4 and 24 days late. For one patient, there was no evidence found that the high-priority appointment occurred at all (MIT 1.008).

## 2 — *DIAGNOSTIC SERVICES*

***Case Review Rating:***
*Proficient*
***Compliance Score:***
*Inadequate*
*(73.3%)*
***Overall Rating:***
*Adequate*

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

In this indicator, our case review and compliance testing yielded different results, with the case reviewers assigning a *proficient* rating and the compliance testing resulting in an *inadequate* score. There were only a few pathology samples in the case reviews. Therefore, we relied on compliance testing to assess SCC's performance in pathology testing and determined that the institution did not consistently retrieve, review, or communicate pathology reports appropriately. Because of the clinical importance of pathology tests, we concluded that the institution had room for improvement in this area and the overall rating for the *Diagnostics Services* indicator was *adequate*.

### *Case Review Results*

We reviewed 143 diagnostic events and found only two deficiencies. One was related to health information management, and the other was a delay in ordered tests. We did not identify any significant deficiencies. The case review rating for this indicator was *proficient*.

**Test Completion**

SCC performed well in the completion of diagnostic tests. There was only one test that was not performed timely:

- In case 25, the provider ordered an urgent electrocardiogram (EKG, a recording of the heart's electrical activity). Instead of obtaining the test the next day, the supervising nurse discontinued the order and inappropriately rescheduled the test to occur one week later.

In comparison with the last cycle, SCC improved its diagnostic test completion. We attributed this improvement to SCC's transition to the electronic health record system (EHRS), which eliminated the problem of lost orders.

**Health Information Management**

SCC also performed very well in the management of diagnostic test results. The staff correctly retrieved, reviewed, and communicated most laboratory and radiology tests to patients through the EHRS. In comparison with Cycle 4, SCC improved in processing these test results. We also attributed this improvement to the EHRS implementation.

**Clinician Onsite Inspection**

We asked SCC to explain the one-week delay in performing the urgent EKG in case 25. The scheduling supervisors explained that the EHRS mistakenly sent the urgent order to the wrong department (specialty services). The supervising nurse in that department canceled the EKG and reordered for the correct department, but with the wrong time frame.

One provider complained that the providers could not view radiology images. During our inspection, we confirmed that the Yard C providers did not have access to radiology images.

**Case Review Conclusion**

SCC improved and reduced the number of deficiencies in comparison to the last cycle. This improvement was largely due to the transition to EHRS. The new system eliminated paper orders for laboratory tests and the possibility of losing them on the way to the laboratory. The automated interface between the laboratory and the EHRS allowed the system to automatically notify the ordering provider to review the results timely. The EHRS also made those results available to the patient's entire health care team. SCC performed very well regarding the *Diagnostic Services* indicator, and the case review rating was *proficient*.

## *Compliance Testing Results*

The institution received an *inadequate* compliance score of 73.3 percent in the *Diagnostic Services* indicator, which encompasses radiology, laboratory, and pathology services. For clarity, we discuss each type of diagnostic service separately below:

**Radiology Services**

- SCC timely performed ordered radiology services for all ten patients sampled (MIT 2.001). Providers then timely reviewed the corresponding diagnostic services reports for nine of the ten patients (90.0 percent). For the remaining patient, the inspectors found no evidence that a provider reviewed the report (MIT 2.002). Providers timely communicated test results to eight of the ten patients (80.0 percent). Two patients' diagnostic test result letters from their providers did not specify the radiology services provided (MIT 2.003).

**Laboratory Services**

- Seven of ten sampled laboratory services were timely performed (70.0 percent); for three patients, the institution provided laboratory services 7, 72, and 139 days late (MIT 2.004). Providers timely reviewed the laboratory results for nine of the ten sampled patients (90.0 percent). For one patient, there was no evidence that the primary care provider reviewed the report (MIT 2.005). The institution timely notified five of the ten sampled patients of the laboratory results timely (50.0 percent). One patient's notification of the laboratory test result was one day late. Four patients' written communications from their providers did not identify the laboratory tests referenced (MIT 2.006).

**Pathology Services**

- SCC clinicians timely received five of ten patients' final pathology reports (50.0 percent). The institution received five reports from two to seven days late (MIT 2.007). Providers timely reviewed the pathology results for seven of the ten reports received (70.0 percent). They reviewed two reports five and 12 days late, and there was no evidence the provider reviewed the remaining report at all (MIT 2.008). Providers timely communicated the final pathology results to six of the ten patients sampled (60.0 percent). For one patient, the provider communicated the pathology report result one day late. The provider's written communication for another patient did not specify the pathology test provided; and for two final patients, the pathology results were not communicated at all (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. We evaluate this quality indicator through our case review only.

### *Case Review Results*

We reviewed 12 cases that required varying types of urgent or emergent care. These reviews yielded 33 events and 13 deficiencies, of which 1 deficiency was significant. The case review rating for this indicator was *adequate*.

**Emergency Preparedness and Response**

SCC responded appropriately for patients requiring urgent or emergent medical attention. There was one significant delay in notifying the TTA or sending the patient to the TTA:

- In case 27, the patient reported swallowing a razor blade. SCC staff did not recognize the situation as an emergency and did not immediately notify the TTA nurse or send the patient to the TTA for further evaluation. Instead, the nurse notified a mental health provider, who also failed to refer the patient to the TTA immediately. The patient arrived in the TTA two hours later, and an x-ray confirmed the presence of a razor blade in the stomach. Only then did the staff send the patient to an emergency department.

**Provider Performance**

TTA provider care was satisfactory during regular work hours. The providers saw patients timely and made appropriate triage decisions. We found two deficiencies in after-hours care. In these cases, the on-call providers did not properly document their reasoning for their actions. Fortunately, the nurses in both cases correctly documented their assessments and decisions, which reflected sound provider decisions.

**Nursing Performance**

SCC nurses usually performed well during emergency responses. The nurses responded quickly, made good assessments, and provided safe care. Although nursing performance was good, we

found three deficiencies related to emergency nursing assessment and intervention. Only one significant deficiency (case 27, already discussed) resulted in a delay in providing emergency medical care.

**Nursing Documentation**

There were timeline discrepancies and poor medical responder documentation in the emergency cases reviewed. Although these deficiencies did not adversely affect patient care, SCC nurses often failed to record the clinical situation and the care they provided accurately or clearly. Incomplete or incorrect documentation occurred in cases 14, 25, 27, 47, and the following:

- In cases 1 and 2, the nurses' documentation of incorrect timelines resulted in what appeared to be delayed care. During the onsite inspection, SCC nursing staff explained that the nurse erroneously recorded when the patients' symptoms started. If the nurse had not made those errors, there would have been no delays.

**Emergency Medical Response Review Committee**

We examined the available committee minutes for the cases reviewed. The EMRRC regularly reviewed emergency medical responses and correctly identified the various problems related to emergency procedures such as nursing interventions and documentation.

**Clinician Onsite Inspection**

We toured the TTA and interviewed the staff. The TTA had one medical bed with ample space to perform medical care. There were two nurses assigned during each watch. One nurse responded to the yard during medical emergencies, while the other nurse remained in the TTA. SCC made changes in response to the Yard C emergency medical response delays we identified in the Cycle 4 medical inspection. The institution had since designated a custody officer and a vehicle to transport medical responders to and from emergency scenes and to ensure immediate access to the entrance gate during emergency events. Also, SCC assigned a TTA nurse to the Yard C clinic during the night shift to give an immediate emergency response.

**Case Review Conclusion**

SCC staff gave acceptable emergency services to their patients. Providers triaged patients correctly, and nurses usually assessed and intervened properly. However, there was no good explanation for why staff did not recognize the medical emergency when a patient swallowed a razor blade. Also, nurses and providers often made documentation errors. Nevertheless, SCC performed satisfactorily regarding the *Emergency Services* indicator, and we rated this indicator *adequate*.

## 4 — *HEALTH INFORMATION MANAGEMENT*

***Case Review Rating:***
*Adequate*
***Compliance Score:***
*Proficient*
*(91.4%)*

***Overall Rating:***
*Proficient*

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

The institution had converted to the new Electronic Health Record System (EHRS) in November 2016, before the testing period; therefore, nearly all testing occurred in the EHRS, with a minor portion of the testing completed in the electronic Unit Health Record (eUHR).

In this indicator, our case review and compliance testing yielded different results, with the case reviewers assigning an *adequate* rating and the compliance testing resulting in a *proficient* score. In the case reviews, we found that SCC had difficulty with the retrieval of some emergency department and specialty records. However, upon further analysis, these were isolated errors and were unlikely to represent a problem with the institution's report-handling processes. As a result, we rated this indicator *proficient.*

### *Case Review Results*

We reviewed 897 events and found only five deficiencies related to health information management, three of which were significant. The case review rating for this indicator was *adequate*.

#### Inter-Departmental Transmission

SCC performed very well with interdepartmental health information transmission, as we did not identify any deficiencies in this area during the review period.

#### Hospital Records

SCC performed well with hospital discharge summaries. We did not identify any problems with the institution obtaining hospital discharge reports.

SCC performed acceptably with the retrieval of emergency department reports. These are the records of outside hospital emergency department visits. There were two instances in which SCC did not obtain hospital records:

- In case 26, SCC staff sent the patient to the emergency department for umbilical pain. SCC staff failed to retrieve or scan the emergency department report into the EHRS.
- In case 27, the patient swallowed a razor blade, and SCC staff sent him to a hospital emergency department. SCC staff failed to retrieve or scan the emergency department report into the EHRS.

**Specialty Services**

We identified a problem with missing specialty reports from one specific cardiology group. At the onsite inspection, the institution provided evidence that their staff repeatedly attempted to retrieve the missing reports but the cardiology group still did not send the information. Thus, the missing cardiology reports did not suggest any problems with SCC's report retrieval process. The *Specialty Services* indicator also discusses this performance.

**Diagnostic Reports**

SCC demonstrated reliable performance in retrieval and review of diagnostic laboratory and radiology reports. The *Diagnostic Services* indicator also discusses this performance.

**Scanning Performance**

SCC displayed excellent scanning performance. Among over 800 documents, there were only a few documents mislabeled or missing. SCC staff mislabeled one diagnostic report and erred in the following two deficiencies:

- In case 49, a TTA flow sheet was scanned with the wrong date in the electronic medical record.
- In case 50, the provider progress note from the OHU was missing from the electronic medical record.

**Legibility**

Legibility was good. Once SCC transitioned to the EHRS, most records were either typed or dictated.

**Clinician Onsite Inspection**

We asked about the few missing and mislabeled documents. The medical records staff claimed that they never received the missing progress note in case 50. For the missing cardiology reports,

the staff requested the reports multiple times, but the specialty group did not respond to those requests. SCC managers had since escalated the issue to CCHCS headquarters.

**Case Review Conclusion**

SCC usually managed health information properly. SCC's scanning performance improved in comparison to Cycle 4. The transition from the eUHR to the EHRS reduced the medical records staff's workload, resulting in fewer errors in document scanning. There were some occasions when the institution was unable to retrieve important cardiology or emergency department reports. Overall, SCC performed well in the *Health Information Management* indicator, and the case review rating was *adequate*.

## *Compliance Testing Results*

The institution scored in the *proficient* range with a compliance score of 91.4 percent in the *Health Information Management* indicator. The following tests earned *proficient* scores:

- SCC's medical records staff timely scanned all five sampled non-dictated progress notes, initial health screening forms, and requests for health care services into patients' electronic medical records (MIT 4.001).

- The medical records staff at SCC timely scanned community hospital discharge reports or treatment records into 10 of the 11 sampled patients' medical records (90.9 percent); staff scanned one report three days late (MIT 4.004).

- SCC scored 100.0 percent in its labeling and filing of documents scanned into patients' electronic medical records (MIT 4.006).

- Among 11 sampled patients admitted to a community hospital and then returned to the institution, SCC's providers timely reviewed 10 corresponding hospital discharge reports within three calendar days of the patient's discharge (90.9 percent). For one patient, the provider reviewed the discharge report four days late (MIT 4.007).

One test received an *adequate* score:

- Institution staff timely scanned 15 of 20 specialty service consultant reports sampled into the patients' electronic medical records (75.0 percent). Staff scanned two high-priority specialty reports one and 13 days late, and three routine specialty service reports two to three days late (MIT 4.003).

## 5 — *HEALTH CARE ENVIRONMENT*

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

***Case Review Rating:***
*Not Applicable*
***Compliance Score:***
*Inadequate*
*(53.0%)*

***Overall Rating:***
*Inadequate*

### *Compliance Testing Results*

The institution received scores in the *inadequate* range on the following eight tests:

- Health care staff ensured that reusable invasive and noninvasive medical equipment was properly sterilized or disinfected in six of nine applicable clinics (66.7 percent). In two clinics, medical staff relied on the cleaning crew to disinfect the exam table before the start of the shift; and in one clinic, staff did not replace the exam table paper between patient encounters (MIT 5.102).

- Clinicians followed proper hand hygiene practices in only six of nine clinics (66.7 percent). In three clinic locations, clinicians did not wash their hands before or after patient contact or before applying gloves (MIT 5.104).

*Figure 1: Medical supplies were stored in boxes directly on the floor.*

- The non-clinic bulk medical supply storage areas did not meet the supply management needs of the medical health care program, resulting in a score of zero for this test. The institution stored medical supplies in a location exposed to excessive heat; and other medical supplies were stored directly on the floor (*Figure 1*) (MIT 5.106).

- Only two of the nine clinics inspected (22.2 percent) displayed adequate medical supply storage and management protocols. We found one or more of the following medical supply deficiencies in seven clinics: staff did not clearly label medical supplies; staff stored germicidal disposable cloths and antiseptic soap together with medical supplies; and staff kept multiple medical supplies beyond the manufacturers' guidelines (MIT 5.107).

- Clinic common areas and exam rooms were sometimes missing core equipment or other essential supplies necessary to conduct a comprehensive exam. As a result, only three of the

nine clinics (33.3 percent) were compliant. In six clinics, we found one or more of the following equipment and supply deficiencies: an AED had an expired calibration sticker; a weight scale did not have a calibration sticker; AED pads were expired; lubricating jelly, hemoccult cards, and a hemoccult developer were missing; an exam table lacked disposable paper covering; a Snellen eye exam chart was missing its distance line (MIT 5.108).

- Clinic common areas had an environment conducive to providing medical services in six of nine clinics (66.7 percent). In two clinics, the location of vital sign and blood draw stations compromised patients' auditory privacy; and in one clinic, clinical staff did not have sufficient space to perform their preparation and administration duties (MIT 5.109).

- Only one of nine clinic exam rooms (11.1 percent) had appropriate space, configuration, supplies, and equipment to allow clinicians to perform a proper clinical examination. In eight clinics, inspectors identified one or more deficiencies: exam rooms measured less than the 100-square-foot minimum; exam rooms did not provide auditory or visual privacy; exam rooms were cluttered; confidential medical records were not shredded at the end of the shift or on a daily basis; and patients were unable to lie fully extended on the exam table due to physical obstructions (*Figure 2*) (MIT 5.110).

*Figure 2: Physical obstructions prevented patients from lying on the table with their legs extended.*

- We examined emergency response bags to determine if SCC's staff inspected the bags daily, inventoried them monthly, and whether the bags contained all essential items. Emergency response bags were compliant in three of the six applicable clinical locations (50.0 percent). In three locations, staff had not inventoried the EMRBs within the last 30 days. One of the three locations stored a nasal cannula in the EMRB beyond the manufacturer's guidelines (MIT 5.111).

Three tests received scores in the *proficient* range:

- Staff appropriately disinfected, cleaned, and sanitized in eight of nine clinics (88.9 percent). In one clinic, the cleaning crew did not regularly maintain cleaning logs (MIT 5.101).

- Eight of the nine clinic locations inspected (88.9 percent) had operable sinks and sufficient quantities of hand hygiene supplies in the exam areas. In one clinic, the patient restroom did not have antiseptic soap (MIT 5.103).

- Health care staff in eight of the nine clinics followed proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste (88.9 percent). In one clinic, staff did not secure the sharps container to a fixed object (MIT 5.105).

**Non-Scored Results**

We gathered information to determine if the institution maintained its physical infrastructure in a manner that supported health care management's ability to provide timely or adequate health care. We did not score this question. When we interviewed health care managers, they had no concerns about the facility's infrastructure or its effect on the staff's ability to provide adequate health care. However, as noted below, the institution had four infrastructure projects underway, which management staff felt would improve the delivery of care at SCC. The following projects started in the fall of 2015, and the institution estimated that they would be complete by the end of summer 2019 (MIT 5.999).

- Project A: Construction of new pharmacy and laboratory building.
- Project B: Renovation of existing central health care building.
- Project C: Construction of new administration building.
- Project D: Renovation of existing Yard C health care building and construction of additional space.

## 6 — *INTER- AND INTRA-SYSTEM TRANSFERS*

***Case Review Rating:***
*Inadequate*
***Compliance Score:***
*Inadequate*
*(66.7%)*
***Overall Rating:***
*Inadequate*

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

### *Case Review Results*

We reviewed 26 cases that yielded 30 inter- and intra-system transfer events. These included 19 hospitalizations and outside emergency room events, each of which resulted in a transfer back to the institution. There were nine deficiencies identified in the cases reviewed. The case review rating for this indicator was *inadequate*.

**Transfers In**

SCC performed poorly ensuring that patients who transferred from other CDCR institutions received sufficient and timely care. The receiving and release clinic (R&R) nurses usually performed acceptably with initial health screening. However, the nurses did not consistently ensure that their newly arrived patients received timely provider and nurse follow-ups and had a continuous supply of medications. We reviewed seven cases in which the patient transferred into SCC from another CDCR institution. Four transfer-in cases showed room for improvement:

- In case 16, the R&R nurse failed to schedule a provider appointment for a patient with uncontrolled diabetes. Fortunately, the primary care team in the clinic identified the patient's medical risk and scheduled a provider appointment immediately.

- In case 17, the patient arrived at SCC before the weekend with an insufficient supply of prescribed medications. There was no evidence the nurse obtained the medications from the after-hours supply or checked if the patient had adequate medication to ensure medication continuity.

- In cases 16, 17, and 18, the R&R nurses failed to refer patients with multiple chronic conditions to the nurse care manager. CCHCS policy requires an initial nurse care management appointment for all newly arrived patients to ensure a smooth transition of health care services.

- In case 20, the patient had a history of throat cancer and received chemotherapy. During the initial health screening, the nurse incorrectly noted that the patient had no history of cancer or radiation therapy.

**Transfers Out**

SCC's transfer-out process was effective. Nurses usually sent current health care information, essential medications, and durable medical equipment to receiving institutions correctly. R&R nurses also performed face-to-face assessments to ensure patients were in a stable condition before transfer. We reviewed four such cases and identified only one deficiency:

- In case 27, SCC staff failed to send the patient's medications with him during the transfer. However, the receiving institution administered the medications correctly despite SCC's error.

**Hospitalizations**

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

We reviewed 19 hospitalizations and outside emergency room events. There were three deficiencies, but no pattern of deficiencies to suggest any process problems. In most cases, SCC nurses properly processed the patients returning from the hospital through the TTA. Medical staff admitted patients who had surgery or needed further observation to the OHU. Nurses performed complete assessments, reviewed hospital reports, and informed providers of findings and recommendations. Providers placed orders promptly while nurses implemented the orders and administered medications timely. The nurses also instructed their patients sufficiently by providing instructions and printed materials, such as medication information, post-procedure care, and follow-up appointments.

**Case Review Conclusion**

Nurses did not perform well during the transfer-in process. In several cases, the R&R nurses did not refer complex patients to nurse care managers. In another case, the patient arrived with an inadequate supply of medication and the nurses did not obtain medications for the patient from the after-hours supply to prevent a lapse in medications. Transfer-out performance was better, with only one significant deficiency; SCC failed to send medication with one patient. Nurses performed well with hospital and emergency department returns. The institution evaluated and

housed patients appropriately. Because the SCC nurses did not perform sufficiently in the transfer-in process, the rating for this indicator was *inadequate*.

### *Compliance Testing Results*

The institution scored in the *inadequate* range for this indicator, with a compliance score of 66.7 percent. The following tests earned scores in the *inadequate* range:

- Of the 25 sampled patients who transferred into SCC, 6 had existing medication orders that required nursing staff to issue or administer medications upon their arrival. Four of these six patients (66.7 percent) received their medications timely. Two patients received their medications late (MIT 6.003).

- SCC scored zero when we tested four patients who transferred out of SCC during the onsite inspection to determine whether the patients' transfer packages included required medications and related documentation. All four transfer packages were missing medication administration records and the transfer checklist. One of the four packages was missing the corresponding medication reconciliation (MIT 6.101).

Two tests received scores in the *proficient* range:

- For all 25 sampled patients who transferred into SCC from other CDCR facilities, nursing staff completed an Initial Health Screening form (CDCR Form 7277) on the same day the patient arrived (MIT 6.001).

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

## 7 — *PHARMACY AND MEDICATION MANAGEMENT*

***Case Review Rating:***
*Adequate*
***Compliance Score:***
*Inadequate*
*(69.8%)*
***Overall Rating:***
*Inadequate*

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

In this indicator, our case review and compliance testing yielded different results, with the case reviewers assigning an *adequate* rating and the compliance testing resulting in an *inadequate* score. Our compliance testing showed that SCC did not administer new prescriptions within the required time frames, did not provide post-hospital discharge medications timely, and had poor storage practices for narcotic medications. Because of the clinical importance of these tests, we rated this indicator *inadequate*.

### *Case Review Results*

We evaluated 59 events related to medications and found three deficiencies related to medication continuity and administration, one of which was significant. The case review rating for this indicator was *adequate*.

**Medication Continuity**

SCC usually ensured medication continuity for patients transferring into the institution, returning from a community hospital, or receiving monthly medications for chronic conditions. We found only two deficiencies in this area:

- In case 8, the patient ran out of his medications and had not taken his chronic medications for six weeks. The pharmacist in charge (PIC) explained that due to the transition to the EHRS, this patient's prescriptions disappeared from his medication list, resulting in the break in continuity. The patient requested refills of his medications; 13 days later, the provider had to reorder the medications due to the computer error.

- In case 17, the patient arrived after hours in SCC with an insufficient supply of medications. The nurse did not obtain the medications from the after-hours supply to ensure medication continuity. The *Inter- and Intra-System Transfers* indicator also discusses this case.

In the case reviews, there were apparent lapses in medication continuity, specifically for one patient in a firefighting camp. However, at the onsite inspection, SCC displayed evidence that a computer problem with the transition to the EHRS caused some patients at camp to receive 90 days' worth of medications every 30 days until the institution eventually identified and corrected the problem. SCC did not dispense medications for several months due to the oversupply. As a result, there was no lapse in the continuity of this patient's chronic medications.

**Medication Administration**

SCC nurses ensured patients received their medications timely and as prescribed. There was only one medication error in the cases reviewed:

- In case 49, the nurse administered medication without a provider's order.

**Clinician Onsite Inspection**

We asked about the apparent lapses in medication continuity for patients in the firefighting camps. SCC staff explained that during the transition to the EHRS, they had problems with loading prescriptions from the prior system to the new one. Also, they explained that at the firefighting camps, staff did not record when they administered the medications, which made it impossible to determine if the camp patients received their medications. SCC managers claimed to have corrected this problem in January 2018, when the CCHCS central pharmacy began processing medication orders for firefighting camp patients and sending paper medication administration records (MARs) along with the medications. Staff at the camps completed these paper MARs and sent them back to SCC for scanning into the EHRS. The case review period did not cover the implementation of this new process.

**Case Review Conclusion**

SCC usually provided good medication continuity for those with chronic conditions, those transferring into or out of the institution, and those that returned from the hospital. The number of deficiencies identified in this category was small but significant. SCC performed well in the *Pharmacy and Medication Management* indicator, and the case review rating was *adequate*.

## *Compliance Testing Results*

The institution received an *inadequate* compliance score of 69.8 percent in the *Pharmacy and Medication Management* indicator. For discussion purposes below, we divide this indicator into three sub-indicators: medication administration, observed medication practices and storage controls, and pharmacy protocols.

### Medication Administration

For this sub-indicator, the institution received an *adequate* compliance score of 75.3 percent. The following tests earned *proficient* scores:

- SCC administered chronic care medications timely to 23 of 24 patients sampled (95.8 percent). For one patient, the nursing staff replenished a medication one day late (MIT 7.001).

- SCC ensured that 24 of 25 sampled patients who transferred from one housing unit to another (96.0 percent) received their ordered medications without interruption. One patient did not receive his medication at the proper dosing interval (MIT 7.005).

Two tests earned scores in the *inadequate* range:

- The institution timely administered or delivered newly prescribed medications to 16 of the 25 patients sampled (64.0 percent). Nine patients received their medications from one to three days late (MIT 7.002).

- SCC timely provided hospital discharge medications to 5 of 11 patients sampled (45.5 percent). For six patients, nursing staff administered discharge medications one to two days late (MIT 7.003).

### Observed Medication Practices and Storage Controls

The institution scored 58.6 percent in this sub-indicator, with the following tests scoring in the *inadequate* range:

- SCC employed adequate security controls for narcotic medications in three of eight (37.5 percent) clinics and medication line locations where the institution stored narcotics. In five clinics, two licensed nursing staff did not perform a controlled substance inventory each shift (MIT 7.101).

- Non-narcotic, refrigerated medications were safely stored in five of nine clinics and medication line storage locations (55.6 percent). At three locations, there was no designated return-to-pharmacy area for these medications. In another location, the refrigerator contained an open vial of influenza vaccine with no record of when staff opened it (MIT 7.103).

- We observed the medication preparation and administration processes at six applicable medication line locations. Nursing staff was compliant with proper hand hygiene and contamination control protocols at three locations (50.0 percent). At three other locations, not all nursing staff washed or sanitized their hands when required, such as before preparing medications or before re-gloving (MIT 7.104).

- Only three of six inspected medication preparation and administration areas demonstrated appropriate administrative controls and protocols (50.0 percent). At three different locations, one or more of the following deficiencies occurred: medication nurses did not ensure patients swallowed directly observed therapy medications; medication nurses did not appropriately disinfect previously opened multi-dose insulin prior to withdrawing medication; and patients waiting to receive their medications did not have sufficient outdoor cover to protect them from heat or inclement weather (MIT 7.106).

Two tests received *adequate* scores:

- SCC safely stored non-narcotic, non-refrigerated medications in six of the eight applicable clinic and medication line storage locations (75.0 percent). In two locations, one or more of the following deficiencies occurred: the clinic stored oral and topical medications together; a previously opened multi-dose bottle of medication was missing the date when staff originally opened it; and the medication cart was unlocked when not in active use (MIT 7.102).

- Nursing staff at five of six applicable medication line locations employed proper administrative controls and followed protocols during medication preparation (83.3 percent). In one location, the nursing staff was unable to verbalize the medication reconciliation process (MIT 7.105).

**Pharmacy Protocols**

SCC scored in the *adequate* range with a compliance score of 78.9 percent in this sub-indicator. The following tests earned *proficient* scores:

- SCC's main pharmacy followed general security, organization, and cleanliness management protocols. In addition, the main pharmacy safely stored both non-refrigerated and refrigerated medications (MIT 7.107, 7.108, 7.109).

- The institution's pharmacist in charge (PIC) followed required protocols for 17 of the 18 medication error reports and monthly statistical reports reviewed (94.4 percent). For one medication error report, the staff did not notify the PIC of the medication error report timely (MIT 7.111).

The following test received an *inadequate* score:

- The PIC properly accounted for narcotic medications stored in SCC's main pharmacy. However, at several of the institution's clinic and medication line storage locations, the PIC did not complete the Medication Area Inspection Checklist forms (CDCR Form 7477). As a result, the institution scored zero on this test (MIT 7.110).

**Non-Scored Tests**

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

- We interviewed patients housed in isolation units to determine whether they had immediate access to their prescribed rescue inhalers and nitroglycerin medications. All four applicable patients interviewed reported they 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 SCC does not have female patients, this indicator does not apply.

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

***Overall Rating:***
*Not Applicable*

## 9 — *PREVENTIVE SERVICES*

This indicator assesses whether the institution offered or provided various preventive medical services to patients. These include cancer screenings, tuberculosis screenings, and influenza and immunizations for patients with chronic conditions. This indicator also assesses whether certain institutions take preventive actions to relocate patients identified as being at higher risk for contracting coccidioidomycosis (valley fever). The OIG rates this indicator entirely through the compliance testing component.

***Case Review Rating:***
*Not Applicable*
***Compliance Score:***
*Proficient*
*(88.0%)*
***Overall Rating:***
*Proficient*

### *Compliance Testing Results*

The institution scored in the *proficient* range in this indicator with a compliance score of 88.0 percent. The following four tests scored in the *proficient* range:

- SCC timely administered tuberculosis (TB) medications to patients. All 25 sampled patients received their required doses of TB medications in the most recent three-month review period (MIT 9.001).
- SCC offered annual influenza vaccinations to 23 of 25 sampled patients subject to the annual screening requirement (92.0 percent). For two patients, there was no evidence the patient received or refused the influenza vacation during the most recent influenza season (MIT 9.004).
- SCC offered colorectal cancer screenings to all 25 sampled patients subject to the annual screening requirement (MIT 9.005).
- We tested whether the institution offered vaccinations for influenza, pneumonia, and hepatitis to patients who suffered from chronic conditions. Among the nine sampled patients with chronic conditions, eight (88.9 percent) were timely offered the vaccinations. For one patient, there was no record that he received or refused the pneumococcal immunization within the last five years (MIT 9.008).

One test received an *adequate* score:

- We sampled 30 patients at SCC to determine whether they received a TB screening within the last year and during the month of their birth; 25 of the 30 patients sampled (83.3 percent) timely received the screening. Four patients did not receive TB screening in their birth month, as CCHCS policy requires, and one patient neither received nor refused the TB screening (MIT 9.003).

One test scored in the *inadequate* range:

- We reviewed SCC's monitoring of 25 sampled patients who received TB medications and noted that the institution complied for 16 of them (64.0 percent). For eight patients, the staff did not perform the required weekly monitoring. Staff also failed to record one patient's weight during a weekly monitoring visit (MIT 9.002).

## 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 as 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 the outpatient housing unit (OHU), correctional treatment center (CTC), or other inpatient units are reported in the *Specialized Medical Housing* indicator, and nursing services provided in the triage and treatment area (TTA) or related to emergency medical responses are reported in the *Emergency Services* indicator, all areas of nursing services are summarized in this indicator.

### *Case Review Results*

We reviewed 312 nursing encounters, 161 of which were in the outpatient setting. Most outpatient nursing encounters were for sick call requests, walk-in visits, RN follow-up, and care coordination. In all, we found 31 deficiencies related to nursing care performance, 3 of which were significant. Overall, the SCC nurses demonstrated appropriate care and nursing competence. The case review rating for this indicator was *adequate*.

**Nursing Assessment**

SCC nurses assessed patients appropriately. They usually asked patients to describe their symptoms and examined pertinent areas of the body related to their complaints. Nursing assessment deficiencies occurred in 6 out of 42 applicable cases, but there was no pattern to these deficiencies that suggested any fundamental problems in this area.

**Nursing Intervention**

SCC nurses usually intervened when needed. Nursing intervention deficiencies occurred in 5 out of 42 applicable cases. When the nurses did not intervene correctly, the errors usually involved failure to inform the provider of the patient's condition, failure to refer the patient to the nurse care manager, or failure to follow provider orders or nursing protocols. These errors usually occurred during nursing sick call and transfers encounters. As with nursing assessment, performance in this area was sufficient, with no serious pattern of deficiencies.

### Nursing Documentation

Overall, nursing documentation was satisfactory and confirmed our finding of sound nursing care. While documentation deficiencies were common (occurring in 9 of the 42 applicable cases), they were typically minor and did not increase the risk of patient harm. Most documentation deficiencies occurred during emergency medical events.

### Nursing Sick Call

We reviewed 49 nursing sick call visits. SCC nurses usually reviewed sick call requests, performed assessments, and implemented interventions timely and correctly.

When sick call deficiencies occurred, they were minor and did not significantly increase the risk of patient harm. In those situations, the nurses did not assess the patient sufficiently, intervene appropriately, or document accurately. We found nursing sick call deficiencies in cases 2, 10, 12, 31, 36, 39, 40, and 46, but there was only one significant deficiency when the nurse failed to recognize a potentially urgent condition and did not assess the patient on the same day:

- In case 40, the nurse did not assess a patient with a recurrent skin infection on the same day the nurse received the request. A skin infection could rapidly progress to a more serious problem affecting the whole body, so the nurse should have evaluated the patient immediately. The nurse waited three days to assess the patient and finally obtained an order for antibiotic medications. Fortunately, the patient did not suffer any complications.

### Urgent/Emergent Care

SCC nurses gave timely and appropriate care to patients during emergency medical responses. However, we discuss one significant deficiency in the *Emergency Services* indicator in which SCC staff failed to recognize an emergency after the patient swallowed a razor blade.

### Care Management

SCC designated the primary care RN as the nurse care manager and assigned one LVN care coordinator to each of the main clinics. The care managers' duties included monitoring patients with diabetes and those receiving hepatitis C treatment. The care coordinators performed health care maintenance services such as TB screening, immunizations, and basic nursing interventions like blood pressure checks, wound care, and pre-procedure instructions. The care managers and coordinators said they were still unfamiliar with the scope of their responsibilities but were eager to learn and willing to improve the delivery of health care services to their patients. Although the duties of the care managers and care coordinators were ill-defined, we reviewed 19 of these nursing encounters and did not find any serious nursing deficiencies.

**Specialized Medical Housing**

OHU nurses gave proper care and showed improvement in nursing assessment and intervention compared to cycle 4. We found only minor documentation deficiencies in this area. We discuss these deficiencies further in the *Specialized Medical Housing* indicator.

**Transfers**

The R&R nurses reviewed health care information and assessed newly arrived patients correctly. They did have trouble ensuring that patients received the correct nurse and provider follow-ups. For patients transferring out of the institution, the R&R nurses performed well. For patients returning from the hospital, the TTA nurses assessed them properly and ensured continuity of care. We discuss these findings further in the *Inter- and Intra-System Transfers* indicator.

**Offsite Specialty Services Returns**

SCC nurses gave good care and ensured provider follow-up for patients returning from specialty services. We reviewed 40 of these nursing encounters and did not find any significant deficiencies.

**Medication Administration**

SCC nurses performed acceptably with medication administration. The *Pharmacy and Medication Management* indicator includes further details.

**Clinician Onsite Inspection**

We visited several clinic areas, attended clinic morning huddles, and interviewed staff. The primary care team held substantial and informative discussions during the morning huddles. Training records showed that SCC held yearly training for nursing staff. Nurse managers reported staff shortages, especially in the TTA during the night shift. Nurses reported no communication barriers with staff or patients and expressed good overall job satisfaction. We also met with the chief nursing executive and supervising registered nurse to discuss the nursing problems we identified in the case reviews. The nursing managers readily addressed the cases, acknowledged the nursing issues needing improvement, and described their plans for corrective action.

**Case Review Conclusion**

Patients at SCC usually received good nursing care, but we found several deficiencies in the case reviews. SCC nursing managers can use the nursing deficiencies we found in this inspection for education and quality improvement purposes. We rated the *Quality of Nursing Performance* at SCC *adequate*.

## 11 — *QUALITY OF PROVIDER PERFORMANCE*

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

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

### *Case Review Results*

We reviewed 211 medical provider encounters and identified 28 deficiencies related to provider performance, 14 of which were significant. Of the 20 cases reviewed, OIG physicians rated one case *proficient*, 16 cases *adequate,* and 3 cases *inadequate*. There was one adverse deficiency in case 12. The case review rating for this indicator was *adequate*.

**Assessment and Decision-Making**

SCC providers usually made sound assessments and good decisions. Though most provider care was appropriate, there were some cases in which significant errors occurred.

- In case 11, the pain management committee recommended that the provider taper off the patient's opioid medications. The provider failed to follow the committee's recommendations and did not record any reason for ignoring them. At the onsite inspection, the provider explained that he felt that he did not have any other options other than to continue the opioid medications. In truth, the provider had not considered other pain medication alternatives.

- In case 12, the provider evaluated the patient who was having intermittent trouble with word-finding and confusion. The provider appropriately considered the possibility of TIAs (transient ischemic attacks, i.e., temporary blockages of blood flow to the brain that can sometimes be a precursor to a permanent stroke). Though the provider ordered the correct ultrasound scans of the heart and neck arteries, the provider should have ordered them with urgent priority. The provider also neglected to order a brain imaging scan. The provider should have sent the patient to the hospital for an emergent workup because he was at significant risk of a stroke. During the onsite inspection, the provider claimed that the patient refused to go to the hospital for an emergent workup but provided no evidence for the claim. The provider's errors, in this case, placed the patient at remarkably elevated risk of significant harm, and we considered those errors adverse deficiencies.

- Also in case 12, a week after the visit mentioned above, the same patient had a follow-up with a second provider. The second provider also failed to address the possibility of TIAs and inappropriately ordered a 90-day follow-up. This second provider missed an opportunity to correct the first provider's errors and to expedite the patient's care.

**Failure to Implement Planned Interventions**

We found three instances in which providers did not follow through with plans that they recorded in their progress notes.

- In case 10, the provider wrote that he would follow up on a urinalysis, but the provider never ordered the test.

- Also, in case 10, the provider told a nurse that the provider would order a urology consultation, but the provider failed to order the specialty referral.

- In case 26, the provider recorded that the patient needed a follow-up in 30 days and needed to have a diagnostic scan rescheduled. The provider did not order the follow-up and did not reschedule the scan. The patient's care would have lapsed if the patient had not submitted a sick call request and if the nurse had not redirected the patient back to the provider.

**Review of Records**

SCC providers appropriately reviewed records in most cases. However, there was a pattern of deficiencies that suggested that the providers needed improvement in this area:

- In case 8, the provider documented that the patient's biopsy results were not available, but in truth, staff already scanned the results into the EHRS three days prior.

- In case 17, the patient transferred into the institution. At the provider appointment, the regular provider was unavailable, and the covering provider performed an incomplete assessment for the newly transferred patient. The patient did not receive his comprehensive evaluation until two months later.

- In case 22, the patient refused a provider appointment. The primary provider failed to review the chart, did not recognize that the patient had no future appointments, and failed to order a follow-up. The patient's care lapsed for nearly a month because of this error.

- In case 26, the patient had an appointment for multiple issues: chronic low back pain, chronic disease, and follow-up after a surgical consultation. The provider only addressed the chronic low back pain and ignored the other problems. Fortunately, another provider saw the patient two weeks later and addressed the remaining issues.

### Chronic Care

SCC performed satisfactorily in this area. The providers monitored their anticoagulation patients appropriately. They treated their hepatitis C and hypertensive patients satisfactorily. The providers usually monitored and treated most diabetes patients appropriately. However, there were a few diabetic management problems:

- In case 8, the provider saw the patient for a chronic care appointment and noted that the patient had diabetic eye problems and that his diabetes had worsened and was out of control. The provider failed to adjust the diabetes medication or record any reason to avoid changing the diabetes medication. This error placed the patient at increased risk for diabetic complications.

- In multiple instances in case 12, the provider saw the patient for uncontrolled diabetes. Each time, the provider made small increases to the long-acting insulin but requested follow-up intervals that were too long. These errors ensured that the patient's diabetes would remain uncontrolled and increased the patient's risk for diabetic complications.

### Specialty Services

SCC providers referred patients to specialists properly, reviewed reports timely, and followed specialty recommendations appropriately. The *Specialty Services* indicator discusses this further.

### Emergency Care

SCC emergency provider performance was good. Providers generally made appropriate triage decisions and sent the patient to higher levels of care when needed. The *Emergency Services* indicator discusses this further.

### Specialized Medical Housing

SCC providers did well in the outpatient housing unit. There were minor deficiencies only. The *Specialized Medical Housing* indicator discusses this in more detail.

### Clinician Onsite Inspection

Since Cycle 4, SCC implemented a primary care home care model, in which the institution assigned providers to a single yard to improve continuity of care. Nonetheless, SCC continued to use a "rover" provider, where a floating, unassigned provider cross-covered several areas, including the TTA and the OHU, and examined patients for whom appointments could not be made due to the lack of available appointments. The chief medical executive and the chief physician and surgeon also examined patients when there were not enough appointments to meet the demand. This utilization of rover providers and medical managers often compromised the continuity of care.

Providers described their morale as good, but not as good as it was in Cycle 4. Most providers felt the CME was fair but declined to give supporting details. Some providers suggested that morale was better when they had the old system of distributing patients and when there was less provider continuity. Those providers were concerned that the Yard C providers would have a higher rate of burnout due to the more challenging patient population housed there.

**Case Review Conclusion**

SCC's overall provider performance was acceptable. However, we found intermittent errors in which providers reviewed records superficially and ordered inappropriate follow-up intervals. We also identified poor continuity of care, a finding that has continued since Cycle 4. In addition, there were some new problems in which providers inexplicably deviated from specialist recommendations, failed to implement planned interventions, and sometimes made poor decisions. Nonetheless, most of these deficiencies occurred in a small minority of the cases and the overall quality of provider care was sufficient in most cases. As a result, we rated SCC's *Quality of Provider Performance* indicator *adequate*.

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## 12 — *RECEPTION CENTER ARRIVALS*

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

***Overall Rating:***
*Not Applicable*

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

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

## 13 — *SPECIALIZED MEDICAL HOUSING*

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

***Case Review Rating:***
*Adequate*
***Compliance Score:***
*Proficient*
*(93.3%)*
***Overall Rating:***
*Adequate*

For this indicator, our case review and compliance testing yielded different results, with the case reviewers assigning an *adequate* rating and the compliance testing resulting in a *proficient* score. In the cases reviewed there was room for improvement in several areas including OHU provider continuity, provider documentation, and nurse documentation. Furthermore, there were only four compliance tests which marginally affected the quality of patient care. Therefore, we heavily relied upon the case review rating for the overall rating of this indicator, which was *adequate*.

### *Case Review Results*

SCC had ten OHU beds and used two of them for mental health patients. We reviewed 12 OHU cases, which yielded 38 provider and 48 nursing events. Because of the high frequency of patient encounters, each event covered up to one month of provider visits and several consecutive days of nursing care. There were six deficiencies, of which one was significant. The case review rating for this indicator was *adequate*.

**Provider Performance**

The SCC rover provider cared for the OHU patients. The rover was a floating, unassigned provider who cross-covered multiple areas, including the OHU, and saw the OHU patients. During this inspection, several providers took turns as the rover. This rotation of providers resulted in poor continuity of care in the OHU. In addition, there were two minor deficiencies related to timeliness of provider progress notes; they did not result in an increased risk of harm:

- In case 20, the provider did not document a progress note within 24 hours of the patient's arrival at the OHU as required by CCHCS policy.
- In case 24, the provider gave verbal orders to the nurse to discharge the patient from the OHU to general housing. However, the provider neglected to order a follow-up appointment. As a result, the provider saw the patient later than CCHCS policy requires.

**Nursing Performance**

OHU nurses gave satisfactory care. Compared to Cycle 4, the OHU nurses improved their assessments and interventions. They accurately assessed their patients' behaviors, medical conditions, and functional abilities every day. They appropriately notified providers whenever their patients' conditions changed. They correctly administered medications and treatments, such as wound care, when ordered. Nurses assisted patients with daily living activities and intervened for their patients' complaints when needed. When they discharged patients from the OHU, the nurses gave thorough discharge instructions, which included medication information, self-care, and a list of pending follow-up appointments. The OHU nurses also gave a report to the clinic nurses to ensure continuity of nursing care.

Although the OHU nurses performed well, we did find some documentation deficiencies, such as incorrect documentation and cloned progress notes (documentation identical in content) in cases 19 and 20.

**Clinician Onsite Inspection**

During the onsite inspection, patients occupied five OHU beds. There was one RN assigned during the day shift and none assigned during the evening and overnight shifts (only LVNs worked those shifts). The nurses we interviewed demonstrated proper knowledge of their responsibilities and OHU procedures.

**Case Review Conclusion**

SCC improved the care delivered to OHU patients since Cycle 4. While the medical care in the OHU was good, we found some problems with provider continuity, provider documentation, and nurse documentation. We rated this indicator *adequate* overall.

## *Compliance Testing Results*

The institution received a *proficient* compliance score of 93.3 percent in this indicator. Two tests earned scores in the *proficient* range:

- For all ten patients sampled, nursing staff timely completed an initial health assessment the same day they admitted the patient to the OHU (MIT 13.001).
- When inspectors observed the working order of sampled call buttons in OHU patient rooms, inspectors found all working properly. In addition, according to staff members interviewed, custody officers and clinicians were able to access patients' locked rooms when emergent events occurred expeditiously. As a result, SCC received a score of 100.0 percent on this test (MIT 13.101).

One test earned an *adequate* score:

- When we tested whether providers completed their Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes at required 14-day intervals, we found that providers completed timely SOAPE notes for eight of the ten sampled patients (80.0 percent). For one patient, the provider completed the SOAPE note two days late; and for one patient, the provider did not document a complete SOAPE note (MIT 13.003).

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## 14 — *SPECIALTY SERVICES*

***Case Review Rating:***
*Proficient*
***Compliance Score:***
*Adequate*
*(81.9%)*

***Overall Rating:***
*Adequate*

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

For this indicator, the case review and compliance testing yielded different results, with the case reviewers assigning a *proficient* rating and the compliance testing resulting in an *adequate* score. Although the institution did well in most specialty areas, our compliance testing showed a significant problem with the transfer-in process. Most patients approved or scheduled for specialty services at a prior institution did not receive the service timely after they transferred into SCC. Because of the clinical importance of this process, SCC had room for improvement in this area. We rated this indicator *adequate* overall.

### *Case Review Results*

We reviewed 132 events related to specialty services, the majority of which were specialty consultations, procedures, and nursing encounters after specialty appointments. There were only two deficiencies in this category. The case review rating for this indicator was *proficient*.

**Access to Specialty Services**

SCC provided specialty services within the required time frames for routine and urgent services. Consultations and follow-ups occurred timely.

**Nursing Performance**

TTA nurses evaluated patients returning from offsite specialty appointments while the telemedicine and specialty nurses processed patients who saw telemedicine and onsite specialists. SCC nurses performed well in assessing the patients, reviewing the specialty reports, providing patient education, and documenting care. Nurses reviewed specialty reports and notified primary care teams of specialists' findings and recommendations.

When a specialty report was not immediately available, the nurse notified the provider and asked the specialty clinic staff to follow up on the missing report. There was only one deficiency:

- In case 25, the patient returned from a specialty appointment with elevated blood pressure. The nurse did not recheck the patient's blood pressure and did not notify the provider. Instead, the nurse released the patient back to his housing.

**Provider Performance**

SCC providers usually ordered proper referrals with the correct priority. The only provider deficiency related to specialty services was in case 12 when the provider should have requested an emergent evaluation of a suspected TIA. We discuss this case further in the *Quality of Provider Performance* indicator.

**Health Information Management**

SCC was able to retrieve nearly all specialty reports. Providers reviewed, signed, and communicated the specialty recommendations to their patients. However, there was one case in which the institution was unable to retrieve an important specialty report.

- In case 6, the patient saw a cardiologist and then saw an electrophysiologist (cardiology sub-specialist who treats problems with the heart's electrical system). SCC did not retrieve either of those reports.

**Clinician Onsite Inspection**

The specialty clinic used a log to track specialty appointments and reports. Specialty clinic staff retrieved and sent the reports to the primary care team and supervisors daily. The telemedicine and onsite specialty nurses were also diligent in obtaining reports and sending them to the providers. Even though SCC managers often redirected the specialty nurses to other clinical areas, the well-established specialty processes ensured that lapses in the transmission of the specialty reports were rare.

We asked about the missing specialty reports in case 6. SCC staff showed evidence that they attempted to retrieve the cardiology report eight times and the electrophysiology report four times. The institution explained that they had serious problems retrieving reports from that specific cardiology department, and the institution had already elevated the issue to the CCHCS utilization management advisor.

**Case Review Conclusion**

SCC provided excellent specialty services. Providers referred patients appropriately, and specialty access was timely. Specialty report handling was good, and the institution was not at fault for the missing specialty reports in the cases reviewed. Specialty nursing care was good. We rated this indicator *proficient*.

## *Compliance Testing Results*

The institution received an *adequate* compliance score of 81.9 percent in this indicator, with the following five tests scoring in the *proficient* range:

- For 14 of 15 patients sampled (93.3 percent), high-priority specialty services appointments occurred within 14 calendar days of the provider's order; one patient received his specialty service three days late (MIT 14.001).

- For 14 of 15 patients sampled (93.3 percent), routine specialty service appointments occurred within 90 calendar days of the provider's order. For one patient, the routine specialty service appointment was 20 days late (MIT 14.003).

- Providers reviewed specialists' reports timely following routine specialty service appointments in 13 of the 15 cases reviewed (86.7 percent). Providers reviewed two reports one and five days late (MIT 14.004).

- SCC's health care management timely denied providers' specialty services requests for 19 of 20 sampled patients (95.0 percent). For one patient, the institution denied a specialty services request one day late (MIT 14.006).

- For 20 patients sampled who had a specialty service denied by SCC's health care management, 19 (95.0 percent) received timely notification of the denied service, including having a provider meet with them within 30 days to discuss alternate treatment strategies. For one patient, there was no evidence the institution ever communicated the denial (MIT 14.007).

One test received an *adequate* score:

- Providers timely received and reviewed specialists' reports for 12 of 15 sampled patients (80.0 percent). For two patients, SCC received the specialist's report six and nine days late. For one patient, the provider reviewed the report nine days late (MIT 14.002).

One test received an *inadequate* score:

- When one institution approves and schedules a patient for specialty services and the patient transfers to another institution, CCHCS policy requires the receiving institution to reschedule and provide the appointments timely. Only 6 of the 20 patients sampled who transferred to SCC with an approved specialty service received their appointment within the required time (30.0 percent). For five patients, the appointments were 23, 51, 59, 87, and 134 days late. For eight patients, there was no evidence the appointments ever occurred. For one patient, the service did not occur and the provider did not timely see the patient (MIT 14.005).

## 15 — *ADMINISTRATIVE OPERATIONS (SECONDARY)*

***Case Review Rating:***
*Not Applicable*
***Compliance Score:***
*Inadequate*
*(74.4%)*
***Overall Rating:***
*Inadequate*

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

### *Compliance Testing Results*

The institution received an *inadequate* compliance score of 74.4 percent in this indicator with several tests scoring in the *inadequate* range:

- The institution did not meet the emergency response drill requirements for the most recent quarter, and as a result, the institution scored zero for this test. More specifically, none of the three watches' drill packages contained a Medical Report of Injury or Unusual Occurrence (CDCR Form 7219) or a Crime/Incident Report (CDCR Form 837). In addition, the second watch drill package did not include the participation of custody staff (MIT 15.101).

- We inspected records from August 2017 for five nurses to determine if their nursing supervisors properly completed monthly performance reviews. Inspectors identified the following deficiencies: the supervisor did not complete the number of reviews required for four nurses; and the supervisors' reviews did not summarize aspects of the nurses' care that were done well or that needed improvement for any of the five nurses (MIT 15.104).

- None of the six SCC providers had a proper clinical performance appraisal completed by their supervisor. For the six providers' clinical performance appraisals, the following deficiencies occurred (MIT 15.106):

- One provider's individual development plan was overdue by 35 days. In addition, the Unit Health Record Clinical Appraisal (UCA) was overdue 47 days, and there was no indication that the supervising physician discussed the UCA reviews with the provider.

- One provider's 360-degree evaluation was missing the date of completion.

- Four providers' UCAs did not indicate that the supervising physician discussed the reviews with them.

- Of the 12 incident packages sampled for emergency medical responses the institution's Emergency Medical Response Review Committee (EMRRC) reviewed during the prior 12-month period, 2 packages complied with CCHCS policy (16.7 percent). Ten of the incident review packages were not timely reviewed at the next corresponding EMRRC meeting (MIT 15.005).

The following 11 tests earned *proficient* scores:

- We reviewed data received from the institution to determine if SCC timely processed at least 95 percent of its monthly patient medical appeals during the most recent 12-month period. SCC timely processed all 12 months' appeals (MIT 15.001).

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

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

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

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

- All ten sampled nurses who administered medications possessed current clinical competency validations, and all nursing staff hired within the last year timely received new employee orientation training (MIT 15.105, 15.111).

- 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).

**Non-Scored Results**

- We gathered non-scored data regarding the completion of death review reports by CCHCS's Death Review Committee (DRC). One unexpected (Level 1) death occurred during our review period. CCHCS policy requires the DRC to complete its death review summary report within 60 calendar days from the date of death and submit the report to the institution's chief executive officer (CEO) within seven calendar days after that. However, the DRC completed its report seven days late (67 days after the death) and submitted it to SCC's CEO 16 days later (MIT 15.998).

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

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# RECOMMENDATIONS

- The CEO and chief medical executive (CME) should improve provider staffing and decrease the institution's reliance on a "rover" provider because the use of the rover provider resulted in poor provider continuity in all areas of the institution.

- The CEO should apply quality improvement methods to develop the institution's ability to properly care for patients transferring into SCC. In this inspection, we found numerous problems with the transfer-in process, including nurses failing to ensure that their transfer patients received provider and nurse follow-ups, the inability to maintain medication continuity, and the inability to provide specialty appointments for those patients who had pending specialty referrals.

- The chief nurse executive and the pharmacist in charge should implement quality improvement methods to correct the institution's ability to administer medications promptly for patients returning from an outside hospital and for those patients with prescriptions for new medications.

- The CEO should expand the institution's diagnostic report tracking system to improve its ability to retrieve, review, and communicate pathology reports because we found the institution had difficulty properly processing these important reports.

- The CEO should ensure that the institution's information technology department installs and verifies that all providers in all areas, including Yard C, are able to view images in the radiology system.

# POPULATION-BASED METRICS

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

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

## *Methodology*

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

## *Comparison of Population-Based Metrics*

For the Sierra Conservation Center, we selected nine HEDIS measures and listed them in the following *SCC Results Compared to State and National HEDIS Scores* table. Multiple health plans publish their HEDIS performance measures at the State and national levels. We provide 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, we 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.

When compared statewide, SCC outperformed most other reporting entities in all five diabetic measures. However, the institution scored lower than Kaiser, Northern and Southern California, for diabetic blood pressure control. When compared nationally, SCC outperformed Medicaid, commercial entities, and Medicare in all five diabetic measures. SCC scored slightly lower than the U.S. Department of Veterans Affairs (VA) for diabetic eye exams.

### Immunizations

Comparative data for immunizations was only fully available for the VA and partially available for Kaiser, commercial plans, Medicaid, and Medicare. With respect to administering influenza vaccinations to younger adults and 65 and older, SCC scored lower than all other reporting entities. The patient refusal rate for younger adults and 65 and older was 42 percent and 21 percent, respectively, which negatively affected the institution's score. SCC scored lower than both Medicare and the VA with regard to administering pneumococcal immunizations to older adults.

### Cancer Screening

With respect to colorectal cancer screening, SCC outperformed Kaiser (Northern California), commercial entities, and Medicare, and scored slightly lower than Kaiser (Southern California) and the VA. There was an 18 percent refusal rate for cancer screening prevention, which negatively impacted SCC's score.

### Summary

SCC's population-based metrics performance reflected a well-functioning chronic care program compared to other state and national health care entities. The institution may improve its scores for immunizations and cancer screenings by reducing patient refusals through patient education.

## SCC Results Compared to State and National HEDIS Scores

| Clinical Measures | California | | | | National | | | |
|---|---|---|---|---|---|---|---|---|
| | **SCC** Cycle 5 Results[1] | HEDIS Medi-Cal 2017[2] | HEDIS Kaiser (No. CA) 2016[3] | HEDIS Kaiser (So.CA) 2016[3] | HEDIS Medicaid 2017[4] | HEDIS Com-mercial 2017[4] | HEDIS Medicare 2017[4] | VA Average 2016[5] |
| **Comprehensive Diabetes Care** | | | | | | | | |
| HbA1c Testing (Monitoring) | **100%** | 87% | 94% | 94% | 87% | 91% | 94% | 99% |
| Poor HbA1c Control (>9.0%)[6, 7] | **8%** | 38% | 20% | 23% | 43% | 33% | 26% | 18% |
| HbA1c Control (<8.0%)[6] | **84%** | 52% | 70% | 63% | 47% | 56% | 63% | - |
| Blood Pressure Control (<140/90)[6] | **82%** | 63% | 83% | 83% | 60% | 62% | 64% | 76% |
| Eye Exams | **85%** | 57% | 68% | 81% | 55% | 54% | 70% | 89% |
| **Immunizations** | | | | | | | | |
| Influenza Shots - Adults (18–64) | **35%** | - | 56% | 57% | 39% | 48% | - | 52% |
| Influenza Shots - Adults (65+) | **57%** | - | - | - | - | - | 71% | 72% |
| Immunizations: Pneumococcal | **71%** | - | - | - | - | - | 74% | 93% |
| **Cancer Screening** | | | | | | | | |
| Colorectal Cancer Screening | **80%** | - | 79% | 82% | - | 62% | 67% | 82% |

1. Unless otherwise stated, data was collected in October 2017 by reviewing medical records from a sample of SCC'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 *Medi-Cal Managed Care External Quality Review Technical Report (July 1, 2016 - June 30, 2017)*.

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

4. National HEDIS data for Medicaid, commercial plans, and Medicare was obtained from the 2017 *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 SCC 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

| Sierra Conservation Center<br>Range of Summary Scores: 53.0% – 93.3% | |
|---|---|
| **Indicator** | **Compliance Score (Yes %)** |
| **1 –** ***Access to Care*** | 83.7% |
| **2 –** ***Diagnostic Services*** | 73.3% |
| **3 –** ***Emergency Services*** | Not Applicable |
| **4 –** ***Health Information Management*** | 91.4% |
| **5 –** ***Health Care Environment*** | 53.0% |
| **6 –** ***Inter- and Intra-System Transfers*** | 66.7% |
| **7 –** ***Pharmacy and Medication Management*** | 69.8% |
| **8 –** ***Prenatal and Post-Delivery Services*** | Not Applicable |
| **9 –** ***Preventive Services*** | 88.0% |
| **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)*** | 93.3% |
| **14 –** ***Specialty Services*** | 81.9% |
| **15 –** ***Administrative Operations*** | 74.4% |
| | |

| 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? | 20 | 5 | 25 | 80.0% | 0 |
| 1.002 | For endorsed patients received from another CDCR institution: If the nurse referred the patient to a provider during the initial health screening, was the patient seen within the required time frame? | 19 | 6 | 25 | 76.0% | 0 |
| 1.003 | Clinical appointments: Did a registered nurse review the patient's request for service the same day it was received? | 30 | 0 | 30 | 100.0% | 0 |
| 1.004 | Clinical appointments: Did the registered nurse complete a face-to-face visit within one business day after the CDCR Form 7362 was reviewed? | 21 | 9 | 30 | 70.0% | 0 |
| 1.005 | Clinical appointments: If the registered nurse determined a referral to a primary care provider was necessary, was the patient seen within the maximum allowable time or the ordered time frame, whichever is the shorter? | 14 | 3 | 17 | 82.4% | 13 |
| 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? | 3 | 1 | 4 | 75.0% | 26 |
| 1.007 | Upon the patient's discharge from the community hospital: Did the patient receive a follow-up appointment within the required time frame? | 10 | 0 | 10 | 100.0% | 1 |
| 1.008 | Specialty service follow-up appointments: Do specialty service primary care physician follow-up visits occur within required time frames? | 21 | 9 | 30 | 70.0% | 0 |
| 1.101 | Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms? | 4 | 0 | 4 | 100.0% | 0 |
| **Overall percentage:** | | | | | **83.7%** | |

| Reference Number | 2 – *Diagnostic Services* | Scored Answers | | | | N/A |
|---|---|---|---|---|---|---|
| | | Yes | No | Yes + No | Yes % | |
| 2.001 | Radiology: Was the radiology service provided within the time frame specified in the provider's order? | 10 | 0 | 10 | 100.0% | 0 |
| 2.002 | Radiology: Did the primary care provider review and initial the diagnostic report within specified time frames? | 9 | 1 | 10 | 90.0% | 0 |
| 2.003 | Radiology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames? | 8 | 2 | 10 | 80.0% | 0 |
| 2.004 | Laboratory: Was the laboratory service provided within the time frame specified in the provider's order? | 7 | 3 | 10 | 70.0% | 0 |
| 2.005 | Laboratory: Did the primary care provider review and initial the diagnostic report within specified time frames? | 9 | 1 | 10 | 90.0% | 0 |
| 2.006 | Laboratory: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames? | 5 | 5 | 10 | 50.0% | 0 |
| 2.007 | Pathology: Did the institution receive the final diagnostic report within the required time frames? | 5 | 5 | 10 | 50.0% | 0 |
| 2.008 | Pathology: Did the primary care provider review and initial the diagnostic report within specified time frames? | 7 | 3 | 10 | 70.0% | 0 |
| 2.009 | Pathology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames? | 6 | 4 | 10 | 60.0% | 0 |
| **Overall percentage:** | | | | | **73.3%** | |

## 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 health care documents (provider progress notes) scanned within 3 calendar days of the patient encounter date? | 5 | 0 | 5 | 100.0% | 0 |
| 4.002 | Are dictated/transcribed documents scanned into the patient's electronic health record within five calendar days of the encounter date? | Not Applicable | | | | |
| 4.003 | Are High-Priority specialty notes (either a Form 7243 or other scanned consulting report) scanned within the required time frame? | 15 | 5 | 20 | 75.0% | 0 |
| 4.004 | Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge? | 10 | 1 | 11 | 90.9% | 0 |
| 4.005 | Are medication administration records (MARs) scanned into the patient's electronic health record within the required time frames? | Not Applicable | | | | |
| 4.006 | During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files? | 24 | 0 | 24 | 100.0% | 0 |
| 4.007 | For patients discharged from a community hospital: Did the preliminary hospital discharge report include key elements and did a primary care provider review the report within three calendar days of discharge? | 10 | 1 | 11 | 90.9% | 0 |
| **Overall percentage:** | | | | | **91.4%** | |

| 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? | 8 | 1 | 9 | 88.9% | 0 |
| 5.102 | Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted? | 6 | 3 | 9 | 66.7% | 0 |
| 5.103 | Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies? | 8 | 1 | 9 | 88.9% | 0 |
| 5.104 | Does clinical health care staff adhere to universal hand hygiene precautions? | 6 | 3 | 9 | 66.7% | 0 |
| 5.105 | Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste? | 8 | 1 | 9 | 88.9% | 0 |
| 5.106 | Warehouse, Conex and other non-clinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program? | 0 | 1 | 1 | 0.0% | 0 |
| 5.107 | Does each clinic follow adequate protocols for managing and storing bulk medical supplies? | 2 | 7 | 9 | 22.2% | 0 |
| 5.108 | Do clinic common areas and exam rooms have essential core medical equipment and supplies? | 3 | 6 | 9 | 33.3% | 0 |
| 5.109 | Do clinic common areas have an adequate environment conducive to providing medical services? | 6 | 3 | 9 | 66.7% | 0 |
| 5.110 | Do clinic exam rooms have an adequate environment conducive to providing medical services? | 1 | 8 | 9 | 11.1% | 0 |
| 5.111 | Emergency response bags: Are TTA and clinic emergency medical response bags inspected daily and inventoried monthly, and do they contain essential items? | 3 | 3 | 6 | 50.0% | 3 |
| **Overall percentage:** | | | | | **53.0%** | |

| 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? | 25 | 0 | 25 | 100.0% | 0 |
| 6.002 | For endorsed patients received from another CDCR institution or COCF: When required, did the RN complete the assessment and disposition section of the health screening form; refer the patient to the TTA, if TB signs and symptoms were present; and sign and date the form on the same day staff completed the health screening? | 25 | 0 | 25 | 100.0% | 0 |
| 6.003 | For endorsed patients received from another CDCR institution or COCF: If the patient had an existing medication order upon arrival, were medications administered or delivered without interruption? | 4 | 2 | 6 | 66.7% | 19 |
| 6.004 | For patients transferred out of the facility: Were scheduled specialty service appointments identified on the patient's health care transfer information form? | Not Applicable | | | | |
| 6.101 | For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents? | 0 | 4 | 4 | 0.0% | 6 |
| **Overall percentage:** | | | | | **66.7%** | |

| 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? | 23 | 1 | 24 | 95.8% | 1 |
| 7.002 | Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames? | 16 | 9 | 25 | 64.0% | 0 |
| 7.003 | Upon the patient's discharge from a community hospital: Were all ordered medications administered, made available, or delivered to the patient within required time frames? | 5 | 6 | 11 | 45.5% | 0 |
| 7.004 | For patients received from a county jail: Were all medications ordered by the institution's reception center provider administered, made available, or delivered to the patient within the required time frames? | Not Applicable | | | | |
| 7.005 | Upon the patient's transfer from one housing unit to another: Were medications continued without interruption? | 24 | 1 | 25 | 96.0% | 0 |
| 7.006 | For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption? | Not Applicable | | | | |
| 7.101 | All clinical and medication line storage areas for narcotic medications: Does the Institution employ strong medication security over narcotic medications assigned to its clinical areas? | 3 | 5 | 8 | 37.5% | 1 |
| 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? | 6 | 2 | 8 | 75.0% | 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? | 5 | 4 | 9 | 55.6% | 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? | 3 | 3 | 6 | 50.0% | 3 |
| 7.105 | Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients? | 5 | 1 | 6 | 83.3% | 3 |
| 7.106 | Medication preparation and administration areas: Does the Institution employ appropriate administrative controls and protocols when distributing medications to patients? | 3 | 3 | 6 | 50.0% | 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 | 100.0% | 0 |

| Reference Number | 7 – *Pharmacy and Medication Management* | Scored Answers | | | | N/A |
|---|---|---|---|---|---|---|
| | | Yes | No | Yes + No | Yes % | |
| 7.108 | Pharmacy: Does the institution's pharmacy properly store non-refrigerated medications? | 1 | 0 | 1 | 100.0% | 0 |
| 7.109 | Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications? | 1 | 0 | 1 | 100.0% | 0 |
| 7.110 | Pharmacy: Does the institution's pharmacy properly account for narcotic medications? | 0 | 1 | 1 | 0.0% | 0 |
| 7.111 | Does the institution follow key medication error reporting protocols? | 17 | 1 | 18 | 94.4% | 7 |
| **Overall percentage:** | | | | | **69.8%** | |

## 8 – *Prenatal and Post-Delivery Services*

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

| Reference Number | 9 – *Preventive Services* | Scored Answers | | | | N/A |
|---|---|---|---|---|---|---|
| | | Yes | No | Yes + No | Yes % | |
| 9.001 | Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed? | 25 | 0 | 25 | 100.0% | 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? | 16 | 9 | 25 | 64.0% | 0 |
| 9.003 | Annual TB Screening: Was the patient screened for TB within the last year? | 25 | 5 | 30 | 83.3% | 0 |
| 9.004 | Were all patients offered an influenza vaccination for the most recent influenza season? | 23 | 2 | 25 | 92.0% | 0 |
| 9.005 | All patients from the age of 50 - 75: Was the patient offered colorectal cancer screening? | 25 | 0 | 25 | 100.0% | 0 |
| 9.006 | Female patients from the age of 50 through the age of 74: Was the patient offered a mammogram in compliance with policy? | Not Applicable | | | | |
| 9.007 | Female patients from the age of 21 through the age of 65: Was patient offered a pap smear in compliance with policy? | Not Applicable | | | | |
| 9.008 | Are required immunizations being offered for chronic care patients? | 8 | 1 | 9 | 88.9% | 16 |
| 9.009 | Are patients at the highest risk of coccidioidomycosis (valley fever) infection transferred out of the facility in a timely manner? | Not Applicable | | | | |
| **Overall percentage:** | | | | | **88.0%** | |

## 10 – *Quality of Nursing Performance*

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

## 11 – *Quality of Provider Performance*

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

## 12 – *Reception Center Arrivals*

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

| Reference Number | 13 – *Specialized Medical Housing* | Scored Answers | | | | N/A |
|---|---|---|---|---|---|---|
| | | Yes | No | Yes + No | Yes % | |
| 13.001 | For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient on the day of admission, or within eight hours of admission to CMF's Hospice? | 10 | 0 | 10 | 100.0% | 0 |
| 13.002 | For CTC and SNF only: Was a written history and physical examination completed within the required time frame? | Not Applicable | | | | |
| 13.003 | For OHU, CTC, SNF, and Hospice: Did the primary care provider complete the Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes on the patient at the minimum intervals required for the type of facility where the patient was treated? | 8 | 2 | 10 | 80.0% | 0 |
| 13.101 | For OHU and CTC only: Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter patient's cells? | 1 | 0 | 1 | 100.0% | 0 |
| **Overall percentage:** | | | | | **93.3%** | |

| Reference Number | 14 – *Specialty Services* | Scored Answers | | | | N/A |
|---|---|---|---|---|---|---|
| | | Yes | No | Yes + No | Yes % | |
| 14.001 | Did the patient receive the high-priority specialty service within 14 calendar days of the primary care provider order or the Physician Request for Service? | 14 | 1 | 15 | 93.3% | 0 |
| 14.002 | Did the primary care provider review the high-priority specialty service consultant report within the required time frame? | 12 | 3 | 15 | 80.0% | 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? | 14 | 1 | 15 | 93.3% | 0 |
| 14.004 | Did the primary care provider review the routine specialty service consultant report within the required time frame? | 13 | 2 | 15 | 86.7% | 0 |
| 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? | 6 | 14 | 20 | 30.0% | 0 |
| 14.006 | Did the institution deny the primary care provider request for specialty services within required time frames? | 19 | 1 | 20 | 95.0% | 0 |
| 14.007 | Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame? | 19 | 1 | 20 | 95.0% | 0 |
| **Overall percentage:** | | | | | **81.9%** | |

| Reference Number | 15 – *Administrative Operations* | Scored Answers | | | | N/A |
|---|---|---|---|---|---|---|
| | | Yes | No | Yes + No | Yes % | |
| 15.001 | Did the institution promptly process inmate medical appeals during the most recent 12 months? | 12 | 0 | 12 | 100.0% | 0 |
| 15.002 | Does the institution follow adverse / sentinel event reporting requirements? | Not Applicable | | | | |
| 15.003 | Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified? | 6 | 0 | 6 | 100.0% | 0 |
| 15.004 | Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting? | 1 | 0 | 1 | 100.0% | 0 |
| 15.005 | Does the Emergency Medical Response Review Committee perform timely incident package reviews that include the use of required review documents? | 2 | 10 | 12 | 16.7% | 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? | Not Applicable | | | | |
| 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 | 0.0% | 0 |
| 15.102 | Did the institution's second level medical appeal response address all of the patient's appealed issues? | 10 | 0 | 10 | 100.0% | 0 |
| 15.103 | Did the institution's medical staff review and submit the initial inmate death report to the Death Review Unit in a timely manner? | 1 | 0 | 1 | 100.0% | 9 |
| 15.104 | Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff? | 0 | 5 | 5 | 0.0% | 0 |
| 15.105 | Are nursing staff who administer medications current on their clinical competency validation? | 10 | 0 | 10 | 100.0% | 0 |
| 15.106 | Are structured clinical performance appraisals completed timely? | 0 | 6 | 6 | 0.0% | 6 |
| 15.107 | Do all providers maintain a current medical license? | 7 | 0 | 7 | 100.0% | 0 |
| 15.108 | Are staff current with required medical emergency response certifications? | 2 | 0 | 2 | 100.0% | 1 |
| 15.109 | Are nursing staff and the Pharmacist-in-Charge current with their professional licenses and certifications, and is the pharmacy licensed as a correctional pharmacy by the California State Board of Pharmacy? | 6 | 0 | 6 | 100.0% | 1 |

| Reference Number | 15 – *Administrative Operations* | Scored Answers | | | | N/A |
|---|---|---|---|---|---|---|
| | | Yes | No | Yes + No | Yes % | |
| 15.110 | Do the institution's pharmacy and authorized providers who prescribe controlled substances maintain current Drug Enforcement Agency (DEA) registrations? | 1 | 0 | 1 | 100.0% | 0 |
| 15.111 | Are nursing staff current with required new employee orientation? | 1 | 0 | 1 | 100.0% | 0 |
| **Overall percentage:** | | | | | **74.4%** | |

# APPENDIX B — CLINICAL DATA

**Table B-1: SCC Sample Sets**

| Sample Set | Total |
|---|---|
| Anticoagulation | 2 |
| CTC/OHU | 3 |
| Diabetes | 3 |
| Emergency Services – Non-CPR | 3 |
| High Risk | 5 |
| Hospitalization | 4 |
| Intra-System Transfers In | 3 |
| Intra-System Transfers Out | 3 |
| RN Sick Call | 18 |
| Specialty Services | 3 |
| | **47** |

## Table B-2: SCC Chronic Care Diagnoses

| Diagnosis | Total |
|---|---|
| Anemia | 5 |
| Anticoagulation | 2 |
| Arthritis/Degenerative Joint Disease | 1 |
| Asthma | 6 |
| COPD | 3 |
| Cancer | 1 |
| Cardiovascular Disease | 3 |
| Chronic Kidney Disease | 1 |
| Chronic Pain | 3 |
| Cirrhosis/End-Stage Liver Disease | 3 |
| Deep Venous Thrombosis/Pulmonary Embolism | 1 |
| Diabetes | 16 |
| Gastroesophageal Reflux Disease | 7 |
| Hepatitis C | 13 |
| Hyperlipidemia | 14 |
| Hypertension | 22 |
| Mental Health | 2 |
| Migraine Headaches | 1 |
| Seizure Disorder | 3 |
| Thyroid Disease | 1 |
| | **108** |

## Table B-3: SCC Event – Program

| Diagnosis | Total |
|---|---|
| Diagnostic Services | 144 |
| Emergency Care | 51 |
| Hospitalization | 28 |
| Intra-System Transfers In | 7 |
| Intra-System Transfers Out | 4 |
| Outpatient Care | 429 |
| Specialized Medical Housing | 102 |
| Specialty Services | 132 |
| | **897** |

## Table B-4: SCC Review Sample Summary

| | Total |
|---|---|
| MD Reviews Detailed | 20 |
| MD Reviews Focused | 2 |
| RN Reviews Detailed | 12 |
| RN Reviews Focused | 27 |
| Total Reviews | 61 |
| Total Unique Cases | 47 |
| Overlapping Reviews (MD & RN) | 14 |

# APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

## Sierra Conservation Center

| 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)<br>• **Randomize** |
| MIT 1.002 | Nursing Referrals (25) | OIG Q: 6.001 | • See ***Intra-system Transfers*** |
| MITs 1.003–006 | Nursing Sick Call (5 per clinic) (30) | MedSATS | • Clinic (each clinic tested)<br>• Appointment date (2–9 months)<br>• **Randomize** |
| MIT 1.007 | Returns from Community Hospital (11) | 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 (4) | 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)<br>• **Randomize**<br>• Abnormal |
| MITs 2.004–006 | Laboratory (10) | Quest | • Appt. date (90 days–9 months)<br>• Order name (CBC or CMPs only)<br>• **Randomize**<br>• Abnormal |
| MITs 2.007–009 | Pathology (10) | InterQual | • Appt. date (90 days–9 months)<br>• Service (pathology related)<br>• **Randomize** |

| Quality Indicator | Sample Category (number of samples) | Data Source | Filters |
|---|---|---|---|
| ***Health Information Management (Medical Records)*** | | | |
| MIT 4.001 | Timely Scanning (5) | OIG Qs: 1.001, 1.002, & 1.004 | • Non-dictated documents<br>• 1st 10 IPs MIT 1.001, 1st 5 IPs MITs 1.002, 1.004 |
| MIT 4.002 | (0) | OIG Q: 1.001 | • Dictated documents<br>• First 20 IPs selected |
| MIT 4.003 | (20) | OIG Qs: 14.002 & 14.004 | • Specialty documents<br>• First 10 IPs for each question |
| MIT 4.004 | (11) | OIG Q: 4.007 | • Community hospital discharge documents<br>• First 20 IPs selected |
| MIT 4.005 | (0) | OIG Q: 7.001 | • MARs<br>• First 20 IPs selected |
| MIT 4.006 | (0) | 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 (11) | Inpatient claims data | • Date (2–8 months)<br>• Most recent 6 months provided (within date range)<br>• Rx count<br>• Discharge date<br>• **Randomize** (each month individually)<br>• 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<br>MIT 5.107–111 | Clinical Areas (9) | 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)<br>• Arrived from (another CDCR facility)<br>• Rx count<br>• **Randomize** |
| MIT 6.004 | Specialty Services Send-Outs (0) | MedSATS | • Date of transfer (3–9 months)<br>• **Randomize** |
| MIT 6.101 | Transfers Out (10) | OIG inspector onsite review | • R&R IP transfers with medication |

| Quality Indicator | Sample Category (number of samples) | Data Source | Filters |
|---|---|---|---|
| ***Pharmacy and Medication Management*** | | | |
| MIT 7.001 | Chronic Care Medication<br>(25) | OIG Q: 1.001 | *See* ***Access to Care***<br>• At least one condition per patient—any risk level<br>• **Randomize** |
| MIT 7.002 | New Medication Orders<br>(25) | Master Registry | • Rx count<br>• **Randomize**<br>• Ensure no duplication of IPs tested in MIT 7.001 |
| MIT 7.003 | Returns from Community Hospital<br>(11) | OIG Q: 4.007 | • See ***Health Information Management (Medical Records)*** *(returns from community hospital)* |
| MIT 7.004 | RC Arrivals – Medication Orders<br>*(N/A at this institution)* | OIG Q: 12.001 | • See ***Reception Center Arrivals*** |
| MIT 7.005 | Intra-Facility Moves<br>(25) | MAPIP transfer data | • Date of transfer (2–8 months)<br>• To location/from location (yard to yard and to/from ASU)<br>• Remove any to/from MHCB<br>• NA/DOT meds (and risk level)<br>• **Randomize** |
| MIT 7.006 | En Route<br>(0) | SOMS | • Date of transfer (2–8 months)<br>• Sending institution (another CDCR facility)<br>• **Randomize**<br>• NA/DOT meds |
| MITs 7.101–103 | Medication Storage Areas<br>(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<br>(varies by test) | OIG inspector onsite review | • Identify and inspect onsite clinical areas that prepare and administer medications |
| MITs 7.107–110 | Pharmacy<br>(1) | OIG inspector onsite review | • Identify & inspect all onsite pharmacies |
| MIT 7.111 | Medication Error Reporting<br>(18) | Monthly medication error reports | • All monthly statistic reports with Level 4 or higher<br>• Select a total of 5 months |
| MIT 7.999 | Isolation Unit KOP Medications<br>(4) | Onsite active medication listing | • KOP rescue inhalers & nitroglycerin medications for IPs housed in isolation units |
| ***Prenatal and Post-Delivery Services*** | | | |
| MIT 8.001–007 | Recent Deliveries<br>*(N/A at this institution)* | OB Roster | • Delivery date (2–12 months)<br>• **Most recent** deliveries (within date range) |
| | Pregnant Arrivals<br>*(N/A at this institution)* | OB Roster | • Arrival date (2–12 months)<br>• **Earliest** arrivals (within date range) |

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

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

| Quality Indicator | Sample Category (number of samples) | Data Source | Filters |
|---|---|---|---|
| ***Administrative Operations*** | | | |
| MIT 15.001 | Medical Appeals (all) | Monthly medical appeals reports | • Medical appeals (12 months) |
| MIT 15.002 | Adverse/Sentinel Events (0) | Adverse/sentinel events report | • Adverse/sentinel events (2–8 months) |
| MITs 15.003–004 | QMC Meetings (6) | Quality Management Committee meeting minutes | • Meeting minutes (12 months) |
| MIT 15.005 | EMRRC (12) | EMRRC meeting minutes | • Monthly meeting minutes (6 months) |
| MIT 15.006 | LGB (0) | 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<br>• 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 (1) | Institution-list of deaths in prior 12 months | • Most recent 10 deaths<br>• 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<br>• **Randomize** |
| MIT 15.105 | Nursing Staff Validations (10) | Onsite nursing education files | • On duty one or more years<br>• Nurse administers medications<br>• **Randomize** |
| MIT 15.106 | Provider Annual Evaluation Packets (6) | Onsite provider evaluation files | • All required performance evaluation documents |
| MIT 15.107 | Provider licenses (7) | Current provider listing (at start of inspection) | • Review all |
| MIT 15.108 | Medical Emergency Response Certifications (all) | Onsite certification tracking logs | • All staff<br>  ○ Providers (ACLS)<br>  ○ Nursing (BLS/CPR)<br>• 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<br><br>(all) | Onsite listing of provider DEA registration #s & pharmacy registration document | • All DEA registrations |
| MIT 15.111 | Nursing Staff New Employee Orientations<br>(all) | Nursing staff training logs | • New employees (hired within last 12 months)<br>• |
| MIT 15.998 | Death Review Committee<br>(1) | OIG summary log - deaths | • Between 35 business days & 12 months prior<br>• CCHCS death reviews |
| | | | |

# CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

August 22, 2018

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

Dear Mr. Wesley:

The Office of the Receiver has reviewed the draft report of the Office of the Inspector General (OIG) Medical Inspection Results for Sierra Conservation Center (SCC) conducted from October 2017 to February 2018. California Correctional Health Care Services (CCHCS) acknowledges the OIG findings.

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

Sincerely,

for

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

cc: Diana Toche, D.D.S., Undersecretary, Health Care Services, CDCR
Clark Kelso, Receiver
Richard Kirkland, Chief Deputy Receiver
Stephen Tseng, M.D., Chief of Medical Inspections, OIG
Penny Horper, R.N., MSN, CPHQ, Nurse Consultant Program Review, OIG
Yulanda Mynhier, Director, Health Care Policy and Administration, CCHCS
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