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Inspector General

Office of the Inspector General

Salinas Valley State Prison
Medical Inspection Results
Cycle 5

October 2017

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

Office of the Inspector General
SALINAS VALLEY STATE PRISON
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FOREWORD

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

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

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

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

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EXECUTIVE SUMMARY

OVERALL RATING:

Inadequate

The OIG performed its Cycle 5 medical inspection at Salinas Valley State Prison (SVSP) from April to June 2017. The inspection included in-depth reviews of 61 patient files conducted by clinicians, as well as reviews of documents from 404 patient files, covering 90 objectively scored tests of compliance with policies and procedures applicable to the delivery of medical care. The OIG assessed the case review and compliance results at SVSP using 13 health care quality indicators applicable to the institution. To conduct clinical case reviews, the OIG employs a clinician team consisting of a physician and a registered nurse consultant, while compliance testing is done by a team of registered nurses trained in monitoring medical policy compliance. Of the indicators, seven were rated by both case review clinicians and compliance inspectors, three were rated by case review clinicians only, and three were rated by compliance inspectors only. The *SVSP Executive Summary Table* on the following page identifies the applicable individual indicators and scores for this institution.

SVSP Executive Summary Table

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

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

Clinical Case Review and OIG Clinician Inspection Results

The clinicians' case reviews sampled patients with high medical needs and included a review of 1,229 patient care events.[1] Of the 13 indicators applicable to SVSP, 10 were evaluated by clinician case review; all 10 were *inadequate*. When determining the overall adequacy of care, the OIG paid particular attention to the clinical nursing and provider quality indicators, as adequate health care staff can sometimes overcome suboptimal processes and programs. However, the opposite is not true; inadequate health care staff cannot provide adequate care, even though the established processes and programs onsite may be adequate. The OIG clinicians identify inadequate medical care based on the risk of significant harm to the patient, not the actual outcome.

Program Strengths — Clinical

- At the onsite inspection, SVSP nurses reported improved morale due to improved staffing levels and the recent promotion of a new chief nursing executive (CNE) who understood SVSP's unique challenges. The nurses reported that their new CNE was committed to quality improvement and had gained support from the nursing managers.

- The providers also reported greatly improved morale due to the sudden influx of providers from the neighboring California Training Facility (CTF). The newly hired providers greatly relieved SVSP's critical provider shortage. The new chief physician and surgeon (CP&S) was believed to be fair and someone who brought a clear sense of direction for the provider group.

Program Weaknesses — Clinical

SVSP's improved staffing occurred after the case review period ended; thus, any benefit from the staffing improvement was not apparent in the case reviews. Indeed, the case review period covered a time when SVSP leadership reported that their staff shortages were the most severe. The OIG clinicians identified the following concerns as the most pressing barriers to health care at SVSP:

- During the review period, SVSP clinicians provided poor access to care. This issue was ubiquitous throughout the case reviews.

- Clinical staff at the institution had trouble reliably performing diagnostic tests that a provider ordered. They also had difficulty retrieving, reviewing, and placing completed tests into the medical record.

- SVSP demonstrated a pattern of delayed emergency response and poor emergency nursing performance.

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

- Serious problems were found at SVSP with inter-departmental transmission, hospital record retrieval, and specialty report retrieval.

- SVSP nurses continued to perform poorly in nursing assessment, nursing intervention, and nursing documentation in most areas of the institution, including the TTA, the outpatient clinics, and the CTC.

- SVSP providers had problems with provider assessment, decision-making, record review, unintended errors, continuity, and anticoagulation services.

Compliance Testing Results

Of the 13 health care indicators applicable to SVSP, 10 were evaluated by compliance inspectors.[2] Of these, one was *proficient*, one was *adequate*, and eight were *inadequate*. Within those 10 indicators, 90 individual compliance questions generated 1,161 data points, which tested SVSP's compliance with California Correctional Health Care Services (CCHCS) policies and procedures.[3] Those 90 questions are detailed in *Appendix A — Compliance Test Results*.

Program Strengths — Compliance

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

- Nursing staff reviewed patient requests for health care services the same day they were received.

- Patients received their chronic care and new medication orders within required time frames.

- The institution performed well with preventive services by timely administering tuberculosis (TB) medications and properly monitoring those patients taking the medications. Patients received timely annual TB screenings; in addition, they were offered immunizations and cancer screenings.

- SVSP processed patient medical appeals timely and addressed all second-level patient medical appeals.

[2] The OIG's compliance inspectors 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.

Program Weaknesses — Compliance

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

- Patients did not always receive their chronic care follow-up appointments within required time frames, and patients who transferred into SVSP from other CDCR institutions did not always receive their nurse referral appointments to see a provider.

- Providers performed poorly when communicating the results of diagnostic services to patients within required time frames.

- Several clinic locations did not follow adequate medical supply storage and management protocols, and most clinic locations did not have essential core medical equipment and supplies. In addition, all emergency response medical bags (ERMBs) inspected were not compliant, with several bags found that were not properly inspected or were missing essential items.

- Several clinic and medication line locations did not properly store non-narcotic medications that required both refrigeration and non-refrigeration.

- SVSP did not always provide patients their high-priority specialty service appointments timely, and the institution did not always receive, or providers did not always review, specialty service reports within required time frames.

Recommendations

The OIG recommends that SVSP leadership implement effective care management and care coordination processes for the institution's patients, so nurses can make appropriate interventions for their chronic care patients when needed.

The OIG recommends that SVSP provide training to nurses to improve their recognition of sick call requests requiring same-day evaluation, improve their quality of assessments, and improve the accuracy of their documentation.

Population-Based Metrics

In general, SVSP performed well as measured by population-based metrics in comparison to the other state and national health care plans reviewed. In comprehensive diabetes care, SVSP outperformed both statewide and national plans in most diabetic measures, while performing less well than only Kaiser for blood pressure control. With regard to immunizations and colon cancer screenings, the institution performed similarly to other statewide and national health care plans. High patient refusal rates for both immunization and colon cancer screening services negatively affected the institution's score, and the institution could improve its score in these measures by educating patients on the benefits of these preventive services.

INTRODUCTION

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

Salinas Valley State Prison (SVSP) was the 11th 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 purely administrative and is not reflective of the actual clinical care provided.

ABOUT THE INSTITUTION

SVSP is located on a 300-acre site five miles north of Soledad, in Monterey County. SVSP primarily houses Level 3 and Level 4 high-security patients. The institution runs clinics in five facilities where staff members handle non-urgent requests for medical care. Patients requiring urgent or emergent care are seen in the institution's triage and treatment area (TTA). SVSP also has a licensed correctional treatment center (CTC) for the provision of inpatient care. SVSP has been designated by California Correctional Health Care Services (CCHCS) as a "basic" care institution. Basic care institutions are those located in rural areas away from tertiary care centers and specialty care providers whose services would likely be used frequently by patients at higher medical risk.

On August 17, 2015, 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, SVSP's vacancy rate among medical managers, primary care providers, supervisors, and rank-and-file nurses was 23 percent in April 2017. The highest vacancy percentage was among primary care providers with a 57 percent vacancy rate, which equated to 6.5 vacant provider positions out of 11.5 authorized positions. SVSP also reported a 17 percent vacancy rate among rank-and-file nursing staff, which equated to 20.2 positions. In addition, six nursing staff members (6 percent) were on long-term medical leave.

SVSP Health Care Staffing Resources as of April 2017

	Management		Primary Care Providers		Nursing Supervisors		Nursing Staff		Totals	
Description	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Authorized Positions	5	3%	11.5	8%	14.3	10%	117.1	79%	147.9	100%
Filled Positions	5	100%	5	43%	7	49%	96.9	83%	113.9	77%
Vacancies	0	0%	6.5	57%	7.3	51%	20.2	17%	34	23%
Recent Hires (within 12 months)	5	100%	3	60%	2	29%	21	22%	31	27%
Staff Utilized from Registry	0	0%	0	0%	0	0%	0	0%	0	0%
Redirected Staff (to Non-Patient Care Areas)	0	0%	0	0%	0	0%	0	0%	0	0%
Staff on Long-term Medical Leave	0	0%	0	0%	0	0%	6	6%	6	5%

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

As of April 4, 2017, the Master Registry for SVSP showed that the institution had a total population of 3,466. Within that total population, 4.2 percent was designated as high medical risk, Priority 1 (High 1), and 8.1 percent was designated as high medical risk, Priority 2 (High 2). Patients' assigned risk levels are based on the complexity of their required medical care related to their specific diagnoses, frequency of higher levels of care, age, and abnormal laboratory results and procedures. High 1 has at least two high-risk conditions; High 2 has only one. Patients at high medical risk are more susceptible to poor health outcomes than are those at medium or low medical risk. Patients at high medical risk also typically require more health care services than do patients with lower assigned risk levels. The chart below illustrates the breakdown of the institution's medical risk levels at the start of the OIG medical inspection.

SVSP Master Registry Data as of April 4, 2017

Medical Risk Level	Number of Patients	Percentage
High 1	145	4.2%
High 2	280	8.1%
Medium	1,791	51.7%
Low	1,250	36.1%
Total	**3,466**	**100%**

OBJECTIVES, SCOPE, AND METHODOLOGY

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

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

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

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

In all areas, the OIG is alert for opportunities to make appropriate recommendations for improvement. Such opportunities may be present regardless of the score awarded to any particular

quality indicator; therefore, recommendations for improvement should not necessarily be interpreted as indicative of deficient medical care delivery.

CASE REVIEWS

The OIG added case reviews to the Cycle 4 medical inspections at the recommendation of its stakeholders, which continues in Cycle 5 medical inspections. The OIG's clinicians perform a retrospective chart review of selected patient files to evaluate the care given by an institution's primary care providers and nurses. Retrospective chart review is a well-established review process used by health care organizations that perform peer reviews and patient death reviews. Currently, CCHCS uses retrospective chart review as part of its death review process and in its pattern-of-practice reviews. CCHCS also uses a more limited form of retrospective chart review when performing appraisals of individual primary care providers.

Patient Selection for Retrospective Case Reviews

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

1. The goal of retrospective chart review is to evaluate all aspects of the health care system. Statewide, high-risk and high-utilization patients consume medical services at a disproportionate rate; 11 percent of the total patient population is considered 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 chart review provides a significantly greater opportunity to evaluate all the various aspects of the health care delivery system at an institution.

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

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

2. The health of less complex patients is more likely to be affected by processes such as timely appointment scheduling, medication management, routine health screening, and

immunizations. To review these processes, the OIG simultaneously performs a broad compliance review.

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

Benefits and Limitations of Targeted Subpopulation Review

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

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

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

Case Reviews Sampled

As indicated in *Appendix B, Table B-1: SVSP Sample Sets*, the OIG clinicians evaluated medical charts for 61 unique patients. *Appendix B, Table B-4: SVSP Case Review Sample Summary* clarifies that both nurses and physicians reviewed charts for 14 of those patients, for 75 reviews in total. Physicians performed detailed reviews of 25 charts, and nurses performed detailed reviews of

15 charts, totaling 40 detailed reviews. For detailed case reviews, physicians or nurses looked at all encounters occurring in approximately six months of medical care. Nurses also performed a limited or focused review of medical records for an additional 34 patients. These generated 1,229 clinical events for review (*Appendix B, Table B-3: SVSP 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 six chronic care patient records, i.e., 3 diabetes patients and 3 anticoagulation patients (*Appendix B, Table B-1: SVSP Sample Sets*), the 61 unique sampled patients included those with 248 chronic care diagnoses, including 14 additional patients with diabetes (for a total of 17) and 3 additional anticoagulation patients (for a total of 6) (*Appendix B, Table B-2: SVSP Chronic Care Diagnoses*). The OIG's sample selection tool allowed evaluation of many chronic care programs because the complex and high-risk patients selected from the different categories often had multiple medical problems. While the OIG did not evaluate every chronic disease or health care staff member, the overall operation of the institution's system and staff was assessed for adequacy.

The OIG's case review methodology and sample size matched other qualitative research. The empirical findings, supported by expert statistical consultants, showed adequate conclusions after 10 to 15 charts had undergone full clinician review. In qualitative statistics, this phenomenon is known as "saturation." The OIG found the Cycle 4 medical inspection sample size of 30 for detailed physician reviews far exceeded the saturation point necessary for an adequate qualitative review. At the end of Cycle 4 inspections, the case review results were re-analyzed using 50 percent of the cases; there were no significant differences in the ratings. To improve inspection efficiency while preserving the quality of the inspection, the samples for Cycle 5 medical inspections were reduced in number. In Cycle 5, for basic institutions with small high-risk populations, case review will use a sample size of detailed physician-reviewed cases 67 percent as large as that used in Cycle 4. For intermediate institutions and basic institutions housing many high-risk patients, case review physicians will use a sample 83 percent as large as that in Cycle 4. For SVSP, the OIG used an 83 percent case review sample size, compared to Cycle 4, because it had many high-risk patients. Finally, for the most medically complex institution, California Health Care Facility (CHCF), the OIG will continue to use a sample size 100 percent as large as that used in Cycle 4.

With regard to reviewing charts from different providers, the case review is not intended to be a focused search for poorly performing providers; rather, it is focused on how the system cares for those patients who need care the most. Nonetheless, while not sampling cases by each provider at the institution, the OIG inspections adequately review most providers. Providers would only escape OIG case review if institutional management successfully mitigated patient risk by having the more poorly performing providers care for the less complicated, low-utilizing, and lower-risk patients. The OIG's clinicians concluded that the case review sample size was more than adequate to assess the quality of services provided.

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

COMPLIANCE TESTING

Sampling Methods for Conducting Compliance Testing

From April to June 2017, registered nurse inspectors obtained answers to 90 objective medical inspection test (MIT) questions designed to assess the institution's compliance with critical policies and procedures applicable to the delivery of medical care. To conduct most tests, inspectors randomly selected samples of patients for whom the testing objectives were applicable and reviewed their electronic unit health records. In some cases, inspectors used the same samples to conduct more than one test. In total, inspectors reviewed health records for 404 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 April 17, 2017, registered nurse field inspectors conducted a detailed onsite inspection of SVSP's medical facilities and clinics; interviewed key institutional employees; and reviewed employee records, logs, medical appeals, death reports, and other documents. This generated 1,161 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 SVSP's plant infrastructure, protocols for tracking medical appeals and local operating procedures, and staffing resources.

For Cycle 5 medical inspection testing, the OIG reduced the number of compliance samples tested for 18 indicator tests from a sample of 30 patients to a sample of 25 patients. The OIG also removed some inspection tests upon stakeholder agreement that either were duplicated in the case reviews or had limited value. Lastly, for Cycle 4 medical inspections, the OIG tested two secondary (administrative) indicators, *Internal Monitoring, Quality Improvement, and Administrative Operations*; and *Job Performance, Training, Licensing, and Certifications*, and have combined these tests into one *Administrative Operations* indicator for Cycle 5 inspections.

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

Scoring of Compliance Testing Results

After compiling the answers to the 90 questions for the 10 applicable indicators, the OIG derived a score for each quality indicator by calculating the percentage score of all *Yes* answers for each of the questions applicable to a particular indicator, then averaging those scores. Based on those results, the OIG assigned a rating to each quality indicator of *proficient* (greater than 85 percent), *adequate* (between 75 percent and 85 percent), or *inadequate* (less than 75 percent).

OVERALL QUALITY INDICATOR RATING FOR CASE REVIEWS AND COMPLIANCE TESTING

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

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

POPULATION-BASED METRICS

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

MEDICAL INSPECTION RESULTS

The quality indicators assess the clinical aspects of health care. As shown on the *SVSP Executive Summary Table* on page *iv* of this report, 13 of the OIG's indicators were applicable to SVSP. Of those 13 indicators, 7 were rated by both the case review and compliance components of the inspection, 3 were rated by the case review component alone, and 3 were rated by the compliance component alone. The *Administrative Operations* indicator is a secondary indicator and, therefore, was not relied upon for the overall score for the institution. Based on this analysis and the results of the case review and compliance testing, the OIG made a considered and measured opinion that the quality of health care at SVSP was ***inadequate***.

Summary of Case Review Results: The clinical case review component assessed ten primary (clinical) indicators applicable to SVSP. Of these ten indicators, OIG clinicians rated all *inadequate*.

The OIG physicians rated the overall adequacy of care for each of the 25 detailed case reviews they conducted. Of these 25 cases, 16 were *adequate*, and 9 were *inadequate*. In the 1,229 events reviewed, there were 504 deficiencies, of which 245 were considered to be of such magnitude that, if left unaddressed, they would likely contribute to patient harm.

Adverse Events Identified During Case Review: Adverse events are medical errors that cause or have the potential to cause 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. Adverse events are typically identified and tracked by all major health care organizations for the purpose of quality improvement. They are not generally representative of medical care delivered by the organization. The OIG identified adverse events for the dual purposes of quality improvement and the illustration of problematic patterns of practice found during the inspection. Because of the anecdotal nature of these events, the OIG cautions against drawing inappropriate conclusions regarding the institution based solely on adverse events. There were three adverse events identified in the case reviews at SVSP:

- In case 4, the patient transferred into SVSP with a lung mass and needed further evaluation. The provider ordered a biopsy of the lung mass with urgent priority (within two weeks), but the biopsy did not occur within the requested time frame. The patient's lung condition worsened, and he required hospitalization seven weeks later. While hospitalized, the patient had a lung biopsy performed. The delayed diagnosis likely contributed to the hospitalization. Had the mass been diagnosed as cancer, the delay could have resulted in even greater harm. This event is further discussed in the *Access to Care* and *Specialty Services* indicators.

- Also in case 4, the patient later developed complications from his chest surgery and developed a severe infection. He had an extremely rapid heart rate, as well as extremely low blood pressure and oxygen levels, and was in the imminently life-threatening condition called shock. Despite this emergent situation, SVSP medical staff waited 32 minutes before calling 9-1-1.This event is further discussed in the *Emergency Services* indicator.

- In case 13, the patient was sent from the clinic to the TTA for swelling in his right leg. The patient did not arrive in the TTA, however, for almost eight hours. When the TTA nurse assessed the patient, the nurse found that his right leg had signs of arterial blockage, a medical emergency. Even after this discovery, however, the TTA provider did not send the patient out immediately. Instead, the provider ordered a routine transportation to an outside hospital emergency room, which resulted in an additional two-hour TTA delay. The delays likely resulted in the subsequent partial amputation of the patient's right leg. This event is also discussed in the *Emergency Services* indicator.

Summary of Compliance Results: The compliance component assessed 10 of the 13 indicators applicable to SVSP. Of these 10 indicators, OIG inspectors rated one *proficient*, one *adequate*, and eight *inadequate*. The results of those assessments are summarized within this section of the report. The test questions used to assess compliance for each indicator are detailed in *Appendix A*.

1 — *ACCESS TO CARE*

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

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(66.1%)
Overall Rating:
Inadequate

Case Review Results

The OIG clinicians reviewed 485 provider, nurse, specialty, and hospital events requiring a follow-up appointment, and identified 101 deficiencies relating to *Access to Care*. Of those, 61 were significant, and were identified once each in cases 3, 8, 14, 19, 24, 29, 36, 51, 53, 54 and 61; two times in cases 5, 9, 10, 38, and 39; three times in cases 15, 16, 17, 18, and 25; four times in case 6; five times in cases 4, 11, and 13; and six times in case 12. Poor health care access affected nearly all aspects of health care delivery at SVSP. This access issue is discussed further in each relevant indicator. Compared to Cycle 4, SVSP continued to perform poorly in this area, with this indicator rated *inadequate*.

Provider-to-Provider Follow-up Appointments

As was observed in Cycle 4, SVSP continued to perform poorly with provider-ordered follow-up appointments. These appointments are among the most critical aspects of the *Access to Care* indicator. Failure to accommodate provider-ordered appointments can often result in lapses in care or can even result in patients being lost to follow-up. Given the severity and prevalence of this problem at SVSP, patients were placed at significant risk of harm. Not only were these deficiencies identified in the vast majority of cases reviewed, they often recurred several times in each case. Follow-up appointments were not only late, but many times, patients never received the appointment. This type of deficiency was identified once in cases 3, 4, 5, 12, 14, 16, 17, 19, 22, and 23; twice in cases 8, 11, 13, 15, 21, and 24; three times in case 25; and four times in case 6. The following representative examples were noted during this case review period:

- In case 12, while hospitalized, the patient was found to have an extensive blood clot. After he returned to SVSP, the provider ordered a one-week follow-up appointment, but it did not occur.

- In case 13, while hospitalized, the patient was found to have a lung mass. The provider wanted the patient to return for evaluation in three months, yet the patient did not receive a provider appointment for more than six months.

- In case 25, the patient saw both a nurse and a provider for night sweats and vomiting. The provider ordered a two-day follow-up, but the appointment did not occur.

RN Sick Call Access

When SVSP received a sick call request during regular business days, the institution was usually able to provide prompt RN sick call access. However, the institution continued in the pattern noted in Cycle 4 of not seeing patients within one business day for sick call requests received on holidays or weekends. Of the 117 sick call encounters reviewed, the OIG clinicians found 13 nursing appointments that did not occur timely. These deficiencies were identified once in cases 5, 6, 7, 10, 39, 40, and 54; and three times in cases 9 and 38. At the onsite inspection, SVSP staff stated no schedulers had been working on holidays or weekends to promptly schedule patients for their appointments.

RN-to-Provider Referrals

SVSP performed poorly with scheduling a provider appointment after a nurse referral. The OIG reviewed 69 events wherein the RN referred the patient to the provider. In 24 of those, the appointment did not occur timely or at all. These deficiencies were identified one time in cases 5, 6, 7, 9, 10, 11, 12, 15, 16, 39, 40, 46, 51, 53, and 54; two times in cases 13, 36 and 38; and three times in case 4.

RN Follow-up Appointments

SVSP did not ensure that RN follow-up appointments occurred timely or at all in 9 of the 31 events reviewed. These deficiencies were identified once in cases 3, 14, and 15; and three times in cases 6 and 12.

Provider Follow-up After Specialty Services

SVSP continued to perform well with providing patients with a provider follow-up appointment after specialty services. The OIG clinicians reviewed 91 diagnostic and consultative specialty services and found only six instances in which a provider follow-up did not occur or was delayed. Such deficiencies occurred once in cases 4, 7, 9, and 13; and twice in case 10.

Intra-System Transfers / Reception Center

Compared to Cycle 4, SVSP experienced challenges with ensuring that a provider saw newly arrived patients within appropriate time frames. The OIG clinicians reviewed seven patients who transferred into SVSP. Each of these transfers required referrals for a provider follow-up. In two of these cases, the provider appointment did not occur timely:

- In case 4, the patient transferred in the midst of an evaluation for a lung mass. The receiving and release (R&R) nurse referred the patient for provider follow-up within two days, but the patient was not seen until six days later. An urgent bronchoscopy (a procedure in which the

specialist examines the airways using a thin tube with an attached camera) with biopsy was due within one week of the patient's arrival. The patient did not receive the bronchoscopy on time. The bronchoscopy request was not approved at SVSP until 12 days after the patient arrived, and past the procedure's due date. The patient's lung condition worsened, and he was hospitalized. This event is also discussed in the *Summary of Results* section (adverse events) and the *Specialty Services* indicator.

- In case 29, the R&R nurse referred the patient to see the provider in two weeks, but the appointment occurred nearly a month later.

Follow-up After Hospitalization

SVSP was able to ensure that patients who returned to the institution from an outside hospital or emergency room were quickly given a provider and, occasionally, an additional nurse follow-up appointment. The OIG clinicians reviewed 44 events wherein a patient returned from an outside emergency department (ED) or hospital. Only four deficiencies were found in which the patient did not receive his provider or RN appointment within the requested time frame. Those deficiencies occurred once in cases 6 and 14; and twice in case 12.

Follow-up After Urgent/Emergent Care

Compared to Cycle 4, SVSP demonstrated marked improvement in its ability to ensure that patients seen in the TTA for urgent or emergent reasons were given prompt follow-up with a provider. The OIG clinicians reviewed 44 TTA encounters wherein the patient was released to housing and required a follow-up appointment. Only three instances were found in which the provider follow-up appointment did not occur within the requested time frame. All three of these deficiencies occurred in case 6, an atypical case in which the patient repeatedly visited the TTA (28 times for the same complaint), likely due to mental illness.

Specialized Medical Housing

SVSP providers did not consistently perform CTC rounds every 72 hours as required by policy. Compared to Cycle 4, these deficiencies occurred more frequently and were identified in cases 2, 4, 13, 18, 58, 59, and 61. While most of these deficiencies were minor deviations and did not affect the quality of care, some of the policy violations were quite lengthy, as observed in the following example:

- In case 12, the patient was monitored in SVSP's CTC while receiving chemotherapy for his cancer. Institutional performance during one period in which SVSP providers did not visit the patient during rounds for ten days was markedly out of compliance with CTC policy. Fortunately, the patient was medically stable during this period.

Specialty Access and Follow-up

SVSP demonstrated marginally adequate performance in providing specialty appointments within requested time frames. Performance in this area is further discussed in the *Specialty Services* indicator.

Diagnostic Results Follow-up

SVSP performed well with provider follow-up appointments in response to abnormal diagnostic tests. The OIG clinicians found no pattern of deficiencies in this area.

Clinician Onsite Inspection

Concerns relating to access to care continued to be widespread during the case review period, compared to Cycle 4, and resulted in a backlog of patient requests. During the onsite inspection, SVSP stated that during the OIG's inspection review period, the institution faced staffing challenges with multiple provider vacancies. Critical staffing shortages resulted in backlog figures that showed an increase of nearly a thousand patients. SVSP executives acknowledged the majority of the deficiencies identified in the case review had occurred, and stated they stemmed from the institution's provider shortage. However, by the time of the clinician onsite inspection, SVSP providers had been approved to receive an annual 15 percent recruitment and retention bonus in addition to their normal salary. The higher compensation had resulted in many new providers joining the institution's staff, effectively resolving the provider-staffing crisis. Most of the new providers had transferred from the nearby CDCR institution, CTF. At the time of the onsite inspection, SVSP executives claimed that clinic backlogs had been resolved. How the sudden loss of providers affected CTF's ability to provide medical care is yet to be determined.

Clinician Summary

During the review period, SVSP continued to experience difficulty in providing patients with adequate access to care. The OIG clinicians found problems in many areas, especially with provider follow-ups, nurse follow-ups, and sick call access during weekends and holidays. In addition, access problems with nurse-to-provider referrals, newly arrived patients, and CTC visiting rounds were prevalent. Conversely, the institution's clinicians performed well with following up after specialty appointments, emergency room visits, and hospitalizations. SVSP markedly improved its ability to provide follow-ups after patients were released from the TTA. SVSP leadership believed that the institution's poor overall performance in this area was due to the provider shortage, but this problem had been resolved with the recent influx of new providers. Despite this bright note, the indicator rating for the review period was *inadequate*.

Compliance Testing Results

The institution performed in the *inadequate* range in the *Access to Care* indicator, with a compliance score of 66.1 percent. The following tests received scores showing room for improvement:

- Among 25 sampled patients transferring into SVSP from other institutions who were referred to a provider based on nursing staff's initial health care screening, only 9 (36 percent) were seen timely. Four patients received their provider appointments from 2 to 16 days late; eight patients received their appointments between 23 and 66 days late; and four patients received their appointments more than three months late (MIT 1.002).

- The OIG inspectors initially sampled 30 patients who submitted a sick call request. Of these 30 sampled patients, four patients ultimately required a second provider follow-up visit. However, of these four applicable sampled patients, only two actually received timely follow-up appointments (50 percent). One follow-up visit occurred 2 days late, and one other visit occurred 40 days late (MIT 1.006).

- Inspectors sampled 25 patients who suffered from one or more chronic care conditions; only 13 of them (52 percent) timely received their provider-ordered follow-up appointments. Twelve other patients received their appointments late, including seven patients whose follow-up appointments occurred between one and 16 days late; four patients whose appointments were between 22 and 55 days late; and one patient whose appointment was more than 6 months late (MIT 1.001).

- For 13 applicable health care services request forms (CDCR Form 7362) sampled, on which nursing staff referred the patient for a provider appointment, only eight patients (62 percent) received a timely appointment. Four patients received their appointments from one to 16 days late; for one patient, the provider appointment was more than 3 months late at the date of OIG testing (MIT 1.005).

- Patients had access to health care services request forms at four of six housing units inspected (67 percent). One inspected housing unit did not have a supply of the forms available for patients' use, and another housing unit did not have a system in place for re-ordering health care services request forms (MIT 1.101).

- Only 21 of 29 sampled patients who received a high-priority or routine specialty service (72 percent) also received a timely follow-up appointment with a provider. Of those eight patients who did not receive a timely follow-up appointment, six patients' high-priority specialty service follow-up appointments were from one to 49 days late. Two patients' routine specialty service follow-up appointments were 42 and 47 days late (MIT 1.008).

The following two tests received scores in the *adequate* range:

- Of 25 sampled patients who were discharged from a community hospital, 19 of them (76 percent) received a timely provider follow-up appointment upon their return to SVSP. Six patients received their follow-up appointments from two to ten days late (MIT 1.007).

- For 24 of the 30 sampled patients who submitted health care services request forms (80 percent), nursing staff completed a face-to-face encounter with the patient within one business day of reviewing the service request form. In the six remaining, the nurse conducted the visit between one and 18 days late (MIT 1.004).

The following test received a *proficient* score:

- Inspectors sampled 30 health care services request forms submitted by patients across all facility clinics. Nursing staff reviewed all service request forms on the same day they were received (MIT 1.003).

2 — *DIAGNOSTIC SERVICES*

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(67.8%)
Overall Rating:
Inadequate

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

Case Review Results

The OIG clinicians reviewed 211 diagnostic events and found 53 deficiencies, 27 of which were significant. Of the 53 deficiencies, 37 related to health information management and 16 related to tests that were ordered, but not completed. Significant deficiencies were identified once in cases 2, 3, 10, 12, 13, 14, 16, 19, 20, and 24; two times in cases 4, 9, 15, 18, 21, 25, and 61; and three times in case 23. The OIG clinicians rated the *Diagnostic Services* indicator *inadequate*.

Test Completion

SVSP did not reliably perform diagnostic tests as ordered by the provider. Failure to perform diagnostic tests can place patients at risk for lapses and delays in medical care. Furthermore, the absence of relevant diagnostic information can even lead to additional provider errors. These failures to complete diagnostic tests as ordered by the provider were pervasive and were identified once in cases 3, 4, 12, 14, 15, 16, 20, 21, 23, and 24; and twice in cases 9, 10, and 25.

- In case 9, the provider ordered X-rays for a possible hand fracture, but they were not performed until the provider re-ordered the X-rays two weeks later. The delayed test could have led to an improper diagnosis or a missed opportunity for appropriate treatment.

- In case 10, the ear, nose, and throat specialist needed X-rays of the patient's sinuses to evaluate the patient's symptoms. The institution did not perform the X-ray as ordered by the provider. Without this needed X-ray information, the specialist may not have had the necessary information to make appropriate decisions.

- In case 12, the patient went to the TTA for nausea and dizziness. After a period of monitoring, the provider there released the patient back to housing with orders for laboratory tests the next day and close follow-up. The laboratory tests ordered for the patient did not occur. Without the requested laboratory information, providers could have misdiagnosed a potentially serious condition.

- In case 23, the provider ordered a laboratory test to evaluate the patient's heart condition. Unfortunately, SVSP performed the wrong test. Without the proper test information, the provider could have made an incorrect diagnosis or ordered the wrong treatment for the patient's heart condition.

Health Information Management

Even when tests were completed, SVSP staff did not reliably retrieve, review, or scan diagnostic reports into the medical record. The OIG clinicians found this to be a widespread problem, identifying such errors once in cases 3, 4, 8, 11, 16, 20, 21, and 24; twice in cases 2, 9, 13, and 14; three times in cases 15, 18, 19, and 61; four times in case 10; and five times in case 23. The following examples illustrate SVSP's problems with handling diagnostic reports:

- In case 2, the patient underwent a procedure to look inside the gastrointestinal tract (upper intestinal endoscopy), which showed lesions that were nodular and ulcerated, and likely related to his stomach cancer. The lesions were biopsied, but SVSP staff did not retrieve or scan the pathology report into the electronic medical record. Although an SVSP provider never reviewed the pathology report, an offsite oncology specialist gave the patient appropriate treatment for the patient's cancer, which had spread.

- In case 9, after a provider ordered a hand X-ray for a second time, the result was not reviewed by an SVSP provider. Fortunately, the X-ray result was normal, and the patient did not require any additional treatment.

- In case 18, the cancer patient underwent both a lymph node biopsy and a bone marrow biopsy. None of the pathology reports were retrieved from or scanned into the electronic medical record by institution staff. As a result, an SVSP provider never reviewed the results. Fortunately, an offsite oncology specialist reviewed the results and recommended appropriate treatment.

- In case 15, the provider ordered a urine toxicology screen. The test was performed, but the report was never retrieved from or scanned into the medical record. As a result, an SVSP provider never reviewed the results. Fortunately, the test was normal, and the patient did not require any additional intervention.

Clinician Onsite Inspection

The OIG clinicians inquired about SVSP's continuing challenges with completing and transmitting test results. After researching several of the deficiencies presented by the OIG clinicians, SVSP identified that many concerns associated with completing tests resulted from errors made by certain staff members. These individuals, who were referred to as "PCP support staff," did not reliably transcribe and transmit provider test orders to the appropriate diagnostic department. SVSP could not explain why there were problems with the retrieval, review, or scanning of the test results.

SVSP managers expect some of these problems to improve when SVSP transitions to the new electronic health record system (EHRS), into which providers will order these tests directly.

Clinician Summary

The institution continued to experience significant challenges with reliably performing laboratory and radiology tests. As noted, many of these deficiencies were attributed to errors by "PCP support staff." SVSP also had significant difficulty with retrieving, reviewing, and placing completed tests in the medical record. These problems resulted in many lapses in patient care, and represented significant and ongoing risks for further lapses. The case review rated this indicator *inadequate*.

Compliance Testing Results

The institution received a compliance score of 67.8 percent in the *Diagnostic Services* indicator, which encompasses radiology, laboratory, and pathology services. For clarity, each type of diagnostic service is discussed separately below:

Radiology Services

- Radiology services were timely performed for seven of ten sampled patients (70 percent), with three sampled patients receiving testing between 7 and 22 days late (MIT 2.001). SVSP providers then timely reviewed the corresponding diagnostic services reports for only six of the ten patients (60 percent); three patients' reports were reviewed from 3 to 21 days late; and for one patient, no evidence was found that the provider ever reviewed the report (MIT 2.002). Providers also timely communicated the test results to only six of the ten patients (60 percent), with four patients' results communicated from 5 to 20 days late (MIT 2.003).

Laboratory Services

- In all ten of the sampled laboratory services, the services were timely performed (MIT 2.004). The institution's providers reviewed eight of the ten resulting laboratory services reports within the required time frame (80 percent); two reports were reviewed one and 39 days late (MIT 2.005). Providers timely communicated laboratory service reports to only six of the ten patients (60 percent). For one patient, the report was communicated one day late, and for the other three patients, no evidence was found that the provider communicated the results (MIT 2.006).

Pathology Services

- Clinicians at SVSP timely received the final pathology report for eight of ten sampled patients (80 percent); no evidence of the other two final pathology reports was found in the electronic medical record (MIT 2.007). Providers timely reviewed the pathology results for five of the eight applicable patients (63 percent). For the three other patients, the provider

documented evidence of review from one to four days late (MIT 2.008). Providers timely communicated the final pathology results to only three of the eight applicable sampled patients (38 percent); results were communicated between 4 and 31 days late for five other patients (MIT 2.009).

3 — *EMERGENCY SERVICES*

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

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

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

Case Review Results

The OIG clinicians reviewed 87 urgent/emergent events and found 48 deficiencies, of which 19 were considered significant. These were identified once in cases 1 and 4; twice in cases 3, 12, 13, and 14; and three times in cases 5, 6, and 15. Delayed response times, inadequate assessments, and poor patient monitoring led to the *inadequate* rating for this indicator.

Emergency Preparedness and Response

SVSP did not consistently respond in an appropriate manner for patients requiring emergent or urgent medical attention. Delays were identified once in cases 1, 3, 4, 5, 6, 12, 13, and 14; and twice in case 15. The following examples illustrate how delays in emergency care placed SVSP patients at an elevated risk of harm:

- In case 3, the patient had a dangerously low temperature, low oxygen levels, and low blood pressure. The provider requested an emergency evaluation. It took SVSP 33 minutes to transport the patient from the yard clinic to the TTA. This delay could have led to even further deterioration of the patient's condition, which was later determined to have been a stroke.

- In case 4, the first medical responders (FMRs) did not immediately call 9-1-1 for a patient who had an extremely rapid heart rate, as well as extremely low blood pressure and oxygen levels. The patient was in the imminently life-threatening condition called shock, but SVSP medical staff waited 32 minutes before calling 9-1-1. This could have been a fatal delay, since most people in shock do not survive.

- In case 5, the patient lost consciousness and fell flat on his face. This type of fainting was uncommon and potentially could have represented a true medical emergency, such as a heart attack or stroke. The TTA provider did not examine the patient until 50 minutes after he arrived in the TTA. During the onsite inspection, the provider stated he had examined the patient as soon as he had been notified; he could not explain why the nurse had not notified him earlier.

- In case 13, the clinic provider ordered the patient to be sent to the TTA for evaluation of leg swelling, but the patient arrived in the TTA nearly eight hours later. He was found to have evidence of blocked arterial blood flow, which required hospitalization. Eventually, the patient required a leg amputation, which may have been preventable had he been treated immediately.

- In case 14, the patient had shortness of breath with very low oxygen levels. The TTA RN arrived at the yard gate, but for unknown reasons, had to wait an additional 20 minutes for the unstable patient. The patient was eventually sent out to a community hospital. This delay increased his risk for developing brain damage due to low oxygen levels, a worsening of his heart and lung conditions, and for developing other hospital-related complications.

Provider Performance

SVSP providers performed satisfactorily concerning emergency care. In the majority of TTA encounters, providers made accurate diagnoses and appropriate triage decisions. Although provider performance was generally good, on a few occasions, provider care was lacking, as shown in the following examples:

- In case 5, when the provider eventually evaluated the patient for fainting, the provider did not consider that the fainting could have resulted from a potentially dangerous cardiac condition and did not obtain an electrocardiogram (EKG).

- In case 13, clinical staff finally evaluated the patient in the TTA after an eight-hour delay. Both the nurse and the provider found evidence of insufficient blood flow to the leg, but the provider did not send the patient to the hospital emergently. The patient had to wait an additional 96 minutes before the institution transported him to the hospital. This additional delay increased the risk of limb loss, and subsequently, the patient did require an amputation.

- In case 15, the patient had cheek swelling, eye discharge, fever, and night sweats. The TTA nurse repeatedly attempted to contact the on-call provider for instructions, but the provider did not respond to these calls for more than one hour.

- In cases 6, 10, and 14 (once each), and cases 12, 13, and 15 (twice each), SVSP providers regularly neglected to write progress notes for their TTA encounters.

Nursing Performance

The OIG clinicians reviewed 87 urgent/emergent events and found 28 deficiencies related to nursing performance. SVSP nurses performed poorly with nursing assessment and nursing documentation. They also demonstrated poor monitoring of their patients' conditions, delayed notifying the TTA in urgent situations, and delayed activating 9-1-1 in emergent situations.

When SVSP nurses performed their initial assessments, they usually did not monitor the patient's condition in the clinic or the TTA. In several of the cases reviewed, the FMRs did not notify the TTA RN of the medical emergency or call 9-1-1 immediately. SVSP nursing documentation was poor. Documentation deficiencies included incomplete emergency medical response timelines, emergency event details, nursing assessments, and nursing interventions. The following examples illustrate many of these deficiencies:

Failure to Assess or Monitor the Patient's Condition

- In case 1, the patient was confused and disoriented. The FMR neither performed a basic assessment nor checked the patient's blood pressure, heart rhythm, pupil response, or blood glucose level.

- In cases 2, 4, 5, and 6, the patients were in the TTA for various conditions, such as chest pain, loss of consciousness, and decreased alertness. The TTA nurse neither checked nor adequately monitored these patients' vital signs, pain levels, or status while in the TTA.

- In case 12, the patient had returned from the hospital earlier in the day for treatment of seizure and a blood clot in his leg. When he developed nausea, vomiting, and abdominal pain, the medication nurse notified the TTA RN of the situation. The TTA RN did not assess the patient.

- In case 15, the patient had jaw pain and swelling. While waiting for transport to the TTA, the clinic RN neither assessed nor monitored the patient's condition for more than an hour. On another occasion, the patient was seen in the TTA for chest and facial pain. Nearly an hour passed before the TTA nurse began to monitor his condition.

Delayed TTA Notification

- In case 3, the telemedicine provider noted the patient was confused and disoriented, and his temperature and blood pressure readings were low. The oxygen levels were unobtainable. The provider noted that this was an emergent situation, and thus, the patient required an immediate transfer to the TTA. The certified nursing assistant (CNA) working with the provider did not inform the clinic RN of the patient's medical condition or of the telemedicine provider's order to send the patient to the TTA for emergent evaluation. SVSP nurses did not notify the TTA until 32 minutes after the provider encounter.

- In case 6, the TTA RN instructed the medication nurse to check the patient because he had complained of chest pain, which was noted on a sick call form. The nurse did not immediately check the patient, report back to the TTA RN, or activate the medical alarm. This was a severely delayed medical response. On another occasion, the patient complained to the medication nurse of chest pain and vomiting; however, the medication nurse did not notify the TTA nurse until 20 minutes later.

Failure to Communicate Adequate Information to the On-call Provider

- In case 1, the patient had end-stage liver disease, hepatitis C, and liver cancer, and he was seen in the TTA for shortness of breath, dizziness, and nausea. The nurse did not inform the on-call provider of the patient's complex medical history. This lack of complete information resulted in the provider sending the patient back to his housing unit. Two days later, the patient was confused and disoriented, and he required hospitalization.

Nursing Documentation

- Once in cases 3 and 12; twice in case 1; four times in case 15; and five times in case 6, the OIG clinicians found missing or incomplete timeline entries for emergency response events or notifications.

- In case 5, while in the clinic, the patient fell to the floor, hitting his head. The clinic nurse neither documented that the patient had lost consciousness nor how long he remained unconscious. When the patient arrived in the TTA, the RN did not document when the provider was called.

- In cases 1, 2, and 3, nurses did not document even the most basic information. They did not document the patients' vital signs or conditions, or include their nursing assessments.

Emergency Medical Response Review Committee

The OIG clinicians reviewed Emergency Medical Response Review Committee (EMRRC) meeting minutes for seven emergency response cases. The committee correctly identified several substantial concerns, such as delays in emergency response, activation of 9-1-1, and general emergency care. The committee also appropriately noted its concerns with nursing documentation, the use of nursing protocols, and the completion of required forms.

Clinician Onsite Inspection

The TTA at SVSP had three beds available to provide urgent and emergent care to patients. Two registered nurses were present throughout each watch (shift), and a medical provider was present during business hours. An on-call provider was available after hours, and on weekends and holidays. On weekends and holidays, an "RN-rover" collected and triaged sick-call requests forms, and provided patient care in the housing areas, such as wound care, prescribed injections, and status

checks. An emergency response van (ERV) and an inter-facility van were both available to transport patients from the housing yards to the TTA. While the TTA staff was responsible for responding to medical emergencies, SVSP also used the fire crew from CTF to assist with emergency response and patient transport when the TTA was too busy to respond. The TTA RNs also conducted nursing visits (rounds) every two hours to provide care to patients on suicide watch in the yards.

During the onsite interviews, the TTA RN reported that, on average, SVSP sends six patients per day to outside hospitals. The TTA supervisor attributed this high transport rate to the institution housing high numbers of patients who either are diagnosed with mental health conditions or who are older with medical concerns pertaining to their age.

Clinician Summary

Compared to Cycle 4, SVSP's performance showed room for improvement, as it was often characterized by delays in emergency response and poor nursing performance. The OIG clinicians rated the *Emergency Services* indicator *inadequate*.

4 — *HEALTH INFORMATION MANAGEMENT*

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(71.0%)
Overall Rating:
Inadequate

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

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

Case Review Results

The OIG clinicians reviewed 1,229 events and found 113 deficiencies related to health information management, of which 73 were significant. Significant deficiencies were widespread and were identified once in cases 3, 5, 11, 12, 21, and 39; 2 times in cases 1, 4, 17, and 20; 3 times in cases 6, 14, 16, 23, and 61; 4 times in cases 2, 8, 9, and 13; 6 times in case 19; 10 times in case 15; and 12 times in case 18.

Inter-Departmental Transmission

The OIG inspectors found that SVSP had major challenges with inter-department transmission. During the onsite inspection, SVSP discovered a pattern whereby many services that were ordered were not performed because the orders had not been delivered to the appropriate department:

- In case 4, a provider ordered a chest X-ray due to the patient experiencing two weeks of coughing and chest pain. The chest X-ray was never performed because the X-ray department never received the requisition.

- In case 11, the provider ordered a follow-up appointment with the orthopedic specialist to examine the post-surgical knee. The appointment did not occur because the order was not received until almost six months later.

- In case 12, the patient was seen in the TTA for nausea and dizziness. The TTA provider ordered important laboratory tests for the very next day, but they were not performed because the laboratory never received the requisition.

- In case 13, the provider referred the patient to a gastrointestinal specialist, but the appointment did not occur. At the onsite inspection, the specialty department explained that it had never received the order. This example is also discussed in the *Specialty Services* indicator.

The OIG inspectors also found that a poor inter-departmental transmission process caused some diagnostic reports to go missing, as in the following examples:

- In case 9, an X-ray of the hand was performed, but was never retrieved or reviewed, and was missing from the electronic medical record. SVSP explained that while the X-ray report had been sent to the clinic, at some point, it had gone missing. Fortunately, the X-ray was normal, and no harm came to the patient.

- In cases 19 and 23, these patients' laboratory tests were not in the medical record. SVSP explained that while the laboratory reports had also been sent to the clinic, they were again somehow lost. Fortunately, the providers had reviewed the reports online, and no lapses in care had occurred.

Hospital Records

Hospital records are critical documents needed for the successful transfer of patient care. Sick patients receiving treatment in the hospital need successful care transfers when discharged. Compared to Cycle 4, SVSP performed extremely poorly with retrieving emergency department (ED) physician reports and hospital discharge summaries. The OIG clinicians reviewed 22 ED events and 22 community hospitalizations. On 20 occasions, the physician report or hospital discharge summary was retrieved late, or more commonly, not at all, as noted in the following examples:

- In case 9, the patient was hospitalized for surgery to reverse a colostomy (an artificial colon opening in the abdomen used to bypass a damaged part of the colon). When the patient saw his provider for follow-up, the provider did not have any hospital records documenting the patient's stay in the hospital and was not even aware that the patient had been hospitalized. There was also a delay in the patient's surgical follow-up, partially due to the institution's failure to retrieve hospital records.

- In case 12, during a hospitalization, the patient was diagnosed with a blood clot in his leg. SVSP retrieved neither the hospital discharge summary nor the discharge medications. The patient was not prescribed anticoagulants upon his return from the hospital. SVSP's failure to retrieve hospital records may have contributed to this lapse in care.

- In case 14, the patient was hospitalized for gastrointestinal bleeding. The entire hospital course was unknown to SVSP providers because SVSP had not retrieved the discharge

summary, consultation reports, or procedure reports. This failure placed the patient at a high risk for lapse in care.

Specialty Services

Compared to Cycle 4, SVSP continued to perform poorly in retrieving specialty reports. Performance in this area is discussed in the *Specialty Services* indicator.

Diagnostic Reports

SVSP did not reliably retrieve, review, or place diagnostic reports into the electronic medical record. Performance in this area is discussed in the *Diagnostic Services* indicator.

Urgent/Emergent Records

SVSP nurses faced challenges with documenting timelines and clinical information. SVSP providers often did not document their TTA encounters. Performance in this area is also discussed in the *Emergency Services* indicator.

Scanning Performance

The OIG clinicians did not identify any significant pattern of mislabeled or misfiled documents. However, there was a pattern of missing documents. This deficiency was identified one time in cases 15, 20, 39, and 52; and three times in case 6.

Legibility

While legibility was, on occasion, difficult to discern, the OIG did not identify any serious patterns of legibility problems during this review.

Clinician Onsite Inspection

The OIG clinicians observed the provider morning report. This daily provider meeting occurred prior to the clinic huddles and included the medical providers, the CME, the CP&S, and the utilization management nurse. During this meeting, on-call providers discussed patients who had received medical services after hours as well as hospitalized patients who could potentially return to the institution. This meeting helped facilitate provider handoffs for those patients who had recently required medical attention.

The OIG clinicians also observed the information transmission during the daily morning huddles. Performance in this area was variable, with adequate and proficient huddles observed in the SVSP A and C yards. However, the B and D yard huddles were unprepared, disorganized, and ineffective. While each yard utilized the same standardized huddle script, the B and D yard staff had not reviewed the cases prior to the huddle, were unfamiliar with the patients, and could not answer even basic queries. The following are examples of the OIG clinician's concerns:

- Clinic RNs had not reviewed the TTA encounters and could not answer why their patients had gone to the TTA or what work-ups had occurred in the TTA.

- Clinic RNs were unfamiliar with their patients and did not provide any background context for the patients discussed. For example, they could not provide a medical history or a summary of recent nursing encounters that may have explained why the patient sought after-hours medical attention.

- Medication nurses were not prepared to report which expiring medications providers had already renewed for patients, and which medications still required a physician's order.

- Providers were also unfamiliar with the patients discussed, but many of the providers were recently hired at the institution in the past few months.

Clinician Summary

SVSP had substantial issues with inter-departmental transmission, hospital record retrieval, specialty report retrieval, diagnostic report transmission, and TTA documentation. Some of the morning huddles were ineffective. While the provider morning report did help mitigate some of these problems, in general, SVSP performed poorly with regard to *Health Information Management*, and the indicator rating was *inadequate*.

Compliance Testing Results

The indicator received an *inadequate* score of 71.0 percent, with the following tests showing room for improvement:

- Medical administrative staff did not always timely scan medication administration records (MARs) into patients' eUHR files, scanning only 11 of 18 sampled documents (61 percent) within the required time frames. Six MARs were each scanned one day late and one MAR was scanned eight days late (MIT 4.005).

- Institution staff timely scanned 13 of 20 sampled documents, including non-dictated provider progress notes, nursing initial health screening forms, and patient health care service requests, into the patient's eUHR within three calendar days of the patient encounter (65 percent). Seven documents were scanned one or two days late (MIT 4.001).

- SVSP's records management staff timely scanned community hospital discharge reports or treatment records for 14 of the 20 sampled patients (70 percent). Six reports were scanned between two and six days late (MIT 4.004).

The following tests received scores in the *adequate* range:

- SVSP scored 75 percent in its labeling and filing of documents scanned into patients' eUHRs. For this test, once the OIG identifies 24 mislabeled or incorrect patient documents,

the maximum points are lost and the resulting score is zero. OIG inspectors found three documents were scanned using the wrong date, and three documents were mislabeled (MIT 4.006).

- The OIG reviewed community hospital discharge reports and treatment records for 24 sampled patients who were admitted to a community hospital and later returned to SVSP. For 18 of the 24 sampled patients (75 percent), the discharge summary reports were complete and timely reviewed by SVSP providers. For three patients, however, providers reviewed the hospital discharge summary reports from two to three days late; for another patient, the review was 105 days late. For two other patients, their hospital discharge reports were missing key information, and no evidence was found that SVSP followed up with the hospital to obtain the report (MIT 4.007).

- For 16 of 20 specialty service consultant reports sampled (80 percent), SVSP staff scanned the reports into the patient's electronic health record within five calendar days. Four sampled documents were scanned between 6 and 42 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. Rating of this component is based entirely on the compliance testing results from the visual observations inspectors make at the institution during their onsite visit.

Case Review Rating:
Not Applicable
Compliance Score:
Inadequate
(47.7%)

Overall Rating:
Inadequate

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

Compliance Testing Results

The institution received an *inadequate* compliance score of 47.7 percent in the *Health Care Environment* indicator, showing room for improvement in the following test areas:

- The non-clinic bulk medical supply storage areas did not meet the supply management process or support medical health care program needs. Multiple medical supplies were found stored beyond the manufacturers' guidelines (MIT 5.106).

- The institution scored zero when inspectors examined emergency medical response bags (EMRBs) in ten applicable clinics to determine if clinical staff inspected the medical bags daily and inventoried them monthly, and whether the bags contained all essential items. All clinics had one or more deficiencies identified, including no evidence of monthly inventory logs; staff on each watch did not always conduct daily inspections of the bag; an EMRB was missing such items as instant glucose tubes, nasal cannula, a rigid cervical collar, oral airways, and an adult-sized blood pressure cuff; and other locations had EMRBs with glucose tubes that were stored beyond manufacturers' guidelines (MIT 5.111).

- Only one of 12 clinic locations (8 percent) met compliance requirements for essential core medical equipment and supplies. The remaining 11 clinics were missing one or more functional pieces of properly calibrated core equipment or other medical supplies necessary to conduct a comprehensive examination. The missing items included a demarcation line for the Snellen eye examination chart; an examination table; hemoccult cards and developers; lubricating jelly; a nebulization unit; an oto-ophthalmoscope; tips for the oto-ophthalmoscope; and tongue depressors. In addition, nebulization units were found with expired calibration stickers (MIT 5.108).

- Only 3 of the 12 clinics inspected followed adequate medical supply storage and management protocols (25 percent). At nine locations, one or more deficiencies were identified: medical supplies were not clearly identifiable (*Figure 1*); staff members' personal food items were stored in the same area as medical supplies (*Figure 2*); and disinfectant agents were stored together with medical supplies (MIT 5.107).

Figure 1: Medical supplies not clearly identifiable

- Six of the 12 clinic examination rooms observed (50 percent) had appropriate space, configuration, supplies, and equipment to allow clinicians to perform a proper clinical examination. Six clinics had examination rooms with one or more deficiencies, which included examination tables with torn or worn vinyl areas that could not be adequately disinfected and could harbor infectious agents; examination tables that could not be extended to allow the patient to lie in a fully unhindered, supine position; confidential records that were left unsecured; examination rooms that had no visual privacy; and one examination room that was too small to allow for adequate patient examinations (MIT 5.110).

Figure 2: Food items (sardines) stored with supplies

- OIG inspectors observed clinician encounters with patients in 12 clinics. Clinicians followed good hand hygiene practices in seven clinics (58 percent). At five clinic locations, clinicians failed to wash their hands before or after patient contact, or before applying gloves (MIT 5.104).

- When inspecting for proper protocols to mitigate exposure to blood-borne pathogens and contaminated waste, 7 of the 12 clinics were compliant. SVSP received a score of 58 percent on this test because four clinics had one or more examination rooms that lacked a sharps container. In another location, the clinic did not have a secured and labeled storage location for biohazardous materials (MIT 5.105).

The following three tests received scores in the *adequate* range:

- Staff appropriately disinfected, cleaned, and sanitized 10 of the 12 sampled clinic locations (83 percent). In two clinics, cleaning logs were missing staff validation for the daily inspection of the restrooms (MIT 5.101).

- Of the 12 clinic locations inspected, 9 (75 percent) had operable sinks and sufficient quantities of hand hygiene supplies in the examination areas. In three clinics, patient

restrooms did not have disposable paper towels and soap available at the time of inspection (MIT 5.103).

- Clinic common areas at 9 of the 12 clinics (75 percent) had environments conducive to providing medical services. The location of vital signs stations in three clinics compromised patients' auditory privacy (MIT 5.109).

One test received a *proficient* score:

- Clinical health care staff at 11 of 12 applicable clinics (92 percent) ensured that reusable invasive and non-invasive medical equipment was properly sterilized or disinfected. In one clinic, medical equipment was not routinely logged when sterilized (MIT 5.102).

Non-Scored Results

- The OIG gathered information to determine whether the institution's physical infrastructure was maintained in a manner that supported health care management's ability to provide timely or adequate health care. The OIG does not score this question. When OIG inspectors interviewed health care managers, they did not identify any significant concerns. At the time of the OIG's medical inspection, SVSP had several significant infrastructure projects underway, which included increasing clinic space at four yards, building a new pharmacy, expanding medication distribution areas, remodeling the TTA, and creating a new space for an obstetrics and gynecological clinic. These projects were started during fall 2016, and the institution estimated they will be completed by the end of summer 2017 (MIT 5.999).

6 — *INTER- AND INTRA-SYSTEM TRANSFERS*

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(67.9%)
Overall Rating:
Inadequate

This indicator focuses on the management of patients' medical needs and continuity of patient care during the inter- and intra-facility 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 facility, the OIG evaluates the ability of the institution to document transfer information that includes pre-existing health conditions, pending appointments, tests and requests for specialty services, medication transfer packages, and medication administration prior to transfer. The OIG clinicians also evaluate the care provided to patients returning to the institution from an outside hospital and check to ensure appropriate implementation of the hospital assessment and treatment plans.

Case Review Results

The OIG clinicians reviewed 51 inter- and intra-system transfer events, including information from both the sending and receiving institutions. These included 40 hospitalization and outside ED events that resulted in a transfer back to the institution. There were 49 deficiencies, of which 28 were significant. Significant deficiencies were identified once in cases 2, 5, 9, 20, 28, and 32; two times in cases 1, 4, 6, 13, and 29; three times in case 12; four times in case 14; and five times in case 15. For Cycle 5, the inter- and intra-system transfer process at SVSP was *inadequate.*

Transfers In

The OIG clinicians reviewed seven patients who transferred from another CDCR institution. SVSP R&R nurses reviewed the health care transfer information and performed adequate initial health screenings. However, they often did not refer clinically high-risk patients to the provider within an appropriate time frame. In addition, provider appointments did not occur timely in cases 4, 29, and in the following:

- In case 1, the patient was diagnosed with a mental illness, and reported auditory and visual hallucinations during the transfer intake screening assessment. The nurse should have immediately referred the patient to a mental health clinician, but this did not occur. The patient also had end-stage liver disease, hepatitis C, liver cancer, and hypertension. Because the patient was classified as high-risk, he should been referred to the medical provider within seven days by the nurse, but again, this did not occur.

- In case 28, the patient was classified as high-risk. The nurse did not refer this patient to the provider within seven days.

Transfers Out

The SVSP nurses performed adequately in the transfer-out cases. While some isolated deficiencies were identified, no specific deficiency patterns were noted.

Hospitalizations

Patients returning from hospitalizations are often at high risk because they have severe illnesses or injuries. They are more susceptible to harm from lapses in care that can potentially occur during any transfer.

SVSP performed poorly with regard to patients returning from the hospital. Most of the significant deficiencies identified stemmed from delays or failures in retrieving hospital reports, as discussed in the *Health Information Management* indicator.

Compared to Cycle 4, SVSP improved with medication continuity for patients returning from a community hospital. However, two significant deficiencies were still identified in this area:

- In case 12, the patient was found to have a blood clot in the hospital and was discharged with two anticoagulant medications. The nurse informed the on-call provider that the patient was taking the two medications, and the provider verbally instructed the nurse to continue them. The nurse, however, did not transcribe orders for these critical medications, and the medications were not ordered or administered. During the onsite inspection visit, the provider admitted that a thorough review of the verbal orders to look for accuracy before signing off on them had not been done. By failing to prescribe and administer critical anticoagulants to this patient recently diagnosed with a blood clot, SVSP placed the patient at high risk of harm.

- In case 14, the patient returned from the ED with recommendations to try diuretic medications to help with his excess fluid retention. Even though the TTA RN informed the on-call provider, the provider inappropriately ignored the recommendations and failed to order these medications, and he did not document why the medications were not prescribed.

For patients returning from the hospital, adequate nursing assessments were critically important for several reasons. Nurses used their assessment to determine the patient's health condition at the time of transfer, to ensure appropriate housing placement, and to confirm that all health care needs of the patient were met. SVSP nurses failed to perform adequate assessments for patients who returned from the hospital or emergency room. Deficiencies where the nurses did not assess their patients upon return from the hospital occurred once in cases 11 and 12; twice in cases 4 and 14; and six times in case 15.

Clinician Onsite Inspection

The R&R nurse's room was very small and did not have space for an examination table. One RN was assigned on each watch during business days. During the onsite inspection, the OIG clinicians observed the R&R nurse complete a transfer packet. The nurse demonstrated satisfactory knowledge of the transfer process. SVSP clinicians assessed patients returning from an outside hospital or ED in the TTA area.

Clinician Summary

While the institution's R&R nurses performed adequately with reviewing newly arrived patients' health information and health screening, they did not refer new high-risk patients to the provider within policy-specified time frames. While SVSP nurses performed adequately with patients transferring out, nurses had significant difficulty in ensuring an adequate transfer-in process for patients returning from the hospital. Nurses often failed to perform adequate nursing assessments for their returning patients, and often did not retrieve hospital discharge summaries and ED reports. There was one case (case 12) in which a critical medication was not given, which placed the patient at high risk of harm. Compared to Cycle 4, SVSP performed poorly with regard to *Inter- and Intra-System Transfers*, and the indicator rating was *inadequate*.

Compliance Testing Results

The institution received an *inadequate* score of 67.9 percent in the *Inter- and Intra-System Transfers* indicator, with the following two tests showing room for improvement:

- The OIG tested 23 applicable patients who transferred into SVSP from another CDCR institution to determine whether they received a complete initial health screening assessment from nursing staff on their day of arrival. SVSP received a score of only 4 percent for this test because nursing staff timely completed the assessment for only one of the sampled patients. Nurses neglected to answer one or more of the screening form questions for the other 22 patients (MIT 6.001).

- Of 20 applicable patients who transferred into SVSP with an existing medication order upon arrival, only 13 (65 percent) received their medications without interruption. Seven patients received their medications from two to five days late (MIT 6.003).

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

- OIG inspectors sampled 19 applicable patients who transferred out of SVSP to another CDCR institution to determine whether staff identified scheduled specialty service appointments on the patients' health care transfer forms. Nursing staff noted the pending specialty service appointments on 15 of 19 transfer forms (79 percent). Staff failed to list pending appointments on four of the patient transfer forms (MIT 6.004).

The following two tests received scores in the *proficient* range:

- Nursing staff timely completed the assessment and disposition sections of the screening form for 21 of the 23 sampled patients (91 percent). Two exceptions were identified: one in which the screening nurse did not identify a specific referral and another in which the screening nurse did not provide the correct screening date (MIT 6.002).

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

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7 — *PHARMACY AND MEDICATION MANAGEMENT*

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(69.2%)
Overall Rating:
Inadequate

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

Case Review Results

The OIG clinicians evaluated 30 medication-specific events and found 17 deficiencies, 7 of which were significant. Significant deficiencies were identified one time in cases 5, 8, 10, and 32; and three times in case 12. The *Pharmacy and Medication Management* indicator rating was *inadequate*.

Medication Continuity

Although SVSP showed some improvement in medication continuity from Cycle 4, the institution continued to have significant problems with chronic care medication administration and continuity. Enough deficiencies were observed to constitute a continuing pattern of concern in this area. The following examples offer insight:

- In case 5, SVSP nurses did not record the diabetic patient's blood sugar levels regularly; and thus, the patient missed multiple doses of insulin.

- In case 7, the patient had hemophilia, a condition whereby he was prone to have serious spontaneous bleeding episodes. The provider prescribed the patient Mononine, a medication to help prevent serious bleeding, but SVSP repeatedly missed administering doses of the medication.

- In case 8, SVSP missed administration of multiple medication doses of several chronic care medications, including insulin for diabetes.

- In case 12, the patient was prescribed warfarin, an important blood thinner. In the span of one month, the medication was not administered on three different occasions. The patient was also prescribed a seizure medication, which lapsed for three days. Furthermore, as

discussed in the *Inter- and Intra-System Transfers* indicator, the TTA nurse and physician, who were on call, neglected to prescribe two anticoagulation medications that the patient needed after he returned from the hospital. This error placed the patient at a high risk of harm from potential blood clot complications.

- In case 32, the patient was transferred to another institution. SVSP did not ensure that all of the patient's essential medications were sent with the patient.

Medication Administration

SVSP also continued to have difficulty with medication administration:

- In case 4, the patient had low blood pressure, but SVSP nurses continued to administer a blood pressure lowering medication, even after the provider ordered it to be held.

- In case 8, the provider changed the patient's insulin dose to better control his diabetes, but SVSP nurses did not implement the order until 11 days later.

- In case 10, the provider ordered an inhaler for the patient to aid breathing, but there was no evidence the patient received the medication.

- In case 12, the provider put a hold on the patient's anticoagulation medication because of high medication levels, but SVSP nurses continued to administer it.

- In case 23, the provider changed the patient's insulin dose to better control his diabetes, but SVSP nurses did not implement the order until six days later.

Pharmacy Errors

No patterns of deficiencies were attributed to the pharmacy department. A clinical pharmacist runs the anticoagulation clinic at SVSP, and anticoagulation performance is further discussed in the *Specialty Services* indicator.

Clinician Onsite Inspection

Medication nurses were knowledgeable about the medication processes for transfers, hospital returns, medication non-compliance, and keep-on-person (KOP) medications. Their only complaint was concerning the packaging of medications that made it difficult to store and retrieve them in the medication cart for efficient administration. The medication nurses' general morale was improved compared to Cycle 4. They reported no problems with medication continuity. When patients returned from the hospital, nurses successfully obtained medications from the Omnicell (the medication dispensing cabinet) and sent them to the clinic.

Clinician Summary

SVSP continued to demonstrate patterns with lapses in medication continuity and delays in medication administration. With regard to *Pharmacy and Medication Management*, the case review indicator rating was *inadequate*.

Compliance Testing Results

The institution received a compliance score of 69.2 percent in the *Pharmacy and Medication Management* indicator. For discussion purposes below, this indicator is divided into three sub-indicators: medication administration, observed medication practices and storage controls, and pharmacy protocols.

Medication Administration

In this sub-indicator, the institution received an average score of 78.6 percent, showing room for improvement in the following areas:

- SVSP ensured that 15 of 25 sampled patients (60 percent) received their medications without interruption when they transferred from one housing unit to another; 3 patients did not receive their medications at the next dosing interval after their transfer occurred; and for the remaining 7 patients, nursing staff did not evidence proper documentation of medication dosing on the MAR (MIT 7.005).

- Nursing staff administered medications without interruption to six of ten patients who were en route from one institution to another and had a temporary layover at SVSP (60 percent). For four patients, there was no medical record evidence that their medications were either administered as ordered or refused (MIT 7.006).

One test received an *adequate* score:

- Clinical staff timely provided new and previously prescribed medications to 21 of 25 sampled patients who had been discharged from a community hospital and returned to the institution (84 percent). Four patients received their ordered "nurse-administered" (NA) medications from one to six days late (MIT 7.003).

Two tests received scores in the *proficient* range:

- Inspectors found that all 25 sampled patients received their newly ordered medication in a timely manner (MIT 7.002).

- Patients timely received chronic care medications for 16 of 18 applicable samples the OIG reviewed (89 percent). One patient did not receive all ordered KOP medications for more than 30 days, while another patient missed four doses of medication (MIT 7.001).

Observed Medication Practices and Storage Controls

In this sub-indicator, the institution received a score of 36.5 percent, with several tests receiving scores in the *inadequate* range:

- The institution employed adequate security controls over narcotic medications in only one of the eight applicable clinic and medication line locations where narcotics were stored (13 percent). At seven clinics, one or more deficiencies were identified: the narcotics logbook lacked evidence on multiple dates that a controlled substance inventory was performed by two licensed nursing staff members; the medication nurse removed narcotic medication from the narcotics' locked bin in a manner that did not allow for a spontaneous physical count; and narcotic medication was found stored beyond the manufacturers' guidelines (MIT 7.101).

- Only one of six inspected medication preparation and administration areas demonstrated appropriate administrative controls and protocols (17 percent). At five different locations, one or more of the following deficiencies were observed: medication nurses did not always ensure that patients swallowed direct observation therapy medications; the medication nurse did not appropriately administer medications as ordered by the provider; and patients waiting to receive their medications did not have sufficient outdoor cover to protect them from heat or inclement weather (*Figure 3*) (MIT 7.106).

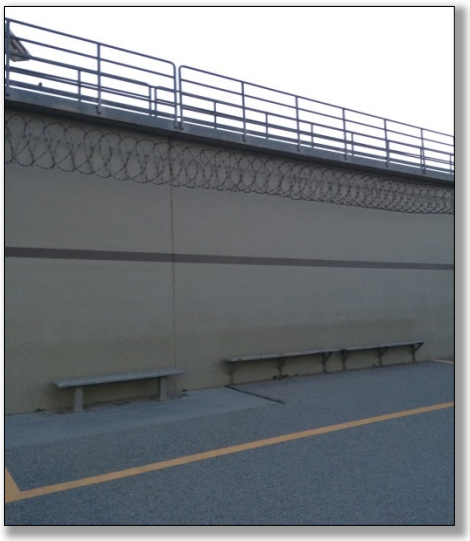

Figure 3: Medication line waiting area with no protection from inclement weather

- SVSP properly stored non-narcotic medications not requiring refrigeration in 3 of the 12 applicable clinic and medication line storage locations (25 percent). In nine locations, one or more of the following deficiencies were observed: the medication area lacked a designated area for return-to-pharmacy medications; external and internal medications were not properly separated when stored; multi-use medication was not labeled with the date it was opened; and medication was stored beyond its expiration date (MIT 7.102).

- Non-narcotic refrigerated medications were properly stored in 3 of 11 clinics and medication line storage locations (27 percent). At the other eight locations, exceptions were found related to refrigerator temperatures not being kept within the acceptable range or the temperature logbook not being completed; and the medication refrigerator lacked a designated area for return-to-pharmacy medications (MIT 7.103).

- Inspectors observed the medication preparation and administration processes at six applicable medication line locations. Nursing staff were compliant regarding proper hand hygiene and contamination control protocols at three locations (50 percent). At the other three locations, not all nursing staff washed or sanitized their hands when required, such as before putting on gloves or re-applying new gloves (MIT 7.104).

One test received a *proficient* score:

- SVSP nursing staff at seven of eight sampled locations (88 percent) employed appropriate administrative controls and protocols when preparing patients' medications. At one medication line location, multiple medications were found not stored in their original labeled packaging (MIT 7.105).

Pharmacy Protocols

In this sub-indicator, the institution received an average score of 99.2 percent, composed of scores received at the institution's main pharmacy, with all tests scoring in the *proficient* range:

- In its main pharmacy, the institution followed general security, organization, and cleanliness management protocols; properly stored and monitored non-narcotic medications requiring refrigeration and those that did not; and maintained adequate controls over and properly accounted for narcotic medications (MIT 7.107, 7.108, 7.109, and 7.110).

- SVSP's pharmacist-in-charge (PIC) timely processed 24 of 25 inspector-sampled medication error reports (96 percent). For one medication error report, the PIC completed a corresponding medication error follow-up report one business day late (MIT 7.111).

Non-Scored Tests

- In addition to the OIG's testing of reported medication errors, inspectors follow up on any significant medication errors found during the compliance testing to determine whether the errors were properly identified and reported. The OIG provides those results for informational purposes only. At SVSP, the OIG found no applicable medication errors (MIT 7.998).

- The OIG interviewed patients in isolation units to determine whether they had immediate access to their prescribed KOP rescue inhalers and nitroglycerin medications. All ten sampled patients had access to their rescue inhalers or nitroglycerin 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.

Because SVSP is a male-only institution, this indicator did not apply.

Case Review Rating:
Not Applicable
Compliance Score:
Not Applicable

Overall Rating:
Not Applicable

9 — *PREVENTIVE SERVICES*

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

Case Review Rating:
Not Applicable
Compliance Score:
Proficient
(95.8%)

Overall Rating:
Proficient

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

Compliance Testing Results

In the *Preventive Services* indicator, the institution received a compliance score of 95.8 percent, with the following tests scoring in the *proficient* range:

- All 25 sampled patients either timely received or were timely offered influenza vaccinations during the most recent influenza season (MIT 9.004).
- SVSP offered colorectal cancer screenings to all 25 sampled patients subject to the annual screening requirement (MIT 9.005).
- The institution scored 97 percent for conducting annual TB screenings. SVSP had timely screened 29 of the 30 sampled patients for TB within the past year. For one patient, however, no evidence was found in the eUHR that a TB screening was done during the patient's most recent birth month as required by CCHCS policy (MIT 9.003).
- SVSP scored 93 percent for the timely administration of TB medications to patients. Of 15 sampled patients, 14 received their required doses of TB medications as ordered in the most recent three-month period reviewed. One patient who was not given a required TB medication dose did not receive the required provider counseling for the missed dose (MIT 9.001).
- The OIG found that 13 of 14 applicable sampled patients (93 percent) received their required monthly or weekly monitoring while taking TB medications. One patient did not receive the required monthly monitoring (MIT 9.002).

- The OIG tested whether patients who suffered from chronic care conditions were offered vaccinations for influenza, pneumonia, and hepatitis. Among the 12 sampled patients with applicable chronic conditions, 11 patients (92 percent) were timely offered these vaccinations. For one patient, however, there was no record that he either received or refused the pneumococcal immunization within the past five years (MIT 9.008).

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10 — *QUALITY OF NURSING PERFORMANCE*

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

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

Case Review Results

OIG clinicians reviewed 423 nursing encounters, of which 184 were outpatient-nursing encounters. Most outpatient nursing encounters were for sick call requests and RN follow-up. In all, there were 154 nursing deficiencies, 46 of which were significant. Patterns of deficiencies identified in the Cycle 4 medical inspection remained evident in the current inspection. Significant deficiencies were found one time in cases 5, 10, 29, 40, and 47; two times in cases 1, 36, and 51; three times in cases 4, 6, 9, 11, 12, 13, and 15; four times in cases 3 and 28; and six times in case 8. The OIG clinicians rated this indicator *inadequate.*

Nursing Assessment

All phases of the nursing process depend on accurate, complete data collection. If inaccurate or incomplete data are recorded, then the overall care of the patient can be compromised. Inaccurate or incomplete data can lead to an incorrect diagnosis, or even inappropriate treatment. The majority of the nursing deficiencies identified in the case reviews were related to inadequate nursing assessments. SVSP nurses rarely performed satisfactory assessments either in the outpatient clinics or for patients returning from the hospital or specialty appointments. The nurses regularly failed to examine pertinent areas of the body related to the patient's health condition or to perform necessary measurements, such as recording basic vital signs or assessing pain levels. The nurses also failed to document the presence or absence of common accompanying signs and symptoms, such as headache, nausea, or vomiting. In emergencies, SVSP nurses would perform initial assessments, but often would not continue monitoring the patient's condition while he was in the TTA. Examples of these deficiencies are also described in the *Emergency Services* indicator.

Nursing Intervention

Nursing staff demonstrated difficulty in meeting some basic nursing care and practice requirements. For example, wound care and dressing changes were not performed as frequently as ordered, and provider orders were sometimes not accurately transmitted or properly followed. Patients returning from the hospital or offsite appointments were rarely given patient education or instructions. For patients returning from a specialist, nurses also failed to obtain specialty reports, to contact the specialist for the initial findings and recommendations, or to refer the patient for provider follow-up. In the CTC, the nurses often failed to report changes in condition or unusual occurrences to a provider, and often did not follow provider orders. During emergencies, sometimes, the FMRs would fail to notify the TTA RN or activate 9-1-1 timely. Additional details regarding these deficiencies are described in the *Intra and Inter-system Transfers, Specialty Services, Emergency Services,* and *Specialized Medical Housing* indicators. The following are examples of nursing intervention deficiencies:

- In cases 12 and 23, the nurse did not transmit the provider's orders for diagnostic tests, and the tests were not performed.

- In cases 3, 6, 10, and 11, nurses failed to implement basic provider orders, such as obtaining vital signs or checking on the patient's condition.

Wound Care

In the cases reviewed for which the provider ordered wound care, the clinic nurses did not perform this service as frequently as the provider ordered:

- In case 3, the nurses did not assist the patient with colostomy care and did not perform requisite skin checks to watch for the development of any pressure ulcers (open sores or lesions).

- In cases 4 and 15, the nurses did not assess the patients' wounds or change the dressings for a week.

- In case 8, the patient was diabetic and had a foot ulcer. The provider ordered daily wound checks and dressing changes, but the nurses did not perform these services as ordered. When the provider ordered that the patient could do his own dressing change, the nurse did not provide the dressing supplies or instruct the patient how to do his own wound dressing.

- In case 9, the nurses did not perform daily wound care 21 times over a 35-day period. The nurses' failure to perform wound dressing changes likely contributed to the slow healing of the wound.

- In case 11, the nurses did not check the patient's wound daily as the provider ordered.

Nursing Documentation

Complete, accurate, and legible documentation is necessary, both to clearly communicate patient needs and for nurses to provide good, general patient care. A pattern of incomplete documentation was identified in both the TTA notes and the FMR notes. In the CTC, one nurse cloned multiple notes that were worded exactly or very similarly to previous entries for several patients. In the outpatient clinics, nurses performed better in this regard, with no definitive pattern discerned for nursing documentation deficiencies.

Nursing Sick Call

The OIG clinicians reviewed 117 nursing sick call visits. Nursing staff often reviewed sick call requests on the same day to identify patients with symptoms that needed a same-day, urgent evaluation. All other patients with medical symptoms were scheduled for RN assessment on the next business day. However, when sick call requests were received on weekends or holidays, there were multiple occasions when the nurses did not assess their patients within one business day. These cases are identified in the *Access to Care* indicator.

More important, sick call nurses frequently did not recognize potentially urgent conditions or did not intervene appropriately. At times, they simply failed to assess the patient. Errors of these types were found in cases 3, 8, 10, 11, 12, and 13, and in the following examples:

- In case 9, the patient had a swollen eye. The nurse assessed the patient two days after reviewing the health care request. Three weeks later, the patient complained of unspecified severe pain, yet the nurse did not assess the patient. On another occasion, the patient complained of stool incontinence, a leaking wound, and pain, but the nurse did not assess the patient. Instead of being assessed within one business day, as required, the patient was forced to wait a week for a provider appointment.

- In case 28, the patient submitted four sick call requests in one month for severe cold intolerance and pain. This high-risk patient had recently arrived at SVSP and wanted to see the provider. The nurse did not assess the patient and instead deferred the patient to an as-yet-unscheduled provider appointment. The patient did not receive a provider appointment for one month, when he should have been seen within one business day.

- In case 40, the patient claimed that he had fallen and that his arms were numb. He also complained of shoulder and hand pain, which interfered with his sleep. The patient may have had a serious injury, possibly requiring urgent intervention. The nurse should have seen the patient the same day of his request, but instead, waited until the following day.

- In case 47, the patient complained of leg pain and swelling, which can sometimes represent a life-threatening blood clot. Since his complaints could have represented a medical emergency, the nurse should have seen him the same day the request was reviewed. The nurse did not assess the patient on the same day, however, but instead waited for the

provider to see the patient the following day. The provider sent the patient to the hospital, where the blood clot was diagnosed.

SVSP nurses also failed to perform adequate assessments during sick call encounters. Primary care RNs often did not utilize the nursing sick call encounter documentation forms, which may have contributed to incomplete nursing assessments. Deficiencies for incomplete assessments were identified one time in cases 2, 4, 5, 7, 8, 10, 38, and 44; two times in cases 34, 36 and 52; three times in cases 9 and 50; six times in case 15; and in the following examples:

- In case 11, the patient had a recent knee surgery. The licensed vocational nurse (LVN) referred the patient to the RN for a warm, swollen, painful knee. The RN did not examine the patient, but instead gave him instructions to take pain medications and to submit a sick call request. With a warm and swollen knee, the nurse should have been concerned about the possibility of an infection or blood clot, and should have assessed the patient.

- In case 12, the nurse saw the patient after a TTA visit to check for headache, dizziness, and nausea. The patient also reported hip pain and hand numbness. The nurse did not assess the patient regarding the status of headaches or dizziness, and did not assess the hip pain or hand numbness.

- In case 51, the patient submitted a sick call request for abdominal pain. The nurse did not assess the patient's abdomen and did not ask about the presence of nausea, vomiting, or changes in bladder or bowel function. Instead, the nurse only made a routine referral to the provider. A week later, the patient submitted another sick call request for abdominal pain, but the nurse never assessed the patient.

Although primary care nurses often did not assess their patients appropriately, they usually had no problems with appropriately referring their patients to the provider. Only one significant deficiency was found:

- In case 36, the patient with a history of hand surgery submitted a sick call request for a swollen and tender finger. The nurse deferred the patient to the next scheduled provider appointment, but this did not occur until six weeks later. The nurse should have initiated a new referral.

Care Management

Primary care RNs also served as the clinic RN care managers. During interviews, the primary care RN explained that their responsibilities were to assess patients for both episodic illnesses and chronic care management. The RNs, in their role as care managers, monitored each patient's chronic condition, assessed health care needs, and provided patient education. However, in the cases reviewed, no evidence was found concerning any effective care management provided by any member of the nursing staff. The only care management performed was that offered by providers.

The SVSP clinics also had an LVN care coordinator whose main responsibilities were to triage sick call requests, perform dressing changes, check vital signs, EKGs, TB screenings, administer injections, and assist the RN as needed. The OIG clinicians concluded that SVSP has not fully implemented the care management and coordination process as required by CCHCS policy.

Urgent/Emergent Care

The OIG clinicians reviewed 87 urgent/emergent events and found 28 nursing deficiencies. Nursing staff displayed patterns of making inadequate assessments, with delays in calling 9-1-1 or notifying the TTA, and incompletely documenting their notes. These findings are also described in the *Emergency Services* indicator.

Specialized Medical Housing

The nursing care provided in the CTC was poor. The OIG clinicians reviewed 64 nursing encounters and found 23 deficiencies. The CTC nurses did not usually report changes in the patient's condition to the provider, implement the provider's orders, or initiate comprehensive patient-specific nursing care plans. These findings are described in the *Specialized Medical Housing* indicator.

Transfers and Reception Centers

When patients were new arrivals to SVSP or returned from a community hospital, nursing staff did a poor job triaging them. The nurses did not make timely referrals to providers for newly arrived patients who were clinically high risk. The nurses often failed to perform adequate assessments for patients who returned from the hospital, and they did not always provide patient education or instructions. These findings were discussed in the *Inter- and Intra- System Transfers* indicator.

Out-to-Medical Return and Specialty Service

The OIG clinicians reviewed 40 nursing encounters from when patients returned from their specialty appointments. The nurses often did not perform adequate assessments for patients returning from offsite appointments. When patients returned without the specialty report, the nurses did not ask the specialist for the initial findings and recommendations. In addition, the nurses did not provide education or instructions to patients who underwent procedures. These findings are discussed in the *Specialty Services* indicator.

Medication Administration

SVSP continued to face challenges with medication continuity and administration. Of the 30 medication-specific events reviewed, 17 deficiencies were identified related to nursing performance. These findings are discussed in the *Pharmacy and Medication Management* indicator.

Clinician Onsite Inspection

The OIG clinicians attended the morning huddles that were held in the outpatient clinics during the onsite inspection. In one of the clinics, the provider was not present during the huddle. All other staff members participated in the team discussion, including the supervising RN. Due to the absence of a provider in this clinic, there was no meaningful discussion of the care plan to address the patient's health care needs. Significant laboratory test results were not discussed. In another clinic, the medical staff were unprepared and had not reviewed the relevant documents. That huddle was prolonged and ineffective due to the staff's unpreparedness and unfamiliarity with the patients. In two of the other clinics, however, the huddles were thorough, and meaningful information was shared.

The OIG clinicians visited the various clinic areas and interviewed the staff. One primary care RN and an LVN care coordinator were assigned in each of the main clinics. On an average day, the nurses picked up 10 to 25 sick call requests in each clinic. The primary care RN and LVN care coordinator each saw approximately ten patients daily. During one interview, a primary care RN claimed that she performed care management by reviewing patients who were new to the primary care team and seeing patients with chronic care conditions at least four times a year. The OIG clinicians also spoke with the LVN care coordinator, medication nurses, the nurse instructor, and nursing supervisors. Nursing staff identified no communication barriers with providers, supervisors, and custody staff when meeting patient care needs. The nurse instructor was very knowledgeable and organized. Training records showed evidence that extensive training had been provided to both new and current nursing staff.

Nursing staff reported improved morale since the OIG's Cycle 4 inspection, as more nurses had been hired recently, including several nursing supervisors and the chief nurse executive (CNE). The staff were still frustrated, however, with the instability of nursing assignments and constant assignment redirection. Nurses attributed this instability to the ongoing electronic health record (EHRS) training and numerous new employees who were still in orientation. Despite their frustration, they expressed optimism that their working conditions would improve soon. Most of the nurses stated that the new CNE was an effective leader. Although the CNE was new to her position, she had been promoted from within SVSP. As a result, the CNE was aware of the institution's nursing challenges and was actively implementing quality improvement measures. The CNE stated she was committed to improving nursing performance and had the support of the nursing staff.

Clinician Summary

Care managers and care coordinators were neither managing nor coordinating care. SVSP nurses continued to perform poorly in nursing assessment, intervention, and documentation. While many of the patients ultimately did receive appropriate care, SVSP nurses failed to perform at a level

consistent with the nursing standards of practice, and the department's own policies and procedures. This poor performance placed their patients at an increased risk of harm. The OIG nursing clinicians had serious concerns regarding inadequate nursing assessment and intervention, and thus rated this indicator *inadequate*.

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11 — *QUALITY OF PROVIDER PERFORMANCE*

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

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

Case Review Results

The OIG clinicians reviewed 292 medical provider encounters and identified 93 deficiencies related to provider performance at SVSP. Of the 93 deficiencies identified, 41 were significant. As a whole, SVSP provider performance was *inadequate*.

Assessment and Decision-Making

SVSP providers repeatedly failed to make sound assessments and accurate diagnoses. Poor assessment and misdiagnosis were found frequently throughout the cases reviewed. Many providers made questionable medical decisions regarding patient care. These deficiencies were pervasive and were identified in cases 4, 5, 6, 8, 9, 12, 17, 19, 21, 22, 23, 24, and in the following:

- In case 1, the patient had liver cirrhosis and liver cancer. Opioid medications were especially dangerous for a patient with a poorly functioning liver. The provider started the patient immediately on a moderate dose of opioid without considering the risk of harm, ensuring proper precautions, or adequate follow-up.

- In case 10, the patient had a long history of allergies and chronic sinusitis. An outside physician heard wheezes in the lungs and thought the patient might have asthma. Another provider had prescribed asthma inhalers. When the patient requested an evaluation for the possibility of asthma, the provider wrongly dismissed the patient's symptoms without providing any further workup. Undiagnosed asthma could have led to progressive lung damage and worsening breathing problems.

- In case 16, the patient developed iron deficiency anemia. Providers were slow to make the diagnosis, and in some encounters missed the diagnosis entirely, even after it had been previously diagnosed by another provider. Iron deficiency is often a sign of cancer for older patients; SVSP providers should have ordered the endoscopy tests needed to evaluate the patient for this disease. This delayed diagnosis placed the patient at an increased risk of harm. During the medical inspection, the OIG notified CCHCS of the providers' errors, and SVSP has since begun an appropriate workup.

Review of Records

SVSP providers frequently did not sufficiently review medical records. This was a common occurrence, with this error identified in cases 9, 14, 16, 17, 20, 23, 25, and in the following:

- In case 8, the patient was sent for a magnetic resonance imaging scan (MRI) to determine whether his foot infection had spread to the bone. The MRI showed that the infection had indeed spread, but the report had never been retrieved. SVSP providers did not review the records and never followed up on the missing MRI report. The providers did not act on the bone infection.

- In case 19, the patient developed a dangerous blood clot. SVSP providers made the error of placing the patient on inadequate doses of anticoagulants (blood thinners). The patient saw a hematology specialist, who recommended increasing the blood thinners' dosages to acceptable levels. Although a provider signed off on the specialty report, these recommendations were completely ignored. The provider's poor review of the records led to wrong decisions and inadequate care.

Unintentional Errors

SVSP providers frequently made unintentional errors. In these situations, the provider documented patient care plans, but did not follow through with ordering proposed interventions. Errors of this type were identified in cases 8, 10, 14, 20, 25, and in the following examples:

- In case 5, the patient had rectal bleeding. While the provider intended to order appropriate laboratory tests and a follow-up appointment in ten days, the provider neglected to place the orders. The evaluation for the patient's rectal bleeding was dropped.

- In case 6, the provider diagnosed many uncontrolled conditions and documented plans to help improve several of them. The provider planned to change medications to help the patient's blood pressure, acid reflux, and diabetes, yet neglected to order any of the medications. As a result, none of the planned changes were implemented.

- In case 23, the patient had uncontrolled diabetes. The provider planned to order laboratory tests to monitor the effectiveness of the medical intervention, but neglected to place the order.

- In case 24, the patient also had uncontrolled diabetes. The provider planned to increase the insulin medication, but neglected to place the order.

Emergency Care

Provider emergency care was satisfactory. Providers in the TTA usually made appropriate decisions and sent patients to higher levels of care when indicated. This area of performance is further discussed in the *Emergency Services* indicator.

Chronic Care

Chronic care performance was satisfactory. Providers demonstrated fair skill and knowledge in caring for most chronic conditions. As long as the providers placed orders according to their documented plans, patients were properly monitored, assessed, and treated. At SVSP, the majority of patients were of low complexity and did not require management of human immunodeficiency virus (HIV) or hepatitis C treatment.

Provider Continuity

Problems with poor provider continuity were widespread as identified in cases 8, 10, 12, 14, 15, 17, 19, 21, and 23.

Specialty Services

Services provided for anticoagulation at SVSP were poor. As long as the patient required simple and long-term anticoagulation treatment, clinical performance was satisfactory. However, if the patient's condition was complex or required close provider oversight, SVSP providers did not provide the necessary services. Providers did not sufficiently supervise the clinical pharmacist, and multiple clinical errors were identified in the complex anticoagulation cases. These findings are discussed further, with additional examples given, in the *Specialty Services* indicator.

While SVSP providers continued to appropriately refer patients for specialty services, they did not adequately review or follow up on the specialists' findings. Please refer to the *Specialty Services* indicator for further details.

Specialized Medical Housing

Provider performance in the CTC was barely acceptable. There was evidence of superficial care, as providers often missed time frames for visiting patients on rounds, and sometimes did not adequately review the medical record or document their provision of care to an acceptable standard. The *Specialized Medical Housing* indicator provides further details for this area.

Documentation Quality

Numerous instances of insufficient documentation were identified, the most common of which were failures to address one or more medical problems, acute medical issues, inadequate discussion to support the medical decision, or the lack of documentation altogether.

Clinician Onsite Inspection

The OIG clinicians observed both provider handoff meetings (morning reports) and the subsequent daily morning huddles. Onsite huddle performance is discussed in the *Health Information Management* and *Quality of Nursing Performance* indicators.

Onsite interviews with providers yielded limited information. Most providers working at SVSP had only recently joined the institution within the past few months and had not been at the institution long enough to give an informed opinion regarding either working conditions or quality of care at SVSP.

Many of the errors in this inspection came as no surprise to the few remaining providers at SVSP who had been present during the OIG's Cycle 4 clinician onsite inspection. During the review period, SVSP providers felt overextended, and the institution was plagued by severe provider understaffing. These remaining providers attributed the errors to simple fatigue. Nonetheless, they described their own morale as good because of the sudden influx of new providers. There was a palpable sense of relief because the work was being distributed among many more people. One provider described the feeling "like seeing a light at the end of the tunnel." The CME, the CP&S, and the other providers were visibly excited at the prospect of providing improved patient care, as the institution had only recently hired a sufficient numbers of providers to staff it.

Medical leadership attributed the following reasons to its recent success with provider recruitment. First, SVSP had successfully recruited the CP&S from the neighboring CDCR institution, California Training Facility (CTF). Second, SVSP had recently implemented a 15 percent recruitment and retention bonus for physicians. These two factors had prompted many physicians from CTF to suddenly transfer to SVSP. Because the additional providers were hired subsequent to the case review period, any positive effects at SVSP due to the new providers joining the institution's medical staff could not have been reflected in the cases reviewed. During the case review period, the lack of physicians continued to place a heavy burden on SVSP's mid-level providers. Due to SVSP's understaffing, nurse practitioners (NPs) saw many of the high-risk patients and stated they had been caring for these patients beyond their scope of practice. Both the CME and the CP&S acknowledged the risk associated with this practice and planned to reduce their reliance on mid-level providers for the care of the high-risk patients.

In general, SVSP's providers stated the CME and the CP&S were fair, consistent, knowledgeable, and approachable. Striving to improve the quality of care, they were often seen in the clinics interacting with staff. They worked diligently to provide the support necessary to the institution's providers, so they could give excellent care to SVSP's patients.

Clinician Summary

The care provided by SVSP medical providers was a cause for concern during the review period. Problems with provider assessment, decision-making, record review, unintended errors, provider continuity, and anticoagulation services all contributed to the rating for this indicator. The findings

noted during the onsite inspection contrasted sharply with those of the case review due to the sudden influx of new providers after the review period had ended. With this influx of additional providers, SVSP leadership expressed hope and optimism that the quality of care would improve significantly. Of the 25 cases reviewed, 16 were *adequate* and 9 were *inadequate*. After considering all relevant factors, the OIG rated SVSP provider performance *inadequate*.

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12 — *RECEPTION CENTER ARRIVALS*

Case Review Rating:
Not Applicable
Compliance Score:
Not Applicable

Overall Rating:
Not Applicable

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

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

13 — *SPECIALIZED MEDICAL HOUSING*

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

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(72.5%)
Overall Rating:
Inadequate

Case Review Results

The institution had 12 medical CTC beds and 10 CTC mental health beds. During the onsite inspection, ten of the medical beds and all mental health beds were filled. The OIG clinicians reviewed 11 CTC admissions, including 53 provider encounters and 64 nursing encounters. Each provider and nurse encounter included up to one month of provider rounds and several consecutive days of nursing care. There were 50 deficiencies, 12 of which were significant. The rating for *Specialized Medical Housing* was *inadequate*.

Provider Performance

The performance of CTC providers at SVSP was acceptable, but OIG clinicians noted some areas of concern. While most provider assessments and decisions were adequate, superficial care was evident. Providers often missed time frames for performing their rounds, and sometimes, they performed inadequate record reviews and the documentation of care provided was at times poor.

Providers had significant trouble complying with state regulations and CCHCS policy for completing their rounds on CTC patients at least once every 72 hours. Fortunately, these lapses did not place the patients at a significantly increased risk of harm. This deficiency occurred far more frequently in Cycle 5 compared to Cycle 4; it is also discussed in the *Access to Care* indicator. Deficiencies in providers conducting patient encounters every 72 hours were found in cases 2, 4, 13, 18, 58, 59, and 61.

SVSP providers occasionally had problems with producing acceptable documentation as noted in the examples below:

- In case 1, the provider discharged the patient to a community hospital, but did not document this in a progress note. The provider did not complete a CTC discharge summary until after the patient had already died in the hospital from poor overall health.

- In case 4, the CTC provider did not complete an adequate CTC discharge summary. This was a significant deficiency because discharge summaries are critically important for a patient's successful transfer of care.

- In cases 58 and 59, a provider used cloned notes on multiple occasions.

Providers sometimes did not properly review medical records, as noted in the following cases:

- In case 2, the patient received chemotherapy for cancer. The provider did not review the laboratory tests that showed a worsening platelet count that was too low.

- In case 13, the provider admitted the patient to the CTC. The patient had received an imaging study (CT scan) two weeks prior, but this report was missing from the eUHR. The provider did not review the report database and was thus not aware of the CT results. This error contributed to the provider's delayed recognition and treatment of the patient's ulcerative colitis (a disease characterized by colon inflammation).

- In case 14, the provider admitted the patient to the CTC, but did not review several recent hospital records that were relevant to the patient's care. The provider was unaware of the patient's recent gastrointestinal bleeding episode, endoscopy, or anemia. The provider was unaware of the recent concern for a fungal lung infection. The provider did not review recent laboratory results and ignored recent recommendations for placing the patient on diuretic therapy.

Nursing Performance

SVSP nurses did not provide adequate nursing care in the CTC. Although the CTC nurses assessed the conditions and functional abilities of patients at least once every shift, they often did not report changes in a patient's condition, implement provider orders, or develop comprehensive nursing care plans. The OIG clinicians found 23 deficiencies in nursing care, 4 of which were significant. In the following cases, significant deficiencies occurred in which CTC nurses did not report to the provider the patient's change in condition:

- In case 4, the nurse did not report to the provider that the patient had a fall. When the patient lost more than 22 pounds in 11 days, the nurse also failed to report the unexplained weight loss to the provider.

- In case 13, the patient lost more than 11 pounds in one week, but the nurse did not report this significant weight loss to the provider. One week later, when the patient had a rapid heart rate and dark brown urine, the nurse did not notify the provider. The patient was later sent to the hospital for tachycardia and lethargy.

The CTC nurses failed to implement provider orders and perform basic nursing care, such as recording fluid intake and urine output, weight checks, and vital signs in the following three cases:

- In case 1, the nurses did not record intake and output every shift as ordered by the provider.

- In case 2, the nurses consistently failed to take vital signs during the first watch.

- In case 58, the nurses did not obtain and record the patient's daily weight when ordered by the provider.

Nursing care plans are essential tools to communicate patient's health care needs and to provide consistent and individualized patient care. Unfortunately, SVSP CTC nurses repeatedly demonstrated a failure to initiate nursing care plans, which were widespread findings.

- In cases 1, 3, 4, 13, 14, 59, 60, and 61, CTC nurses did not initiate nursing care plans.

- In case 4, the nurses did not initiate care plans to address patient health care needs when the patient had a fall incident.

- In case 13, the nurse did not initiate a nursing care plan for a patient with unexplained weight loss.

Nursing documentation was generally appropriate in the CTC. One second-watch CTC nurse, however, cloned multiple notes for several patients (cases 2, 58, 59, 60, and 61) that were worded exactly or very similarly to the previous entries, and that always were recorded at the same time of the day.

Clinician Onsite Inspection

SVSP attributed problems with CTC provider performance to critically low staffing levels during the review period. Many providers stated that the institution had been short several doctors at the time, and the remaining providers were simply exhausted. Between the end of the review period and the onsite inspection, there had been a large influx of new providers. These providers included a new CP&S, and multiple providers who had recently transferred from the neighboring CDCR institution. The CME, the CP&S, and the providers expressed optimism that with the provider shortage resolved, all provider performance issues at SVSP would improve, including those at the CTC. Provider performance is further discussed in the *Quality of Provider Performance* indicator.

The CTC had adequate medical supplies, emergency equipment, and clinic space, and nurse staffing levels were appropriate. A shift lead RN, two RNs, and one LVN were assigned to each watch. During the second and third watches, a psychiatric technician (PT) and a certified nursing assistant (CNA) were also assigned to patient care. The shift lead RN verbally gave shift reports during each shift change. At the time of the OIG clinicians' visit, 10 of the 12 medical beds and all 10 mental health beds were filled. Some of the nursing staff interviewed were recently hired or were not regularly assigned to the CTC. As a result, these nurses were unfamiliar with some of their responsibilities. During the onsite inspection, most of the regular nursing staff were attending the EHRS training. The OIG clinicians attended the weekly CTC grand rounds. The CTC provider, nursing staff, CP&S, utilization management nurse, and nursing supervisor were present during the rounds. Each CTC medical patient's case was discussed, including the care plan, current issues, or barriers to care.

Clinician Summary

CTC provider performance was acceptable, with occasional superficial care and many instances of missed time frames for performing their rounds. CTC nursing performance was poor, as nurses often failed to report changes in patient condition, follow provider orders, or initiate nursing care plans. Given the significance of these problems, the case review rating for *Specialized Medical Housing* was *inadequate*.

Compliance Testing Results

For this indicator, SVSP received an *inadequate* score of 72.5 percent, with the following test showing room for improvement:

- When the OIG inspectors tested whether providers completed their Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes at required three-day intervals, providers missed one or two notes on all ten sampled patients, resulting in a score of zero for this test (MIT 13.003).

The following three tests, however, all scored in the *proficient* range:

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

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

- Providers evaluated nine of the ten sampled patients within 24 hours of admission to the CTC (90 percent). One patient received an evaluation by the provider 46 minutes after the 24-hour compliance period (MIT 13.002).

14 — *SPECIALTY SERVICES*

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

Case Review Rating:
Inadequate
Compliance Score:
Inadequate
(74.5%)
Overall Rating:
Inadequate

Case Review Results

The OIG clinicians reviewed 55 specialty consultations, 36 specialty procedures, 40 anticoagulation encounters, and 40 nursing encounters related to *Specialty Services*. In this category, 84 deficiencies were found, 3 of which were due to an outside specialist and for which SVSP was not penalized. Of the 81 remaining deficiencies, however, 54 were significant; these were identified once in cases 1, 14, 23, and 61; two times each in cases 2, 4, 12, and 13; three times each in cases 9, 11, and 15; four times each in cases 16 and 17; seven times in case 19; eight times in case 8; and ten times in case 18. For the *Specialty Services* indicator, the case review rating was *inadequate.*

Access to Specialty Services

SVSP did not perform well in providing access to specialty services. SVSP's performance in this area was variable, with some cases demonstrating good specialty access, while others were characterized by extremely poor access. Examples demonstrating how poor specialty access increased the risk for lapses in care, and thus, increased the risk of harm to the patient occurred in cases 5, 9, 16, 21, and the following:

- In case 4, the patient had a lung mass. The provider ordered a biopsy within two weeks to determine the cause of the mass. The biopsy did not occur until seven weeks later, at which time the patient was hospitalized because his lung condition had worsened.

- In case 11, the patient recently had knee surgery and returned to SVSP from an outside hospital. The provider ordered physical therapy to occur every three days. The patient did not receive any physical therapy until almost four months later.

- In case 13, the patient was newly diagnosed with ulcerative colitis, a type of large intestine inflammation. The provider referred the patient to a gastrointestinal specialist, but the appointment did not occur. This example is also discussed in the *Health Information Management* indicator.

- In case 17, SVSP staff monitored the patient who had lung cancer. The provider arranged for and ordered a specific appointment date with the medical oncologist, but SVSP did not arrange the appointment as ordered. The patient eventually saw the oncologist three weeks later. Fortunately, the delay did not affect the patient's care.

Nursing Performance

At SVSP, patients returning from offsite specialty appointments were processed in the TTA. The nurses often failed to perform adequate nursing assessments, ensure retrieval of the specialty report, or provide patient education. These deficiencies were demonstrated in the following cases:

- In case 6, the patient returned from an eye surgery. The nurse did not assess the patient and did not provide any post-operative instructions.

- In cases 7 and 11, SVSP nurses also did not assess their patients upon return from their specialty appointments.

- In case 8, the patient returned from an offsite wound care clinic. The nurse did not obtain an order for wound care and did not provide the patient with any wound care instructions. On three other occasions, the nurse did not assess the patient upon return from an offsite appointment. On two occasions, the nurse documented that the patient returned with the specialty report when there was no specialty report. When the patient returned without any specialty findings or recommendations, the nurse did not contact the specialist to follow up on the missing information. Furthermore, when the patient returned from an urgent specialty appointment, the nurse did not refer the patient for a provider follow-up.

- In case 15, the patient was sent to an outside specialty clinic seven times for specialty consultations, procedures, and follow-ups. On four occasions, the nurses did not assess the patient upon his return and did not provide patient instruction or education.

- Once in cases 9 and 59, and twice in cases 8 and 15, upon return from an offsite specialist, nurses neglected to check their patients' vital signs.

Provider Performance

As in Cycle 4, providers continued to make appropriate referrals for specialty services. Deficiencies in this area were uncommon, and the OIG clinicians found no distinct pattern of problems. Although specialty referral performance was good, SVSP can use the following exceptions for quality improvement purposes:

- In case 1, the patient arrived at SVSP with an existing diagnosis of liver cancer. The provider should have referred the patient to the cancer specialist with urgent referral (within 14 days) instead of routine priority (within 90 days). Fortunately, the patient was seen by the telemedicine cancer specialist within an appropriate time frame.

- In case 4, the patient arrived at SVSP in the midst of an evaluation for a lung mass. The patient was due for a procedure to look inside the lungs with a camera the next day, but the provider made no effort to ensure the procedure was completed promptly. Furthermore, the provider wanted to evaluate a liver mass two months later, but ordered an incorrect imaging study.

SVSP providers did not adequately review or follow up on specialty consultants' findings. Cases 14, 17, 19, and the following are examples that show how SVSP providers did not adequately review specialty findings:

- In case 8, the patient was diabetic and had a chronic, non-healing foot ulcer. The patient was sent to an orthopedic specialist multiple times. The patient had an MRI of his foot to see whether the infection had traveled deep into the bone. This MRI showed that the infection had indeed traveled into the bone, but SVSP staff did not retrieve the MRI report, and providers made no attempt to discover the result. SVSP did not retrieve the report until after the OIG clinicians pointed out the error during their onsite inspection. At one point, the patient claimed that the specialist had wanted to perform a surgical procedure. However, SVSP staff never retrieved the specialist reports, and the provider made no efforts to retrieve the reports or to communicate with the specialist. The provider made a decision to defer the surgery without ever knowing what course of treatment the surgeon had recommended or why. The undiagnosed bone infection could have led to a foot amputation and other related complications.

- In case 19, the patient had a blood clot, but his warfarin (an anticoagulant) levels were low. Because the patient was at high risk of blood clot progression, the specialist recommended increasing the warfarin dose and prescribing a second anticoagulant while waiting for the warfarin levels to reach target levels. Even though a provider signed off on the specialty report, the provider ignored the recommendations. This error placed the patient at high risk for complications from the blood clot.

- In case 23, the patient saw a lung specialist for a lung nodule. The specialist recommended a repeat CT scan (a type of imaging study). The recommendations were ignored at subsequent provider visits, despite a provider signature on the specialty report. The lung nodule could have represented a cancer. The provider should have ordered the CT scan and monitored the nodule to ensure that it was not a cancer.

For anticoagulation, SVSP used a clinical pharmacist to regularly track, monitor, and assess the institution's anticoagulation patients. The clinical pharmacist usually followed an anticoagulation protocol, notified the provider, and obtained orders when needed. For the majority of simple anticoagulation patients, the anticoagulation clinic performed acceptably. However, for complex anticoagulation patients who needed in-depth assessment and decision-making, there were clinical errors and inadequate physician supervision, as noted in the following examples:

- In case 12, the patient had high warfarin levels, which raised his risk of significant bleeding. On one occasion, the clinical pharmacist decreased the dose by a marginal amount that was unlikely to sufficiently lower the warfarin levels. On another occasion, the clinical pharmacist held the medication for a few days, but did not decrease the medication dose. The patient then resumed the medication at the inappropriately high dose. On two occasions, the pharmacist did not order repeat warfarin level monitoring within appropriate time frames. These errors increased the chance of bleeding for this patient.

- In case 19, the patient had an acute blood clot that required treatment with a second anticoagulant (Lovenox) while waiting for the warfarin levels to reach target levels. The patient was not receiving the correct dose of Lovenox, yet the pharmacist recommended continuing the insufficient dose. After six months, the patient had still not reached his target warfarin levels. The pharmacist consulted with a physician, who mistakenly thought the patient was being adequately treated and recommended stopping the treatment, yet another error that increased the risk of blood clot complications.

- In case 22, the patient had a mechanical heart valve. When the patient needed to have a procedure, the patient was instructed to stop his warfarin blood thinner. To prevent blood clots during the period without warfarin, the patient needed to be prescribed a second blood thinner (a process known as bridging). SVSP did not bridge the medications, thus exposing the patient to an elevated risk of blood clots and strokes.

Health Information Management

SVSP had tremendous difficulty with processing specialty reports. Specialty reports were often completely missing from the medical record, or staff retrieved them late. Little evidence was uncovered that providers communicated with the specialists directly to obtain this information. Even had the providers done so, the information would not have been readily available to any subsequent medical staff. The absence or delayed processing of specialty reports was severe and widespread. These deficiencies placed patients at a high risk for lapses in care because important information was unavailable to the primary care providers. The following are some examples detailing these failures with specialty report handling:

- In case 2, the patient had stomach cancer that had spread widely throughout the body. The patient had a CT scan to monitor the cancer, but this scan was missing from the electronic medical record and had not been reviewed by a provider. Unaware of the CT results, SVSP providers could have delayed treatment or ordered inappropriate treatment. Fortunately, the offsite oncologist monitored the patient closely and gave him the necessary treatment, even as the patient ultimately succumbed to his disease.

- In case 9, the patient had an imaging test of the intestines in preparation for surgery. The imaging report was missing from the electronic medical record and had not been reviewed by a provider. This oversight persisted, even after a provider requested retrieval of the

report. If the test had shown any significant abnormality, it may have been necessary to cancel the surgery due to safety concerns. The patient underwent surgery anyway, and fortunately, the lack of review did not affect the surgical outcome.

- In case 15, the patient had surgery of the jaw and face to remove old hardware and perhaps help his lockjaw symptoms. The surgeon's report was missing from the medical record and had not been reviewed by a provider. At a subsequent visit, the surgeon claimed he had recommended antibiotics after the surgery. However, because the surgeon's recommendations were never retrieved, the patient was not placed on antibiotics. The patient subsequently developed a post-operative infection, which required hospitalization.

- In case 16, the patient underwent surgery to remove a lesion on his neck. The surgeon's report and the pathology reports were missing from the electronic medical record, and had not been reviewed by a provider. Since the lesion may have represented skin cancer, the institution should have retrieved the report and had it reviewed by a provider. Fortunately, the offsite surgeon reviewed the report and verified that the entire skin cancer was successfully removed.

Clinician Onsite Inspection

In responding to some of the questions asked by the OIG clinicians, SVSP found the reasons for their concerns with specialty services were usually related to two issues. Sometimes, SVSP did not have sufficient specialty provider availability to meet specialty access policy requirements. However, a greater worry was the finding that specialty appointments sometimes did not occur because the specialty department never received the order. This finding is also discussed in the *Health Information Management* indicator. During the onsite inspection, offsite specialty reports were not given to providers for review during either the morning report meeting or the clinic huddles.

Clinician Summary

Specialty access at SVSP was inconsistent. For patients returning from offsite specialty appointments, SVSP nurses performed poorly. SVSP providers appropriately referred patients for specialty services, but did not adequately follow up on those findings. Complex anticoagulation patients did not receive proper care. Providers did not adequately supervise the clinical pharmacist who ran the anticoagulation clinic. SVSP experienced severe problems with specialty report processing: numerous specialty reports were missing from the electronic medical record and were not reviewed by a provider. These problems at SVSP resulted in case review assigning an *inadequate* rating for this indicator.

Compliance Testing Results

The institution received an *inadequate* compliance score of 74.5 percent in the *Specialty Services* indicator. The following tests showed room for improvement:

- Among 20 applicable specialty service denials that were sampled, only 9 patients (45 percent) received a timely notification of the service denial, which included a provider appointment with the patient within 30 days to discuss alternative treatment strategies. For one of the 11 exceptions, the provider's follow-up visit occurred seven days late. For two other patients, the visits were 30 and 33 days late. For one patient, the visit was 79 days late. For seven patients, there was no evidence of a provider follow-up appointment to discuss the denial (MIT 14.007).

- For 10 of the 15 sampled patients (67 percent), high-priority specialty service appointments occurred within 14 days of the provider's order. Three patients received their specialty service appointments from two to eight days late. Two other patients received their appointments 20 and 59 days late (MIT 14.001).

- When SVSP providers ordered high-priority specialty services for patients, the ordering provider did not always review the specialty report within the required time frame. Providers timely reviewed 11 of the 15 sampled specialty reports (73 percent). For two samples, the reports were reviewed one day late; and for two other samples, the reports were reviewed 16 and 49 days late (MIT 14.002).

Three tests received scores in the *adequate* range:

- Specialists' reports were timely reviewed by a provider following routine specialty service appointments for 11 of the 14 applicable cases reviewed (79 percent). Two reports were reviewed one and four days late, and in one case, no evidence was found that the specialty report was received and reviewed by the provider (MIT 14.004).

- When an institution approves or schedules a patient for specialty services appointments and then transfers the patient to another institution, CCHCS policy requires that the receiving institution ensure that the patient's appointment occurs timely. At SVSP, 16 of the 20 sampled transfer-in patients received their specialty services appointments within the required time frame (80 percent). Three patients received their appointments 20 and 38 days late, and for one other patient, the appointment was over four months late (MIT 14.005).

- The OIG inspectors tested the timeliness of SVSP's administrative denials of provider specialty service requests. For 16 of the 19 applicable sampled patients (84 percent), such requests were denied in a timely manner. Three patients' requests were denied from one to four days late (MIT 14.006).

One test received a *proficient* score:

- For the 15 sampled patients, all routine specialty service appointments occurred within 90 calendar days of the provider's order, except for one patient (93 percent) whose appointment was 30 days late (MIT 14.003).

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15 — *ADMINISTRATIVE OPERATIONS (SECONDARY)*

Case Review Rating:
Not Applicable
Compliance Score:
Adequate
(82.1%)
Overall Rating:
Adequate

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

Compliance Testing Results

The institution scored in the *adequate* range in the *Administrative Operations* indicator, receiving a compliance score of 82.1 percent. The following tests received scores in the *proficient* range:

- The institution promptly processed all patient medical appeals in each of the most recent 12 months (MIT 15.001).
- The OIG reviewed the one adverse/sentinel event (ASE) that occurred at SVSP during the prior six-month period, which required a root cause analysis. Inspectors' examination concluded that the institution timely followed ASE reporting requirements (MIT 15.002).
- SVSP 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 of the patients' appealed issues (MIT 15.102).
- The OIG's inspectors examined the nursing reviews completed by five different nursing supervisors for their subordinate nurses; in all instances, the reviews were sufficiently completed (MIT 15.104).

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

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

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

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

- Nine of the ten sampled nurses (90 percent) were current on their clinical competency validations. For one nurse, the evaluation was not completely filled out by the nursing instructor (MIT 15.105).

The following three tests received scores in the *adequate* range:

- Inspectors reviewed six recent months' worth of Quality Management Committee (QMC) meeting minutes and confirmed that the QMC evaluated program performance and took action when the committee identified improvement opportunities. Five meetings were compliant (83 percent); the one sampled exemption did not evidence review of the institutional scorecard performance data (MIT 15.003).

- SVSP's Local Governing Body (LGB) met quarterly and exercised its overall responsibilities for the quality management of patient health care in three of the four prior quarters (75 percent). There was no evidence found that general management and planning were discussed in the meeting minutes provided by the institution during the prior third quarter (MIT 15.006).

- Three of four SVSP providers had a proper clinical performance appraisal completed by their supervisor (75 percent). The supervising physician utilized the Individual Development Plan (Form 637) instead of the Appraisal Form 636 for probationary evaluation (MIT 15.106).

The following three tests showed room for improvement:

- The institution did not meet the emergency response drill requirements for the most recent quarter for all of its three watches. More specifically, the institution's first- and third-watch drill packages did not contain completed triage and treatment services flow sheets (CDCR Form 7464), and the second-watch drill package was missing the time frames of all elements, recommendations on areas needing improvement or additional training, and the CDCR Form 7464 as required by CCHCS policy (MIT 15.101).

- Of the 12 sampled incident packages for emergency medical responses reviewed by the institution's EMRRC during the prior 12-month period, only 2 (17 percent) complied with policy. Ten of the EMRRC event checklist forms inspected were not fully completed (MIT 15.005).

- SVSP had nine patient deaths that occurred during the OIG's sample test period. Five of the nine (56 percent) death review packets were in compliance. For the remaining three death review packets, SVSP's medical staff incorrectly submitted the Initial Inmate Death Report (CDCR Form 7229A). Because the deaths were suicides, the Initial Inmate Suicide Report (CDCR Form 7229B) should have been used instead. In another packet, the CEO or CME did not initial the report (CDCR Form 7229A) (MIT 15.103).

Non-Scored Results

- The OIG gathered non-scored data regarding the completion of death review reports by the Death Review Committee (DRC) of CCHCS. Nine deaths occurred during the OIG's review period: six unexpected (Level 1) deaths and three expected (Level 2) deaths. The DRC was required to complete its death review summary report within 60 days from the date of death for the Level 1 deaths and within 30 days from the date of death for the Level 2 deaths; the reports were then to be submitted to the institution's CEO within seven calendar days thereafter. However, for the six Level 1 deaths, the DRC completed its reports from 7 to 78 days late (67 to 137 days after death) and submitted them to SVSP's CEO 32 to 70 days late; for the three Level 2 deaths, the DRC completed its reports from 13 to 33 days late (42 to 70 days after death) and submitted them to the CEO 3 to 22 days late (MIT 15.998).

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

RECOMMENDATIONS

The OIG recommends that SVSP leadership implement effective care management and care coordination processes for the institution's patients, so nurses can make appropriate interventions for their chronic care patients when needed.

The OIG recommends that SVSP provide training to nurses to improve their recognition of sick call requests requiring same-day evaluation, improve their quality of assessments, and improve the accuracy of their documentation.

POPULATION-BASED METRICS

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

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

Methodology

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

Comparison of Population-Based Metrics

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

Results of Population-Based Metrics Comparison

Comprehensive Diabetes Care

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

When compared statewide, SVSP outperformed Medi-Cal in all five diabetic care measures. Furthermore, SVSP outperformed Kaiser Permanente (North and South regions) in four of the five diabetic care measures, with Kaiser performing better in blood pressure control. When compared nationally, SVSP outperformed or matched Medicaid, Medicare, commercial health plans, and the VA in all five of the diabetic care measures.

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, SVSP scored lower than all reporting entities except Medicaid and commercial health plans. The patient refusal rate of 47 percent for influenza vaccinations negatively affected the institution's score. When administering influenza and pneumococcal vaccinations to older adults, SVSP outperformed Medicare and scored slightly lower than the VA.

Cancer Screening

With respect to colorectal cancer screening, SVSP scored lower than all reporting entities except Medicare and commercial health plans. The 20 percent patient refusal rate negatively affected the institution's score for this measure.

Summary

SVSP's population-based metrics performance reflected an adequate chronic care program in comparison to other reporting statewide and national health care plans. The institution may improve its scores for immunizations and colorectal cancer screening by reducing patient refusals through patient education of the benefits of these preventive services.

SVSP Results Compared to State and National HEDIS Scores

Clinical Measures	California				National			
	SVSP Cycle 5 Results[1]	HEDIS Medi-Cal 2015[2]	HEDIS Kaiser (No. CA) 2016[3]	HEDIS Kaiser (So. CA) 2016[3]	HEDIS Medicaid 2016[4]	HEDIS Com-mercial 2016[4]	HEDIS Medicare 2016[4]	VA Average 2015[5]
Comprehensive Diabetes Care								
HbA1c Testing (Monitoring)	**100%**	86%	94%	94%	86%	90%	93%	98%
Poor HbA1c Control (>9.0%)[6, 7]	**15%**	39%	20%	23%	45%	34%	27%	19%
HbA1c Control (<8.0%)[6]	**76%**	49%	70%	63%	46%	55%	63%	-
Blood Pressure Control (<140/90)[6]	**79%**	63%	83%	83%	59%	60%	62%	74%
Eye Exams	**89%**	53%	68%	81%	53%	54%	69%	89%
Immunizations								
Influenza Shots - Adults (18–64)	**51%**	-	56%	57%	39%	48%	-	55%
Influenza Shots - Adults (65+)	**74%**	-	-	-	-	-	72%	76%
Immunizations: Pneumococcal	**91%**	-	-	-	-	-	71%	93%
Cancer Screening								
Colorectal Cancer Screening	**75%**	-	79%	82%	-	63%	67%	82%

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

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

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

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

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

6. For this indicator, the entire applicable SVSP 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

Salinas Valley State Prison **Range of Summary Scores: 47.73% – 95.75%**	
Indicator	**Compliance Score (Yes %)**
1 – ***Access to Care***	66.07%
2 – ***Diagnostic Services***	67.78%
3 – ***Emergency Services***	Not Applicable
4 – ***Health Information Management (Medical Records)***	71.02%
5 – ***Health Care Environment***	47.73%
6 – ***Inter- and Intra-System Transfers***	67.92%
7 – ***Pharmacy and Medication Management***	69.24%
8 – ***Prenatal and Post-Delivery Services***	Not Applicable
9 – ***Preventive Services***	95.75%
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)***	72.50%
14 – ***Specialty Services***	74.45%
15 – ***Administrative Operations***	82.09%

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?	13	12	25	52.00%	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?	9	16	25	36.00%	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
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?	24	6	30	80.00%	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?	8	5	13	61.54%	17
1.006	Sick call follow-up appointments: If the primary care provider ordered a follow-up sick call appointment, did it take place within the time frame specified?	2	2	4	50.00%	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?	19	6	25	76.00%	0
1.008	Specialty service follow-up appointments: Do specialty service primary care physician follow-up visits occur within required time frames?	21	8	29	72.41%	1
1.101	Clinical appointments: Do patients have a standardized process to obtain and submit health care services request forms?	4	2	6	66.67%	0
Overall percentage:					**66.07%**	

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?	7	3	10	70.00%	0
2.002	Radiology: Did the primary care provider review and initial the diagnostic report within specified time frames?	6	4	10	60.00%	0
2.003	Radiology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	6	4	10	60.00%	0
2.004	Laboratory: Was the laboratory service provided within the time frame specified in the provider's order?	10	0	10	100%	0
2.005	Laboratory: Did the primary care provider review and initial the diagnostic report within specified time frames?	8	2	10	80.00%	0
2.006	Laboratory: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	6	4	10	60.00%	0
2.007	Pathology: Did the institution receive the final diagnostic report within the required time frames?	8	2	10	80.00%	0
2.008	Pathology: Did the primary care provider review and initial the diagnostic report within specified time frames?	5	3	8	62.50%	2
2.009	Pathology: Did the primary care provider communicate the results of the diagnostic study to the patient within specified time frames?	3	5	8	37.50%	2
Overall percentage:					**67.78%**	

3 – *Emergency Services*

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

Reference Number	4 – *Health Information Management*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
4.001	Are non-dictated healthcare documents (provider progress notes) scanned within 3 calendar days of the patient encounter date?	13	7	20	65.00%	0
4.002	Are dictated/transcribed documents scanned into the patient's electronic health record within five calendar days of the encounter date?	Not Applicable				
4.003	Are High-Priority specialty notes (either a Form 7243 or other scanned consulting report) scanned within the required time frame?	16	4	20	80.00%	0
4.004	Are community hospital discharge documents scanned into the patient's electronic health record within three calendar days of hospital discharge?	14	6	20	70.00%	0
4.005	Are medication administration records (MARs) scanned into the patient's electronic health record within the required time frames?	11	7	18	61.11%	0
4.006	During the inspection, were medical records properly scanned, labeled, and included in the correct patients' files?	18	6	24	75.00%	0
4.007	For patients discharged from a community hospital: Did the preliminary hospital discharge report include key elements and did a primary care provider review the report within three calendar days of discharge?	18	6	24	75.00%	0
Overall percentage:					**71.02%**	

Reference Number	5 – *Health Care Environment*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
5.101	Are clinical health care areas appropriately disinfected, cleaned and sanitary?	10	2	12	83.33%	0
5.102	Do clinical health care areas ensure that reusable invasive and non-invasive medical equipment is properly sterilized or disinfected as warranted?	11	1	12	91.67%	0
5.103	Do clinical health care areas contain operable sinks and sufficient quantities of hygiene supplies?	9	3	12	75.00%	0
5.104	Does clinical health care staff adhere to universal hand hygiene precautions?	7	5	12	58.33%	0
5.105	Do clinical health care areas control exposure to blood-borne pathogens and contaminated waste?	7	5	12	58.33%	0
5.106	Warehouse, Conex and other non-clinic storage areas: Does the medical supply management process adequately support the needs of the medical health care program?	0	1	1	0.00%	0
5.107	Does each clinic follow adequate protocols for managing and storing bulk medical supplies?	3	9	12	25.00%	0
5.108	Do clinic common areas and exam rooms have essential core medical equipment and supplies?	1	11	12	8.33%	0
5.109	Do clinic common areas have an adequate environment conducive to providing medical services?	9	3	12	75.00%	0
5.110	Do clinic exam rooms have an adequate environment conducive to providing medical services?	6	6	12	50.00%	0
5.111	Emergency response bags: Are TTA and clinic emergency medical response bags inspected daily and inventoried monthly, and do they contain essential items?	0	10	10	0.00%	2
Overall percentage:					**47.73%**	

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?	1	22	23	4.35%	2
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?	21	2	23	91.30%	2
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?	13	7	20	65.00%	5
6.004	For patients transferred out of the facility: Were scheduled specialty service appointments identified on the patient's health care transfer information form?	15	4	19	78.95%	1
6.101	For patients transferred out of the facility: Do medication transfer packages include required medications along with the corresponding transfer packet required documents?	6	0	6	100%	0
Overall percentage:					**67.92%**	

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?	16	2	18	88.89%	7
7.002	Did health care staff administer, make available, or deliver new order prescription medications to the patient within the required time frames?	25	0	25	100%	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?	21	4	25	84.00%	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?	15	10	25	60.00%	0
7.006	For patients en route who lay over at the institution: If the temporarily housed patient had an existing medication order, were medications administered or delivered without interruption?	6	4	10	60.00%	0
7.101	All clinical and medication line storage areas for narcotic medications: Does the Institution employ strong medication security over narcotic medications assigned to its clinical areas?	1	7	8	12.50%	4
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?	3	9	12	25.00%	0
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?	3	8	11	27.27%	1
7.104	Medication preparation and administration areas: Do nursing staff employ and follow hand hygiene contamination control protocols during medication preparation and medication administration processes?	3	3	6	50.00%	6
7.105	Medication preparation and administration areas: Does the institution employ appropriate administrative controls and protocols when preparing medications for patients?	7	1	8	87.50%	4
7.106	Medication preparation and administration areas: Does the Institution employ appropriate administrative controls and protocols when distributing medications to patients?	1	5	6	16.67%	6
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

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
7.109	Pharmacy: Does the institution's pharmacy properly store refrigerated or frozen medications?	1	0	1	100%	0
7.110	Pharmacy: Does the institution's pharmacy properly account for narcotic medications?	1	0	1	100%	0
7.111	Does the institution follow key medication error reporting protocols?	24	1	25	96.00%	0
Overall percentage:					**69.24%**	

8 – *Prenatal and Post-Delivery Services*

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

Reference Number	9 – *Preventive Services*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
9.001	Patients prescribed TB medication: Did the institution administer the medication to the patient as prescribed?	14	1	15	93.33%	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?	13	1	14	92.86%	1
9.003	Annual TB Screening: Was the patient screened for TB within the last year?	29	1	30	96.67%	0
9.004	Were all patients offered an influenza vaccination for the most recent influenza season?	25	0	25	100%	0
9.005	All patients from the age of 50 – 75: Was the patient offered colorectal cancer screening?	25	0	25	100%	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?	11	1	12	91.67%	13
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:					**95.75%**	

10 – *Quality of Nursing Performance*

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

11 – *Quality of Provider Performance*

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

12 – *Reception Center Arrivals*

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

Reference Number	13 – *Specialized Medical Housing*	Scored Answers				N/A
		Yes	No	Yes + No	Yes %	
13.001	For OHU, CTC, and SNF: Did the registered nurse complete an initial assessment of the patient on the day of admission, or within eight hours of admission to CMF's Hospice?	10	0	10	100%	0
13.002	For CTC and SNF only: Was a written history and physical examination completed within the required time frame?	9	1	10	90.00%	0
13.003	For OHU, CTC, SNF, and Hospice: Did the primary care provider complete the Subjective, Objective, Assessment, Plan, and Education (SOAPE) notes on the patient at the minimum intervals required for the type of facility where the patient was treated?	0	10	10	0.00%	0
13.101	For OHU and CTC Only: Do inpatient areas either have properly working call systems in its OHU & CTC or are 30-minute patient welfare checks performed; and do medical staff have reasonably unimpeded access to enter patient's cells?	1	0	1	100%	0
Overall percentage:					**72.50%**	

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?	10	5	15	66.67%	0
14.002	Did the primary care provider review the high priority specialty service consultant report within the required time frame?	11	4	15	73.33%	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	93.33%	0
14.004	Did the primary care provider review the routine specialty service consultant report within the required time frame?	11	3	14	78.57%	1
14.005	For endorsed patients received from another CDCR institution: If the patient was approved for a specialty services appointment at the sending institution, was the appointment scheduled at the receiving institution within the required time frames?	16	4	20	80.00%	0
14.006	Did the institution deny the primary care provider request for specialty services within required time frames?	16	3	19	84.21%	1
14.007	Following the denial of a request for specialty services, was the patient informed of the denial within the required time frame?	9	11	20	45.00%	0
Overall percentage:					**74.45%**	

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
15.002	Does the institution follow adverse / sentinel event reporting requirements?	1	0	1	100%	0
15.003	Did the institution Quality Management Committee (QMC) meet at least monthly to evaluate program performance, and did the QMC take action when improvement opportunities were identified?	5	1	6	83.33%	0
15.004	Did the institution's Quality Management Committee (QMC) or other forum take steps to ensure the accuracy of its Dashboard data reporting?	1	0	1	100%	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	16.67%	0
15.006	For institutions with licensed care facilities: Does the Local Governing Body (LGB), or its equivalent, meet quarterly and exercise its overall responsibilities for the quality management of patient health care?	3	1	4	75.00%	0
15.101	Did the institution complete a medical emergency response drill for each watch and include participation of health care and custody staff during the most recent full quarter?	0	3	3	0.00%	0
15.102	Did the institution's second level medical appeal response address all of the patient's appealed issues?	10	0	10	100%	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?	5	4	9	55.56%	0
15.104	Does the institution's Supervising Registered Nurse conduct periodic reviews of nursing staff?	5	0	5	100%	0
15.105	Are nursing staff who administer medications current on their clinical competency validation?	9	1	10	90.00%	0
15.106	Are structured clinical performance appraisals completed timely?	3	1	4	75.00%	0
15.107	Do all providers maintain a current medical license?	12	0	12	100%	0
15.108	Are staff current with required medical emergency response certifications?	2	0	2	100%	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%	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
15.111	Are nursing staff current with required new employee orientation?	1	0	1	100%	0
Overall percentage:					**82.09%**	

APPENDIX B — CLINICAL DATA

Table B-1: SVSP Sample Sets

Sample Set	Total
Anticoagulation	3
CTC/OHU	4
Death Review/Sentinel Events	3
Diabetes	3
Emergency Services – CPR	2
Emergency Services – Non-CPR	3
High Risk	5
Hospitalization	4
Intra-System Transfers In	3
Intra-System Transfers Out	3
RN Sick Call	24
Specialty Services	4
	61

Table B-2: SVSP Chronic Care Diagnoses

Diagnosis	Total
Anemia	7
Anticoagulation	6
Arthritis/Degenerative Joint Disease	8
Asthma	12
COPD	14
Cancer	13
Cardiovascular Disease	13
Chronic Kidney Disease	5
Chronic Pain	21
Cirrhosis/End-Stage Liver Disease	2
Coccidioidomycosis	1
Deep Venous Thrombosis/Pulmonary Embolism	6
Diabetes	17
Gastroesophageal Reflux Disease	13
Gastrointestinal Bleed	1
Hepatitis C	22
Hyperlipidemia	15
Hypertension	36
Mental Health	21
Rheumatological Disease	1
Seizure Disorder	5
Sickle Cell Anemia	1
Sleep Apnea	6
Thyroid Disease	2
	248

Table B-3: SVSP Event – Program

Program	Total
Diagnostic Services	222
Emergency Care	118
Hospitalization	59
Intra-System Transfers In	7
Intra-System Transfers Out	4
Outpatient Care	465
Specialized Medical Housing	141
Specialty Services	213
	1,229

Table B-4: SVSP Review Sample Summary

	Total
MD Reviews Detailed	25
MD Reviews Focused	1
RN Reviews Detailed	15
RN Reviews Focused	34
Total Reviews	75
Total Unique Cases	61
Overlapping Reviews (MD & RN)	14

APPENDIX C — COMPLIANCE SAMPLING METHODOLOGY

Salinas Valley State Prison (SVSP)

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

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Health Information Management (Medical Records)			
MIT 4.001	Timely Scanning (20)	OIG Qs: 1.001, 1.002, & 1.004	• Non-dictated documents • 1st 10 IPs MIT 1.001, 1st 5 IPs MITs 1.002, 1.004
MIT 4.002	(0)	OIG Q: 1.001	• Dictated documents • First 20 IPs selected
MIT 4.003	(20)	OIG Qs: 14.002 & 14.004	• Specialty documents • First 10 IPs for each question
MIT 4.004	(20)	OIG Q: 4.007	• Community hospital discharge documents • First 20 IPs selected
MIT 4.005	(18)	OIG Q: 7.001	• MARs • First 20 IPs selected
MIT 4.006	(13)	Documents for any tested inmate	• Any misfiled or mislabeled document identified during OIG compliance review (24 or more = No)
MIT 4.007	Returns From Community Hospital (25)	Inpatient claims data	• Date (2–8 months) • Most recent 6 months provided (within date range) • Rx count • Discharge date • **Randomize** (each month individually) • First 5 patients from each of the 6 months (if not 5 in a month, supplement from another, as needed)
Health Care Environment			
MIT 5.101–105 MIT 5.107–111	Clinical Areas (12)	OIG inspector onsite review	• Identify and inspect all onsite clinical areas.
Inter- and Intra-System Transfers			
MIT 6.001–003	Intra-System Transfers (25)	SOMS	• Arrival date (3–9 months) • Arrived from (another CDCR facility) • Rx count • **Randomize**
MIT 6.004	Specialty Services Send-Outs (20)	MedSATS	• Date of transfer (3–9 months) • **Randomize**
MIT 6.101	Transfers Out (6)	OIG inspector onsite review	• R&R IP transfers with medication

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Pharmacy and Medication Management			
MIT 7.001	Chronic Care Medication (25)	OIG Q: 1.001	*See* ***Access to Care*** • At least one condition per patient—any risk level • **Randomize**
MIT 7.002	New Medication Orders (25)	Master Registry	• Rx count • **Randomize** • Ensure no duplication of IPs tested in MIT 7.001
MIT 7.003	Returns from Community Hospital (25)	OIG Q: 4.007	• See ***Health Information Management (Medical Records)*** *(returns from community hospital)*
MIT 7.004	RC Arrivals – Medication Orders *N/A at this institution*	OIG Q: 12.001	• See ***Reception Center Arrivals***
MIT 7.005	Intra-Facility Moves (25)	MAPIP transfer data	• Date of transfer (2–8 months) • To location/from location (yard to yard and to/from ASU) • Remove any to/from MHCB • NA/DOT meds (and risk level) • **Randomize**
MIT 7.006	En Route (10)	SOMS	• Date of transfer (2–8 months) • Sending institution (another CDCR facility) • **Randomize** • NA/DOT meds
MITs 7.101–103	Medication Storage Areas (varies by test)	OIG inspector onsite review	• Identify and inspect clinical & med line areas that store medications
MITs 7.104–106	Medication Preparation and Administration Areas (varies by test)	OIG inspector onsite review	• Identify and inspect onsite clinical areas that prepare and administer medications
MITs 7.107–110	Pharmacy (1)	OIG inspector onsite review	• Identify & inspect all onsite pharmacies
MIT 7.111	Medication Error Reporting (25)	Monthly medication error reports	• All monthly statistic reports with Level 4 or higher • Select a total of 5 months
MIT 7.999	Isolation Unit KOP Medications (10)	Onsite active medication listing	• KOP rescue inhalers & nitroglycerin medications for IPs housed in isolation units
Prenatal and Post-Delivery Services			
MITs 8.001–007	Recent Deliveries *N/A at this institution*	OB Roster	• Delivery date (2–12 months) • **Most recent** deliveries (within date range)
	Pregnant Arrivals *N/A at this institution*	OB Roster	• Arrival date (2–12 months) • **Earliest** arrivals (within date range)

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Preventive Services			
MITs 9.001–002	TB Medications (15)	Maxor	• Dispense date (past 9 months) • Time period on TB meds (3 months or 12 weeks) • **Randomize**
MIT 9.003	TB Evaluation, Annual Screening (30)	SOMS	• Arrival date (at least 1 year prior to inspection) • Birth Month • **Randomize**
MIT 9.004	Influenza Vaccinations (25)	SOMS	• Arrival date (at least 1 year prior to inspection) • **Randomize** • Filter out IPs tested in MIT 9.008
MIT 9.005	Colorectal Cancer Screening (25)	SOMS	• Arrival date (at least 1 year prior to inspection) • Date of birth (51 or older) • **Randomize**
MIT 9.006	Mammogram *N/A at this institution*	SOMS	• Arrival date (at least 2 yrs prior to inspection) • Date of birth (age 52–74) • **Randomize**
MIT 9.007	Pap Smear *N/A at this institution*	SOMS	• Arrival date (at least three yrs prior to inspection) • Date of birth (age 24–53) • **Randomize**
MIT 9.008	Chronic Care Vaccinations (25)	OIG Q: 1.001	• Chronic care conditions (at least 1 condition per IP—any risk level) • **Randomize** • Condition must require vaccination(s)
MIT 9.009	Valley Fever (number will vary) *N/A at this institution*	Cocci transfer status report	• Reports from past 2–8 months • Institution • Ineligibility date (60 days prior to inspection date) • **All**

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

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Administrative Operations			
MIT 15.001	Medical Appeals (all)	Monthly medical appeals reports	• Medical appeals (12 months)
MIT 15.002	Adverse/Sentinel Events (1)	Adverse/sentinel events report	• Adverse/sentinel events (2–8 months)
MITs 15.003–004	QMC Meetings (6)	Quality Management Committee meeting minutes	• Meeting minutes (12 months)
MIT 15.005	EMRRC (12)	EMRRC meeting minutes	• Monthly meeting minutes (6 months)
MIT 15.006	LGB (4)	LGB meeting minutes	• Quarterly meeting minutes (12 months)
MIT 15.101	Medical Emergency Response Drills (3)	Onsite summary reports & documentation for ER drills	• Most recent full quarter • Each watch
MIT 15.102	2nd Level Medical Appeals (10)	Onsite list of appeals/closed appeals files	• Medical appeals denied (6 months)
MIT 15.103	Death Reports (10)	Institution-list of deaths in prior 12 months	• Most recent 10 deaths • Initial death reports
MIT 15.104	RN Review Evaluations (5)	Onsite supervisor periodic RN reviews	• RNs who worked in clinic or emergency setting six or more days in sampled month • **Randomize**
MIT 15.105	Nursing Staff Validations (10)	Onsite nursing education files	• On duty one or more years • Nurse administers medications • **Randomize**
MIT 15.106	Provider Annual Evaluation Packets (4)	Onsite provider evaluation files	• All required performance evaluation documents
MIT 15.107	Provider licenses (12)	Current provider listing (at start of inspection)	• Review all
MIT 15.108	Medical Emergency Response Certifications (all)	Onsite certification tracking logs	• All staff o Providers (ACLS) o Nursing (BLS/CPR) • Custody (CPR/BLS)
MIT 15.109	Nursing staff and Pharmacist in Charge Professional Licenses and Certifications (all)	Onsite tracking system, logs, or employee files	• All required licenses and certifications

Quality Indicator	Sample Category (number of samples)	Data Source	Filters
Administrative Operations			
MIT 15.110	Pharmacy and Providers' Drug Enforcement Agency (DEA) Registrations (all)	Onsite listing of provider DEA registration #s & pharmacy registration document	• All DEA registrations
MIT 15.111	Nursing Staff New Employee Orientations (all)	Nursing staff training logs	• New employees (hired within last 12 months) •
MIT 15.998	Death Review Committee (9)	OIG summary log - deaths	• Between 35 business days & 12 months prior • CCHCS death reviews

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES' RESPONSE

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October 25, 2017

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

Dear Mr. Wesley:

The purpose of this letter is to inform you that the Office of the Receiver has reviewed the draft report of the Office of the Inspector General (OIG) Medical Inspection Results for Salinas Valley State Prison (SVSP) conducted from April 2017 to July 2017. California Correctional Health Care Services (CCHCS) acknowledges the OIG findings.

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

Sincerely,

Janet Lewis

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

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